NHS
Humber
NHS Foundation Trust

Annual Report and Accounts

2016 - 2017

Caring, Learning and Growing

CONTENTS

Welcome from our Chairman and Chief Executive 5

Performance Report 7

A Statement from the Chief Executive 8
About the Trust 11
Vision, values and strategic aims 12
Development and performance 13
Principal risks and uncertainties 14

Performance analysis 16

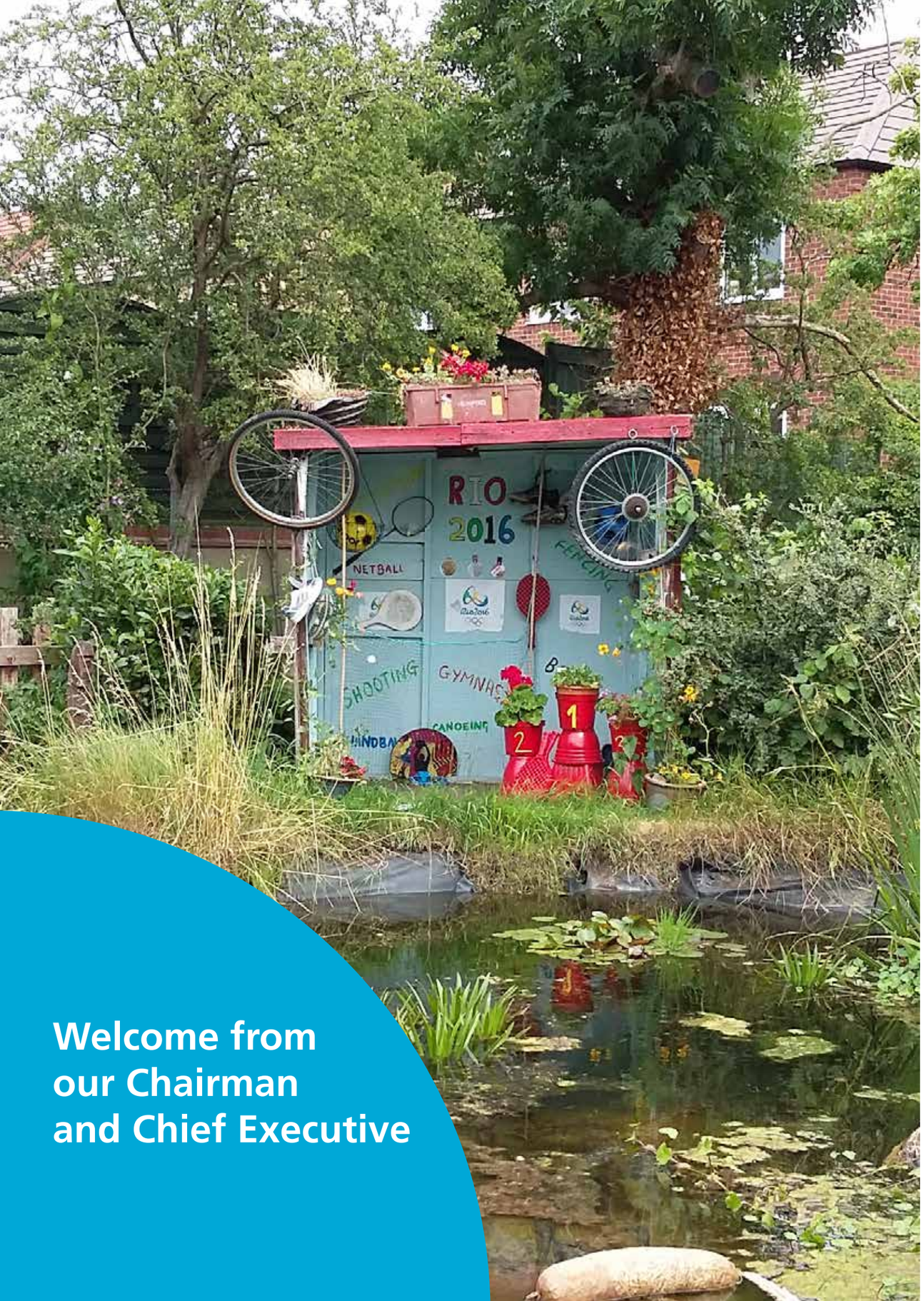
Summary of the financial year 17
Financial results 2015/16 17
Environmental Statement 22
Social, community and human rights issues 24

Accountability Report 25

Directors' Report 26
Remuneration Report 31
Staff Report 39
Code of Governance 48
Single Oversight Framework 68
Statement of accounting officer's responsibilities 69
Annual Governance Statement 70
Equality and diversity 84
Independent Auditor's Report to the Board of Governors and Board of Directors of Humber NHS Foundation Trust 87

2016/17 Audited Accounts 93

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



Welcome from our Chairman and Chief Executive

Chairman and Chief Executive's foreword

The pace of change in the NHS during the past year has been challenging, with providers under pressure to come up with new ways of delivering services focussed on prevention.

Despite facing a traditional problem – providing better services to more people, many with increasingly complex needs - with limited resources, here at Humber we have improved the quality of our services to such an extent that there is now a real sense of optimism about our future. Staff throughout the organisation feel we have embarked on an exciting new era of service transformation that will deliver further improvements.

The quality and safety of the care we deliver was assessed by the Care Quality Commission (CQC) in April 2016 and in August 2016 the Trust was rated overall as 'Requires Improvement' – with 'good' for 'caring'. The report praised the 'positive interaction between staff and patients'. It added: "We saw that patients were treated with kindness, dignity and respect, and were supported. Staff were committed to their roles and compassionate about the patients they were caring for." The CQC revisited the Trust in December 2016 and lifted the warning notices noting the improvements that had been made.

Once again, this year, the passion and dedication of our staff has been outstanding. They continue to rise to the challenge of an ever-changing landscape, demonstrating their commitment, care, competence and compassion every single day. The success of the organisation, the quality of our services and the satisfaction of our service users is entirely down to our staff and their personal and professional commitment.

Our community services in East Riding transferred to a new non-NHS provider on 1st April 2017 following a competitive tender during 2016. We were extremely disappointed to lose these services and the staff who provided them because we submitted a good, solid bid. The bid was our most successful ever in terms of overall score, and our community services in East Riding had been rated 'good' by the CQC following a previous assessment process.

Despite the difficulties we faced during the year, our hard-working, loyal and dedicated staff - our greatest asset - have tackled them magnificently, working effectively and responding quickly to meet the CQC's requirements and complete the safe transfer of our community services in East Riding while continuing to improve services.

We continue to provide community services in Whitby and Pocklington. We have also been able to progress the many new opportunities which have presented themselves throughout the year.

Consequently, our expansion into primary care continues at a pace, with the Trust now responsible for the delivery of primary care services at a growing number of GP practices – a great asset.

We have also introduced a single point of access and rapid response service for people suffering mental ill health and preparations to open a new 'Crisis Pad' for those requiring urgent help were delivered on 6th April 2017.

The Trust has retained and redesigned its '0-19' service and our learning disability services have won multiple awards.

We exceeded our target for recruiting patients to research trials and are among the small number of trusts to have balanced our books and achieved a financial surplus.

The Trust has introduced addictions services in East Riding and gained national recognition for our involvement in 'Strokestra', an initiative which proved that music can aid the recovery of people who have had strokes.

In 2016 we developed our new strategy in preparation for its launch in the new year. We also developed our mission, vision and values – caring, learning and growing: the keystones on which all of our efforts are built.

Increasingly, and despite the challenges of the past 12 months, there is a sense that the Trust is moving forward. The rapid pace of internal change and relentless drive for improvement is being led by our new Chief Executive, who brings more than 30 years' experience to the role.

In line with the national recruitment picture, we have during the year, experienced recruitment and retention challenges. We have however developed a Recruitment and Retention Strategy and an overarching Workforce and Organisational Development Strategy to enable us to have the right staff numbers and skills at the right time.

Patients have remained at the centre of everything we have done and our staff have regularly gone beyond the call of duty to provide them with outstanding care.

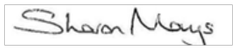
The compassion, competence and courage shown by our staff throughout the year have been inspirational, and we would like to formally record our thanks to them for everything they have done. As we indicated earlier, staff are the Trust and the success of the organisation is driven entirely by our staff and their personal and professional integrity. Staff roles require constant juggling and prioritisation of tasks, but they achieve this, and much more, with great skill.

In accordance with the Trust's mission and vision, staff are driving our determination to work more smartly, to integrate services and avoid duplication, and to make them better and more effective.

Our staff are playing a key role in the Humber Coast and Vale Sustainability and Transformation Plan, a blueprint which envisages a radical overhaul of local health services.

This plan must succeed if we and our colleagues in the public, private and voluntary sectors are to meet the healthcare demands of the future.

We can assure you that in everything we do, excellence will continue to be our goal.



SHARON MAYS

Chairman

MICHELE MORAN

Chief Executive

Performance Report

The purpose of the Performance Report is to provide information on Trust services, its vision, values and strategic aims. It also provides information on our development, performance and principal risks to our objectives during 2016/17.

A statement from the Chief Executive

The Trust has faced significant challenges during the past 12 months but continues to develop and rise to the challenges.

Care Quality Commission (CQC) inspectors rated the quality and safety of our care in April 2016 as 'requiring improvement' - despite rating us 'good' for caring. The CQC has since acknowledged the improvements we have made to our services by withdrawing all of our warning notices.

Another challenge we faced was the awarding of our contract to provide community services in East Riding to a non-NHS provider. However, we successfully ensured the safe transfer of services – and more than 500 staff – to the new provider.

And despite the unprecedented pressure on our services, we have maintained a sustainable business capable of meeting the healthcare challenges of the future. Apart from delivering more than £4 million of cost savings, we are one of the few trusts to have balanced our books and reported a surplus. As a consequence, our financial risk rating remains 'good'.

As a provider of mental health, community, GP and specialist services, we are accountable to our service users and commissioners. These include NHS England, NHS Hull CCG, NHS East Riding CCG, and NHS Hambleton, Richmondshire and Whitby CCG. It is their responsibility to design, develop and buy health services for the people who live in their areas.

The Trust regularly provides information about our performance to our commissioners and engages with them by taking part in monthly contract management and sub-group meetings. These sessions focus on quality, service development and finance.

We have worked closely with our commissioners to expand our involvement in primary care, establish a 'Crisis Pad' for people suffering intense emotional distress, and to overhaul our 0-19 learning disability services in the East Riding. A section on the Trust's most notable achievements during the year is included in this report.

Changes have also been made to the Trust's Executive Management Team with the appointment of a new Chief Executive and Director of Finance. The Trust is planning to streamline its organisational structure and we have overhauled the Trust's strategy, mission, vision and values following consultation with staff, governors, members and partners.

The Trust's strategic goals 2016/17 are: innovating in quality and patient safety; enhancing prevention, wellbeing and recovery; fostering integration, partnership and alliances; developing an effective and empowered workforce; maximising an efficient and sustainable organisation; and promoting people, communities and social values.

Our mission is to be a 'multi-specialty healthcare and teaching provider committed to caring, learning and growing' – our three values. The Trust's vision is to be 'a leading provider of integrated health services, recognised for the care, compassion and commitment of our staff and known as a great employer and a valued partner'.

As for the quality of our staff and services, I regularly receive letters of praise and read patient experience feedback from the Friends and Family Test. A selection of these fantastic comments is included opposite:

The care and individual care package I received was second to none.

Anything I needed I only had to phone and also my wife who is my Carer was always informed about my needs or her needs and support.

Stroke Service – ER

Our nurse showed great knowledge and care. She turned my life around. As a family we are all grateful for her care.

Whitby Cardiac Specialist Nurses

We are very impressed with the speedy and caring way we have been dealt with. The whole team have been incredibly supportive.

CAMHS - Crisis Team

Having Cognitive Behavioural Therapy changed my life. I recommend it to friends and also via my work in the police. I am now happy in a way I never thought possible and have the tools to deal with bad days.

Psychological Wellbeing Service - Hull – East

After struggling most of my life with depression and anxiety the service has helped me understand why and control my symptoms. Now I feel I can put the past behind me, no longer live in such fear and face the future one day at a time and 'be myself'.

Haltemprice Mental Health Team

The care and help we have received has been amazing, I cannot thank them enough for what they have done for us, mainly for me for suffering Post Natal Depression. Thank you soooo much!

Driffield Health Visitors

Our Friends and Family test results show that 99.5% of respondents find our staff friendly and helpful; 99.3% believe they receive sufficient information; and that 98.8% feel they are involved as much as they want to be in their care. The targets for all three categories is 90% and we have significantly overachieved in these areas.

There are many outstanding successes I could mention, but I will restrict myself to a handful, including:

Strokestra; this pioneering project between our Hull Integrated Community Stroke Service (HICSS) and the Royal Philharmonic Orchestra (RPO) established that creative music-making can be used to support the rehabilitation of stroke patients. The initiative gained national media attention.

Research and Development; the team are leading innovative work and will continue developing our capacity to ensure we progress further as an effective teaching trust. Our reputation for research continues to grow, and we have exceeded our target for recruiting patients to studies by some distance.

Humber Recovery College takes an educational, rather than a clinical or therapeutic, approach to improving mental health. Professionals and students work together to plan, deliver and take part in courses with the aim of helping students recognise their own resourcefulness, talents and abilities, and equip them with the knowledge and tools so they can become experts in their own care. The emphasis is on hope, control and opportunity. Our college is the only one in the Humber Coast and Vale Sustainability and Transformation Plan footprint and is central to our plans.

Crisis Pad – this was identified as a key priority by the Trust and its partners in the Hull and East Riding Mental Health Crisis Concordat. The service

was developed in year and officially opened on 6th April 2017. The service provides a safe, calm and welcoming environment to support people in acute emotional distress.

Assisted by our Rapid Response Service, our charity provider, Humbercare, helps patients solve their own problems, manage their mental health and reduce their risk of self-harm.

The Trust is continuing to forge strong working relationships with our partners in health and social care. One of many forums for this work is the Humber Coast and Vale Sustainability and Transformation Plan (HCVSTP).

If we and our partners in the local health economy are to succeed with our vision to transform health and social care services so they can meet the challenges of the future, this plan must succeed. Although much has been achieved, there is a great deal to be done, not least in ensuring the public play a full role in shaping our proposals.

But our focus is not only outwards but inwards, too. Our staff are our greatest asset and we know that we must invest in their skills if they are to deliver the excellent care our patients and regulators want and deserve. We have launched a new staff charter founded on our new values of caring, learning and growing, as well as a personal responsibility framework. The Trust is also complementing these initiatives by doing what it can to promote staff health and wellbeing.

Although recruitment and retention remains an issue, just as it is in many parts of the NHS, we are trying to devise imaginative means of ensuring we attract the staff we need. The Trust is also committed to speeding up the time it takes to get new recruits in place.

There is still much work to be done to ensure Humber is regarded by our staff as a great place to work. While some of our staff survey results were encouraging, we must do more to safeguard the interests of our staff. Listening to, supporting, nurturing, advising and leading – our managers must do all this and more.

We are committed to investing in leadership and training for all of our staff, and I am pleased to report that at the end of March 2017, overall training compliance was running at 86.8%, above the 75% target.

Overall, I would judge our performance in the past 12 months to be good, especially given the pressure on services and budgets. Critically, and in the face of immense challenges, we are improving.

Our task in 2017-18 and beyond is to ensure this upward trajectory continues.

MICHELE MORAN

Chief Executive

26 MAY 2017

About our Trust

Humber NHS Foundation Trust provides a wide range of health and social care services including acute and forensic inpatient mental health services, community mental health services, Child and Adolescent Mental Health Services (CAMHS), community services, substance misuse and learning disability services. The Trust serves patients across a large geographical area that includes Hull, the East Riding of Yorkshire and North Yorkshire and provides specialist mental health services to people from across the UK.

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 2,500 staff across more than 70 sites at locations throughout the East Riding, Hull and Whitby.

We became a foundation trust seven years ago. We acquired community health services from NHS East Riding of Yorkshire in April 2011. Prior to this (since October 1994), Humber Mental Health Teaching NHS Trust delivered mental health, learning disabilities and addictions services to people in Hull and the East Riding.

Our income in 2016/17 was £143m, 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
- bladder and bowel specialist care
- child and adolescent mental health
- children's, including speech and language therapy, physiotherapy and school nursing
- chronic fatigue - a multi-disciplinary service for adult patients with a diagnosis of Chronic Fatigue Syndrome
- counselling
- diabetes
- drug and alcohol
- 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
- healthy lifestyle support through our award-winning Health Trainers
- Huntington's disease team
- inpatient and community mental health for working-age adults and older people
- intermediate care
- learning disability community and inpatient
- long-term conditions
- Macmillan nurses
- nutrition and dietetics
- out-of-hours and unscheduled care
- pain management
- palliative care
- perinatal mental health
- physiotherapy
- podiatry
- psychiatric liaison
- psychological interventions
- psychotherapy
- stroke
- therapy (physiotherapy, speech and language)
- tissue viability
- traumatic stress

Further information about services and referral pathways can be found on our website at 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 community and mental health services receive a wide range of care and therapeutic treatments in a variety of settings including their own homes, GP practices and health centres, outpatient clinics, hospitals, local authority premises and our inpatient units. More specialised care is provided by the psychiatric intensive care unit and forensic services.

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.

Vision, values and strategic aims 2017 - 2020

Our Vision

We aim to be a leading provider of integrated health services, recognised for the care, compassion and commitment of our staff and known as a great employer and valued partner.

Our Values and what they mean

Caring for people while ensuring they are always at the heart of everything we do.

Learning and using proven research as a basis for delivering safe, effective, integrated care.

Growing our reputation for being a provider of high quality services and a great place to work.

Our Strategic Goals

- Innovating quality and patient safety
- Enhancing prevention, wellbeing and recovery
- Fostering integration, partnership and alliances
- Developing an effective and empowered workforce
- Maximising an efficient and sustainable organisation
- Promoting people, communities and social values

Development and Performance

Our performance management framework tracks progress against key performance indicators. This is based our strategic goals and is shared with our Board on a monthly basis. Added to this is a risk register which reports 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, our 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. The purpose of this is to ensure involvement of staff at all levels in understanding and influencing performance in their areas of responsibility.

Celebrating success

The inspiring and innovative work our staff do across the Trust every day to improve the lives of our patients and service users was celebrated at our annual Staff Awards on 1 December 2016 at Willerby Manor Hotel.

This year, we had 11 categories that staff could nominate themselves or a colleague for. We also had the Patient Choice Award which gave patients, their families and carers a chance to nominate a member of our staff or team who has gone the extra mile to provide outstanding care.

Our staff awards winners were:

- **Team of the Year - Mental Health Services**
  New Bridges Inpatient Unit – Occupational Therapy and Activity and Clinical Team
- **Team of the Year - Children's and Learning Disability Services**
  Granville Court
- **Team of the Year - Specialist Services**
  Humber Centre Mural Painting Team
- **Team of the Year - Community and Older People's Mental Health Services**
  East Riding Community Respiratory Team
- **Team of the Year - Corporate Services**
  Voluntary Services
- **Innovation and Progress**
  Hull and East Riding Child and Adolescent Mental Health Services
- **Improving Patient Dignity and Respect and Safety - sponsored by Scamp Security**
  Jacob Penkethman – Homeless Foot Clinic Service
- **Working in Partnership with other Agencies - sponsored by Clark Weightman**
  Pocklington Health and Social Care Hub
- **Delivering Compassionate Care**
  Huntington's Disease Team
- **Rising Star - sponsored by Citycare**
  Dr Jade Smith
- **Outstanding Team of the Year**
  Granville Court
- **Patient Choice Award**
  East Riding Pulmonary Rehabilitation Team

In addition, there was also the Chairman's Award which was awarded to Steve Taylor, Information Officer, and Karl Tamminen, Clinical Specialist in Forensic Art Therapy, for their vision, ambition, drive and commitment to create a mural in our Humber Centre to mark its 20th anniversary. The mural was created in a connecting part of the Humber Centre called The Street, largely due the facilities based along it, such as the laundry, canteen and shop.

This year our event was sponsored by Konica Minolta, along with Citycare, Clark Weightman and Scamp Security who sponsored an award.

Principal Risks and Uncertainties

The risks outlined below have been identified as the principal risks to the delivery of the Trust's key objectives.

More detail regarding the risks to which the Trust has been exposed in 2016/17 is included in full within the table in the Annual Governance Statement on page 70.

Quality and Patient Safety

- Risk of inappropriate management and escalation of safer staffing concerns.
- Risk of not safeguarding vulnerable children and adults in line with statutory duties.
- Ensuring a robust approach to clinical policy development, review and implementation.
- Having a rigorous approach to mortality governance and learning from unexpected deaths across our services.
- Develop processes that demonstrate organisational learning from Serious Incidents, Serious Event Analyses and adverse incidents.
- Compliance with the Mental Health Act (MHA) and the Mental Capacity Act (MCA)/ Deprivation of Liberty Safeguards (DOLS).
- Maximisation of research and development programmes, due to staff not referring patients into research studies.
- Failure of Integrated Governance processes which could lead to poor performance ratings, registration failures and/or damage the Trust in relation to commissioners, regulators and the public.

Prevention, Wellbeing and Recovery

- Equipping patients and carers with skills and knowledge needed via social prescribing.
- Failure to meet early intervention targets (national – Improving Access to Psychological Therapies [IAPT], Early Intervention in Psychosis [EIP], Dementia).
- Failure to meet early intervention targets (local – Child and Adolescent Mental Health Services [CAMHS], Autism Spectrum Disorder [ASD], Children and Young People [CYP]).
- Ensuring the right level of physical healthcare support and that there is a cohesive alignment of mental health and physical health services to get parity of esteem.

Integration, Partnerships and Alliances

- Lack of involvement in Sustainability and Transformation Plans or Patient Led Assessment of the Care Environment (PLACE) plans.
- The Trust does not achieve the informatics strategy due to lack of funding and specialist resources required.
- Utlising evidence-based practice to inform and influence business decisions, resulting in the delivery of outdated service models, an inability to effectively compete with other providers and a subsequent loss of business/income and reputation.
- There is a risk to future sustainability and reputation, arising from a failure to compete effectively and build excellent relationships with partners and stakeholders via partnership working, and all communications and marketing activities.

Effective and Empowered Workforce

- Current CQUINs targets for Health and Wellbeing in place and possibility that lack of current capacity and focus may result in these not being achieved.
- Failure to recruit and retain appropriately qualified, skilled and experienced workforce will directly impact on the Trust's ability to meet its objectives.
- Failure to achieve compliance with statutory and mandatory training could result in staff not having the right skills and competencies required to ensure safe care to patients and safety within the environment.
- Failure to implement the Trust's Workforce Plan and Strategy may result in an inability to achieve the changes to culture and reputation which are aspired to by the organisation.

Efficient and Sustainable Organisation

- There is a risk to future sustainability and reputation arising from a failure to compete effectively because we have not maintained and developed strategic alliances and partnerships and not increased our commercial/ market understanding.
- Failure of Integrated Governance processes.
- Adverse impact of inadequate IT systems, failing to effectively support management decisions, performance management or contract compliance.
- Failure to complete appropriate clinical assessment information due to multiple recording processes and systems.
- Trust is unable to agree 2017/18 and 2018/19 contract with commissioners within agreed national timescales.
- Trust is unable to contain Agency Expenditure within its target ceiling from NHS Improvement, the consequence of which would impact on the Trust's Use of Resources score.
- Failure to achieve the organisation's Cost Improvement Programme, control total, and required NHS Improvement Use of Resources score for 2016/17.
- Failure to address all risks identified as part of the capital application process due to lack of capital resource.
- Failure to improve the overall condition and efficiency of our estate.

People, Communities and Social Values

- Fail to support and deliver social values initiatives that have a positive impact and reduce reliance on our services.
- Failure to meet our targets to reduce our carbon footprint.
- Failure to deliver services that improve the lives of those within our commissioned area.

The principal risks to the achievement of strategic goals are managed through the Board Assurance Framework which is reviewed on a monthly basis by the Executive Management Team. The framework is presented to the Trust Board and Audit Committee on a quarterly basis for assurance and oversight.

Going Concern

The 2016/17 accounts have been prepared on a going concern basis. Going concern is a fundamental accounting concept underpinning the preparation of accounts whereby organisations are viewed as having sufficient resources to continue in operational existence for the foreseeable future. Assets and liabilities are consequently recorded on the basis that the organisation will be able to realise its assets and discharge its liabilities in the normal course of business.

The Board have assessed the going concern status in regards to the loss of the community services contract and assessed that it will have no impact on the organisations status.

Performance Analysis

Summary of the Financial Year

We are reporting an operating surplus of £0.407m for the year, bolstered by the receipt of national Sustainability and Transformation Funding, on income of £143m. After finance costs, we have recorded a £1.8m deficit.

Performance against our NHS Improvement target (Control Total) was a £0.8m surplus, against a planned deficit of £0.4m, this performance enabled the receipt of Sustainability and Transformation funding which supported the overall financial position for the Trust.

Operationally, it has been a challenge to deliver this result. There remains a level of underachievement against our efficiency programme, with the result that we have continued to consider non-recurrent savings, which although successful, do not impact beneficially on subsequent years' financial plans. £4m of cost efficiencies were generated, which enabled us to come close to delivering our financial targets for 2016/17.

Income received to deliver core services increased by 1.1% in 2016/17. The Trust gained additional income from new contracts for community services in Whitby and from the acquisition of three GP surgeries in the area.

The closing cash balance decreased to £9.9m in the year due to operational and capital expenditure; this is expected to rise above £10m in the early part of 2017/18, when a number of outstanding receipts will be paid.

Our total capital spend in the year was £3.8m. Schemes included expenditure on the rolling programme of IT equipment replacement, a number of ligature-risk reduction projects across the estate and the purchase of GP premises.

We have an expected year-end financial risk rating of 2. This is primarily based on our continuing strong liquidity. Ratings are assessed between 1 and 4, with 1 reflecting the strongest performance.

Financial results 2016/17 – Headlines

- Income of £143m, an increase of £13.6m
- Deficit of £1.8m after other adjustments
- Operating surplus of £0.407m
- Closing cash balance of £9.9m (£15.1m at 31 March 2016)
- Net current assets of £6.9m (£6.6m at 31 March 2016)
- Total net assets of £70.9m (£67.8m at 31 March 2016)

Income and expenditure

Income in the period was £143m, including an increase in income from commissioners of 1.1% compared to £129.5m in the prior year. The majority of other additional income received, £6.1m, was due to the Trust commencing service delivery under the Whitby community services contract. Further additional income was received in relation to GP surgeries and from social care services for Kingston upon Hull City Council.

Expenditure has increased due to costs associated with the new services and cost pressures through temporary staffing; but overall for 2016/17 the Trust achieved an operating surplus of £0.803m against the NHS Improvement control total.

Capital Expenditure

Capital expenditure totalled £3.4m during the year, and there was a receipt of a donated asset to the value of £0.4m. Principal expenditure items included IT infrastructure projects, programmed replacement of IT equipment, estate projects including ligature-risk reduction works in our mental health units and the purchase of GP premises. Other capital expenditure covered a range of projects and facilities, including addressing backlog maintenance issues.

During 2016/17 we commissioned a comprehensive revaluation of the Trust's estate, conducted by District Valuer Services. Whilst this revaluation and in-year expenditure added to the value of our assets, under government accounting policy a review of the estate using the modern equivalent

asset basis resulted in a significant impairment charge (£2.9m) to the Income and Expenditure account. The overall net value of Property, Plant and Equipment for the Trust increased in the year by £2.3m.

Management costs

Management costs for the year amounted to £8.3m, which equates to 5.74% of income. This shows a small increase in value and decrease in the percentage of total costs when compared to the previous year.

Details of directors' remuneration are provided on pages 31-37.

Better payments practice code

In accordance with the Confederation of British Industry's (CBI) Better Payment Practice Code, our policy is to pay non-NHS trade creditors within 30 days of receipt of goods or services, or of a valid invoice (whichever is the later), unless other payment terms have been agreed with the supplier. The figures for NHS creditors by value paid within 30 days rose from 95% to 97%, while the number of invoices paid reduced slightly to 94%. We will continue to focus on this important performance measure.

	2016/17		2015/16	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	34,460	57,785	27,140	25,363
Total non-NHS trade invoices paid within target	32,998	52,837	26,705	24,913
Percentage of non-NHS trade invoices paid within target	96%	91%	98%	98%
Total NHS trade invoices paid in the year	575	2,304	340	2,594
Total NHS trade invoices paid within target	538	2,377	322	2,483
Percentage of NHS trade invoices paid within target	94%	97%	95%	95%

Financial Outlook

We have responded well to the financial challenges faced by the Trust, and by the wider NHS, over the last three years in particular, with over £11.3m of cost-efficiency savings generated in that period.

The outcome of the re-procurement by NHS East Riding CCG of community services was announced in November 2016, with the Trust unsuccessful in retaining the contract. The directors have reappraised the Trust's structure, operating costs and future financial viability and are satisfied with the actions and plans established in response. Although Trust income will reduce in 2017/18 due to the loss of that contract, other significant areas of growth include;

- Successful acquisition of two GP practices (income £1.5m)
- Successful tender outcome for Granville Court Learning Disability Services (increased income £1.0m)
- Further income opportunities exist for the Trust, which include:
- Further acquisition of GP practices
- CAMHS Tier 4 services

The Trust, however, operates in an environment of rising costs, increased expectations and increasing demand, all of which adds to the financial challenges we face. Efficiency savings will continue to be required for the foreseeable future. Coupled with the effect of cost inflation, this has placed increasing emphasis on the need to pursue financial efficiencies throughout the organisation.

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 continued careful financial management to remain in a healthy financial position. Staff at all levels are encouraged to identify savings opportunities and a series of workshops held in the year to consider suggestions will be repeated in 2017/18.

Medium-term plans demonstrate the need to deliver further cost improvements over the next four-five years. Given the savings already achieved, the challenge to identify additional savings increases. We continue to operate a robust process for identifying and implementing cost savings projects, which are approved by both the Medical Director and the Director of Nursing to avoid negative impacts on patient safety or quality of care.

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

We continue to perform well against our Commissioning for Quality and Innovation (CQUIN) framework, with a high level of achievement of these indicators in 2016/17. Focus on these indicators in 2017/18 will not be relaxed in order to ensure this level of income remains in place.

Performance Analysis

How Performance is measured

The Trust has an Integrated Performance Tracker which reports performance against identified key performance indicators to the Board on a monthly basis. Indicators reported to the Board are based around both the Monitor Risk Assurance Framework (Access and Outcomes Measures) and the Care Quality Commission's Intelligent Monitoring Framework (Caring, Effective, Safe, Responsive and Well Led).

Performance during the year

Performance to the end of March 2017 for the NHS Improvement Assurance Framework is summarised in the table below:

Indicator Definition	Threshold / Target	Current month RAG Definition	Frequency	Quarter 1 Q1	Quarter 2 Q2	Quarter 3 Q3	Quarter 4 Q4	YTD
Referral to Treatment - Non Admitted 18 weeks (Alfred Bean only)	90.0%	✓	Good	Mthly	97.6%	97.8%	98.1%	96.9%	97.6%
Referral to Treatment - Incomplete 18 Weeks (Alfred Bean only)	92.0%	✓	Good	Mthly	98.6%	98.7%	98.9%	99.1%	98.8%
Total Time In A&E - spent waiting less than 4 hours	95.0%	✓	Good	Mthly	99.9%	99.9%	99.9%	99.9%	99.9%
Care Programme Approach (CPA) Formal Review within 12 months	95.0%	✓	Good	Mthly	95.4%	96.1%	95.4%	95.3%	95.4%
Admissions to Inpatients services - Access via Crisis (gate-keeping)	95.0%	✓	Good	Mthly	99.5%	100.0%	100.0%	100.0%	99.9%
Early Intervention In Psychosis (EIP) - First episode treated within 2 weeks	50.0%	✓	Good	Mthly	50.0%	95.2%	91.4%	80.0%	77.0%
Improved Access to Psychological Therapies (IAPT) - Treated in 6 weeks of referral	75.0%	✓	Good	Mthly	89.5%	94.4%	97.6%	95.7%	94.4%

continued...

Improved Access to Psychological Theraples (IAPT) - Treated in 18 weeks of referral	95.0%	✓	Good	Mthly	99.3%	99.4%	99.8%	100.0%	99.6%
Care Programme Approach (CPA) Follow Up within 7 days of discharge	95.0%	✓	Good	Mthly	97.6%	98.4%	96.6%	98.0%	97.6%
Clostridium Difficile Objective - Humber	4	✓	Good	Mthly	2	0	0	0	2
Clostridium Difficile Objective - Whitby	4	✓	Good	Mthly	0	0	0	0	0
Minimising Mental Health Delayed Transfers of Care - As at Month End	7.5%	✓	Good	Mthly	3.1%	3.4%	4.6%	6.5%	4.3%
Mental Health Data Completeness - Identifiers (as at month end)	97.0%	✓	Good	Mthly	99.7%	99.7%	99.7%	99.7%	99.7%
Mental Health Data Completeness - Outcomes (as at month end)	50.0%	✓	Good	Mthly	87.4%	86.7%	87.8%	82.8%	86.2%
Certification against Compliance - Access to healthcare for people with Learning Disability	Y/N	✓	Good	Qtrly	met	met	met	met	See Qtr end result
Community Services Data Completeness - Referral to treatment information	50.0%	✓	Good	Qtrly	100.0%	100.0%	100.0%	100.0%	See Qtr end result
Community Services Data Completeness - Referral to treatment	50.0%	✓	Good	Qtrly	66.0%	66.0%	66.0%	66.0%	See Qtr end result
Community Services Data Completeness - Treatment activity information	50.0%	✓	Good	Qtrly	75.0%	75.0%	75.0%	75.0%	See Qtr end result

Performance against the CQC Intelligent Monitoring Framework:

Indicators	All KPI Assurance Levels : Caring			
	Total Assurance	Limited Assurance	No Assurance	Being Developed
Total Entries **11**	**10**	**0**	**1**	**0**
Period Ending:			March 2017	
Quarter Ending:			Q4	

Indicators	All KPI Assurance Levels : Safe			
	Total Assurance	Limited Assurance	No Assurance	Being Developed
Total Entries **6**	**5**	**0**	**1**	**0**
Period Ending:			March 2017	
Quarter Ending:			Q4	

Indicators	All KPI Assurance Levels : Well Led			
	Total Assurance	Limited Assurance	No Assurance	Being Developed
Total Entries **19**	**14**	**2**	**3**	**0**
Period Ending:			March 2017	
Quarter Ending:			Q4	

Indicators	All KPI Assurance Levels : Effectiveness			
	Total Assurance	Limited Assurance	No Assurance	Being Developed
Total Entries **12**	**5**	**1**	**6**	**0**
Period Ending:			March 2017	
Quarter Ending:			Q4	

Indicators	All KPI Assurance Levels : Responsive			
	Total Assurance	Limited Assurance	No Assurance	Being Developed
Total Entries **8**	**4**	**3**	**1**	**0**
Period Ending:			March 2017	
Quarter Ending:			Q4	

Environmental Statement

Sustainability

Sustainability and embedding sustainable development from the top down within the organisation has been the fundamental goal for the Environmental Manager this year. After introducing the Board-approved Sustainable Development Management Plan (SDMP) and Sustainable Development Action Plan (SDAP) the Trust has devised a strategy for monitoring developments into the future.

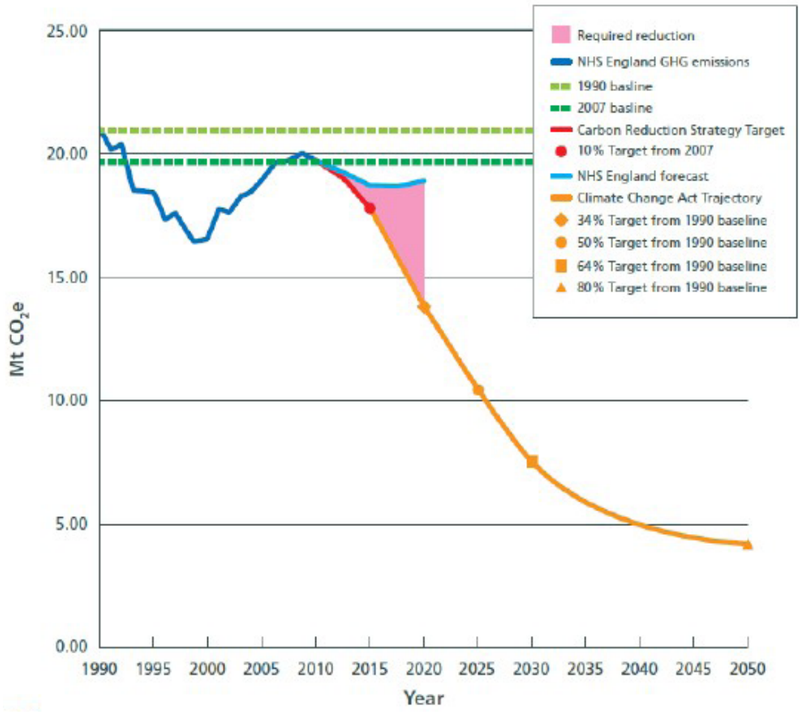
In 2016/17 the challenges facing NHS organisations through financial austerity and cuts has made an already difficult task much more problematic. Although the Trust has had these restrictions, we have adapted and shown we can still perform and focus on our impact on the environment and change and evolve into an organisation focussed on the future.

The driving force behind the reduction of all trusts' energy consumption are the guidelines set by the Government's (Sustainability Development Unit [SDU] Sustainability Strategy 2015) which outlines that all trusts must reduce their carbon footprint by 10% by 2015/16 and 34% by 2020, based on 2007 levels. The NHS has been set a target to reduce its emissions by 80% by 2050. As a Trust we are committed to helping to get to this target by looking at innovative ways of reducing our own emissions. This could be new technologies and behavioural change across our organisation.

The graph below shows the progress the NHS is making as a whole. This is the 2017 forecast supplied by the SDU.

You can download a copy of our Sustainable Development Management Plan from our Trust website.

Summary of Progress - NHS as a whole



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 the Trust's environmental performance and collaborate with the SDAP Sustainability Development Action Plan monitoring and targeting areas for improvement. Our current score is 47%.

One of the overarching successes for this year has been the introduction of the WARP-IT reuse software, which allows staff to exchange unwanted office items with other staff in the Trust. We have committed to using the software for three years from the 1 February 2017.

When we launched Warp-It on 1 February we gave ourselves a savings target of £21,000 in the first year. The new system has proved popular with staff and as of 25 April 2017 we have already saved a total of £15,925 and 7 CO2 (Ton).

Electric vehicles (EV) are increasing not only in the organisation but across the UK. With the rise of the electric vehicle, the Trust has installed a number of EV posts for staff to use and charge their vehicles at work. Through projects driven by development, we hope to increase the number EV posts across the Trust, helping to further reduce the Trust's impact on air pollution and the environment. Energy used by the new fleet of vehicles, including the two Estates full electric vehicles, has equated to 8,978 kWh saving 5,028 CO2 (Ton) going into the atmosphere.

Another large initiative we started this year was the 'TRUST IN GREEN' campaign. The aim of the campaign is to change the behaviour of staff towards energy conservation through education and support from the Trust. One of the main parts of the campaign is to change staff behaviour towards energy conservation and introduce a network of Green Champions made up of staff that will lead by example in the workplace. It's important to embed this message across the organisation through social media, poster campaigns and training.

TRUST IN GREEN

Utilities and energy

The Trust has joined other members of the Northern and Yorkshire Energy and Environment Group NYEEG who are establishing a northern framework to give NHS Trusts greater buying power and a more confident service with regards to energy procurement. The Trust will be using Inenco as our consultant and will be going into the contract with great optimism for the future.

Although there are going to be large increases in gas and electricity charges over the coming months and years, we will be working with our partners to look at ways of reducing our energy consumption and getting the best value for money available.

During 2016/17 we increased our gas and electricity usage by 1% (53320 kWh). However, even though we increased our usage the cost was less due to the low price of oil per barrel and gas during this period offsetting the p/pkWh on net average of 1.18 p/pkWh. As the non-commodity prices on our electric bill are set to soar this year, we have already seen an increase of 12% on the climate change levy (CCL). In 2017 the non-energy commodity costs are projected to rise substantially and the Trust will see an increase of 26% and 3% respectively. This is due to strong demand and tight supplies.

Gas costs have been at an all-time low during 2016/17. This is due to the low price of a barrel of oil and an increase in the supply of Liquefied Natural Gas (LNG) - the Trust has really benefitted from this over the past year. We have also seen a 10% drop in consumption due to better management of our gas systems and installation of new high-efficiency boilers and a 42% drop in cost. Unfortunately, this will not be the same next year as prices are on the up. CCL was down by 3%.

Water costs have been steady with no increase on last year. There is a real buzz around the deregulation of the water industry which happened

on 1 April 2017, making the water market more competitive for organisations. The Trust will be looking at its procurement of water over the coming months. Over the past year there has been a drop in water consumption of 25%, which in part reflects actions taken by the Trust to address known issues; this has led to a 23% difference in total spending across the Trust.

Social Community and Human Rights

We have developed a Public Patient and Carer Equality Strategy which sets out our commitment of how we plan to meet the needs and wishes of local people and our staff, and meet the duties and requirements of the Equality Act 2010 and the national NHS Equality Delivery System (EDS).

It also sets out how we recognise the differences between people, and how we aim to make sure that (as far as possible) any gaps and inequalities are identified and addressed.

The following principles underpin our work:

- Support and respect for everyone's human rights as a fundamental basis for our work with people
- Identifying and removing barriers that prevent the people we serve from being treated equally
- Treating all people as individuals, respecting and valuing their own experiences and needs
- Finding creative, sustainable ways of supporting human rights, improving equality and increasing diversity
- Working with the people who use our services, their carers and staff towards achieving equality
- Learning from what we do – both from what we do well and from where we can improve
- Using everyday language in our work
- Working together to tackle barriers to equality across our organisation.

We have an Equality, Diversity and Human Rights Policy in respect of our employment. The effectiveness of these policies is routinely monitored through incidents and other events to ensure that none of our services adversely affect any one section of the communities we serve, or any one of the protected characteristics.

Conclusion

We delivered our expected financial performance last year despite national efficiency requirements being applied and the loss of income from some commissioned services with effect from 1 April 2017. This was a positive achievement given that it was the fifth successive year of pressures on the level of income, and the difficulties in identifying further cost improvements. As ever, it was very much a team effort across the whole organisation to deliver this financial performance, without compromising patient care. We achieved the majority of our performance targets for the year.

In conclusion, it is appropriate to reaffirm the comments made last year. We will continue to face financial challenges both in 2017/18 and beyond, but we remain positive that these challenges will be met, despite the effort required to do so, and the likelihood of facing some difficult decisions in future.

The Financial Statements included in this report (and also available on our website) are a summary of the information in the full accounts which are available on our website and on demand by emailing our Communications Team **hnf-tr.communications@nhs.net:**

Our 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 our Trust's performance, business model and strategy.

SHARON MAYS

Chairman

MICHELE MORAN

Chief Executive

Accountability Report

Directors' Report

The Board of Directors sets the strategic goals and objectives of the Trust and monitors the Trust's performance against these objectives, 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 changes at Board level. In August 2016, Chief Executive David Hill left the organisation and Michele Moran was appointed as interim Chief Executive, taking up the post in September 2016. Following a robust interview process Michele was appointed to the substantive Chief Executive post in January 2017.

Adrian Snarr, Director of Finance, Informatics and Infrastructure left the organisation in March 2017. Peter Beckwith served as Acting Director of Finance until a robust recruitment process led to his appointment to the substantive position with effect from 1 April 2017.

Dr Dasari Michael gave notice of his intention to resign as Medical Director to allow him to focus on his clinical position. A recruitment campaign commenced in March for the post.

Non-Executive Director John Whitton came to the end of his term of office and left the Trust at the end of August 2016. Mike Cooke and Mike Smith were appointed as non-executive directors in September and October 2016 respectively and the Chairman was appointed for a further term of office. The Governor Appointments, Terms and Conditions Committee oversaw the process and details are provided within the Council of Governors' section of the report.

The chairman of the Board of Directors is Sharon Mays and the Board of Directors comprised seven non-executive directors (including the chairman) and six executive directors (including the chief executive). Non- Executive Director Andrew Milner is also the Senior Independent Director (SID).

Elizabeth Thomas, Director of Human Resources and Diversity, is a non-voting member of the Board of Directors.

The Board of Directors reviews and evaluates its performance via a process 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.

Each Board of Directors sub committee produces an annual report on its activities, achievements and plans for the year ahead which 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 led the evaluation of the non-executive directors supported by the Council of Governors' Appointments, Terms and Conditions Committee.

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 plan and progress is monitored throughout the year. The chairman is consulted concerning the corporate, as opposed to professional, performance of the executive directors. Regular meetings with the Non-Executive Directors and the chairman are held without the executive directors being present. The Board of Directors' 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 ends
Sharon Mays	Trust Chairman and Chairman of Council of Governors and Remuneration and Nomination Committee	16 September 2014	15 September 2020
David Hill	Chief Executive	1 July 2014	Left 31 August 2016
Michele Moran	Interim Chief Executive Substantive Chief Executive	1 September 2016 29 January 2017	N/A
John Whitton	Independent Non-Executive Director	1 February 2010	31 August 2016
David Crick	Independent Non-Executive Director, Chair of Mental Health Legislation Committee	1 June 2012	31 May 2018
Andrew Milner	Independent Non-Executive Director, Chair of Strategic Investment Committee and Senior Independent Director	1 April 2013	30 September 2017
Peter Baren	Independent Non-Executive Director, Chair of Integrated Audit and Governance Committee (now Audit Committee) and Charitable Funds Committee	1 December 2013	31 January 2020
Paula Bee	Independent Non-Executive Director	1 March 2016	28 February 2019
Mike Cooke	Independent Non-Executive Director, Chair of Quality Committee	1 September 2016	31 August 2019
Mike Smith	Independent Non-Executive Director	1 October 2016	30 September 2019
Teresa Cope	Chief Operating Officer	1 April 2015	N/A
Hilary Gledhill	Director of Nursing, Quality and Patient Experience	1 June 2015	N/A
Dasari Michael	Medical Director	1 May 2014	N/A
Adrian Snarr	Director of Finance, Informatics and Infrastructure	9 December 2013	up to 9 March 2017
Peter Beckwith	Acting Director of Finance	10 March 2017	31 March 2017
Elizabeth Thomas (non-voting)	Director of H R & Diversity	1 February 2014	N/A

The composition of the Board of Directors allows it to fulfil its statutory and constitutional functions and to comply with its provider licence. 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 is chair of 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. A joint visit programme to inpatient facilities for governors and non-executive directors is in place.

The Board of Directors delegates 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 Operational Management Group met on a monthly basis to ensure delegated duties were discharged.

Executive and non-executive directors had a visibility programme which involved them travelling to the Trust's sites and meeting its teams. This included shadowing staff to gain a better understanding of the services being provided and any issues staff were facing.

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 acknowledges 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 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 Trust Board has approved a three-year Risk Management Strategy which sets out the Trust's commitment to embedding an integrated approach to managing risk. It is recognised that a proactive approach to risk management can enable a reduction in harm to patients and staff, assist in creating safer care environments and is essential for the achievement of the organisation's strategic goals as well as the Trust's corporate and clinical objectives.

The Trust has undertaken a self-assessment to identify areas for improvement within risk management and has developed a plan for implementing its Risk Management Strategy. Risk management objectives have also been developed which are based on the outcome of the risk maturity assessment carried out by the Trust in line with national guidance and best practice.

An exercise has also been completed to define the Trust's risk appetite or the level of risk that it is prepared to accept, tolerate, or be exposed to. A risk appetite statement has been developed that was agreed by the Board and which defines the level of risk that can be accepted against key domain areas as well as the Trust's strategic goals.

The Trust Board has the overall responsibility for risk management throughout the Trust and reviews the Board Assurance Framework and Trust-wide risk register on a quarterly basis. Risks identified by Board committees and sub-groups are recorded on the relevant directorate/care group risk register and managed through the necessary forum.

Regular updates from the Executive Management Team and Integrated Audit and Governance Committee are received by the Board for further assurance around the application of risk management within the organisation.

The Integrated Audit and Governance Committee is the Board committee with overarching responsibility for risk. The role of the committee is to scrutinise and review the Trust systems of governance, risk management and internal control. Regular assurance is sought in terms of the Trust's risk management arrangements to enable oversight of the approach to risk as well as the Trust-wide risk register and Board Assurance Framework to focus on individual risks and suitability of identified controls.

Leadership for risk management across the organisation is provided by the Executive Management Team (EMT) and is chaired by the Chief Executive. The Executive Management Team gives consideration to the development of systems and processes, with individual directors championing risk management within their own area of responsibility. The group fulfils the lead function for managing the Trust-wide Risk Register, reviewing all proposed new risks for inclusion, monitoring existing risk entries on a regular basis and considering requests for risk de-escalations.

The Operational Performance and Risk Group is chaired by the Chief Operating Officer and considers risk registers at a care group level. The group is responsible for ensuring that risk assessments are consistent, timely and that appropriate actions have been taken to manage and mitigate the level of risk. Care group risk registers are cross-referenced to identify any emerging themes or trends in terms of risk and items can be escalated for consideration of the Executive Management Team when required.

These arrangements ensure that the Trust has an effective process for managing all types of risk and that it is making appropriate risk management decisions to enable the organisation to deliver its objectives.

Enhanced quality reporting

Humber NHS Foundation Trust uses a 'traffic light' or 'RAG-rating' system to report on performance and quality against selected priorities and Key Performance Indicators (KPIs). This is translated to reflect the organisation's performance on the selected priorities and initiatives and is reported internally at three levels:

Level 1: Monthly and quarterly performance and quality reports to the Trust Board via the Integrated Performance Tracker (IPT)/Quality Dashboard.

Level 2: Monthly care group reports via a dashboard to the operational care groups and their directors.

Level 3: Monthly performance reports at team level to service managers and team leaders.

The Trust reports externally to our commissioners via contract activity reporting on a monthly basis which highlights service performance and quality within the organisation.

Reporting processes within the Trust ensure that it can effectively monitor its clinical processes and activity through performance and quality reporting that trigger alerts when issues are identified. It also allows for the analysis of root causes of problems by considering timely information gathered from different sources at various levels of the Trust. As such, the Trust is able to effectively manage people and processes to improve decisions, be more effective in service delivery and deliver better quality services.

Meetings are held regularly with commissioners, Board members, care group directors, service managers and with team leaders and their teams. Internal and external audits are undertaken to ensure our methods of calculation and delivery meet the national and local guidelines.

All Monitor and CQC indicators are reported in the Trust's Integrated Performance Tracker and

in care group dashboards. KPIs that are failing to either meet a target or are showing a continued downward trajectory (subsequently at risk of breaching a target) are reported by exception on Performance Indicator returns (PIs). PIs are discussed with operational staff to understand the issues and problems and current action plans are agreed that would support the development of services and make improvements that will enable the Trust to meet its contractual obligations.

More information on the governance arrangements within the organisation can be found in the Annual Governance Statement and the Annual Quality Accounts.

The Care Quality Commission

The Care Quality Commission (CQC) carried out its announced scheduled inspection of the Trust from 11th-14th April, 2016.

Following the inspection, the Trust received a full report into the quality of care provided. Some of the feedback in the report was positive and reinforced the commitment and care provided by staff. However, the CQC highlighted three areas for which warning notices were issued regarding lack of effective governance arrangements in respect of the use of rapid tranquilisation (RT), lack of effective processes and procedures regarding use of seclusion, and use of blanket restrictions with regards to monitoring patient mail within forensic services.

The Trust took immediate action and provided a comprehensive response to the CQC on 14th June, 2016. The formal CQC reports were received by the Trust in early August and were published on 10th August 2016 with the Trust's Quality Summit held on 7th October, 2016. A comprehensive improvement plan was drawn up to respond to the warning notices, regulation breaches, 'must do' and 'should do' actions and it was presented to the Trust Board in November 2016. This included a number of actions requiring direct commissioner involvement to be completed which have been included in the plan.

Financial Requirements

The Trust remains compliant with cost allocations and charging requirements laid down by HM Treasury.

Section 43 (3a) 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 2016/17.

Statement as to disclosure to auditors: Each director at the time of approving this report has confirmed that, as far as the Director is aware, there is no relevant audit information of which the NHS Foundation Trust's Auditor is unaware. The Director has taken all the necessary steps in order to be aware of the relevant audit information and to establish that the Trust's Auditor is aware of that information.

Remuneration Report

Annual statement on remuneration

The Remuneration Committee determines the salaries of the Chief Executive and the other executive directors by considering market rates. All directors are on permanent contracts with the Chief Executive and other directors having a six-month notice period. There is no performance-related pay and no compensation for early termination for directors. The Chief Executive has the potential to earn a discretional annual non-consolidated performance-related bonus.

The Council of Governors determines the pay for the Chairman and non-executive directors and in so doing takes into account comparative remuneration of other foundation trusts. They are on fixed term, renewable contracts. There is no performance-related pay and no compensation for early termination.

The major decisions on senior managers' remuneration:

The Remuneration Committee agreed a cost of living award for the Chief Executive and executive directors - in line with Agenda for Change - of 1% with effect from 1 April 2016.

There were no other changes relating to senior managers' remuneration made during the year and the Council of Governors is currently reviewing the salaries of the Chair and non-executive directors.

SHARON MAYS

Chairman

MICHELE MORAN

Chief Executive

Policy on Board Remuneration

Non-Executive Director Remuneration Policy

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 2015/16 and 2016/17 are provided in Table 3. The information included in this table is subject to audit. These allowances are not pensionable remuneration.

TABLE 1

Element	Policy
Fee payable	A 'spot fee' which is reviewed annually. The setting of that fee and the subsequent review are undertaken with reference to national benchmarking data and national pay awards (Agenda for Change).
Percentage uplift (cost-of-living increase)	Reviewed annually by the Nominations Committee taking into consideration national pay awards and financial implications.
Travel	Travel and subsistence expenses are reimbursed and paid with remuneration via payroll.
Pension contributions	Non-Executive Directors do not have access to the NHS Pension scheme.
Other remuneration	None

Executive Director Remuneration Policy

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. The Chief Executive has the potential to earn a discretional annual non-consolidated performance-related bonus. Details of the salaries and allowances of the Chief Executive and other executive directors during 2015/16 and 2016/17 are shown in Table 3. Details of the pension benefits of the Chief Executive and other executive directors are also shown in Table 5. 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 other senior managers currently employed within the Trust, with the exception of two senior managers who are on Very Senior Manager contracts. 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 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 8 to the Annual Accounts.

TABLE 2: Executive Director Remuneration Policy

Element	Policy
Salary	A 'spot' salary which is reviewed annually. The setting of the salary and the subsequent review are undertaken with reference to national benchmarking data and national pay awards (Agenda for Change).
Taxable benefits	Travel and subsistence expenses are reimbursed and paid with salary via payroll.
Annual performance related bonuses	No performance related bonuses are paid for directors. The Chief Executive has the potential to earn a discretional annual non-consolidated performance related bonus.
Long-term performance related bonuses	No long term performance related bonuses are paid.
Pension-related benefits	Executive directors and service directors can access the NHS Pension scheme.
Percentage uplift (cost-of-living increase)	Reviewed annually by the Remuneration Committee taking into consideration, national pay awards and financial implications.

TABLE 3: Salaries and allowances of Trust Board and other senior managers (1 April 2016 – 31 March 2017)

Chair and non-executive directors

Name and Title	2015/16 Salary (Bands of £5000)	2015/16 Taxable Benefits (Nearest £100)	2015/16 Annual performance Related Bonus (Bands of £5000)	2015/16 Long Term Performance Related Bonus (Bands of £5000)	2015/16 Pension Related Benefits (Bands of £2,500)	2015/16 Total (Bands of £5000)	2016/17 Salary (Bands of £5000)	2016/17 Taxable Benefits (Nearest £100)	2016/17 Annual performance Related Bonus (Bands of £5000)	2016/17 Long Term Performance Related Bonus (Bands of £5000)	2016/17 Pension Related Benefits (Bands of £2,500)	2016/17 Total (Bands of £5000)
S Mays Chairman	40-45					40-45	40-45					40-45
J Whitton Non-Executive Director (up to August 2016)	10-15					10-15	5-10					5-10
P Baren Non-Executive Director	15-20					15-20	15-20					15-20
A Milner Non-Executive Director	10-15					10-15	10-15					10-15
P Bee Non-Executive Director (from March 2016)							15-20					15-20
M Cooke Non-Executive Director (from October 2016)							5-10					5-10
M Smith Non-Executive Director (from October 2016)							5-10					5-10
D Crick Non-Executive Director	10-15					10-15	10-15					10-15

Executive Directors

Name and Title	2016/17						2015/16					
	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 Hill Chief Executive (up to 31st August 2016)	60-65	3,500			110 – 112.5	175 - 180	145-150	7,500			0	150-155
M Moran Chief Executive (from to 1st September 2016	95-100				10-12.5	110 - 115						
A Snarr Director of Finance	120-125	3,300			0	120 - 125	105-110	4,500			32.5-35	145-150
E Thomas Director of Human Resources & Diversity	90-95	3,200			27.5-30	120 - 125	85-90	5,100			20-22.5	115-120
D Michael* Medical Director	160-165			10 - 15	25 – 27.5	200 - 205	155-160			10-15	2.5-5	175-180
T Cope Chief Operating Officer	100-105	4,000			115-117.5	220 - 225	100-105	1,900				100-105
H Gledhill Director of Nursing, Quality & Patient Experience	100-105				67.5-70	165 - 170	80-85					80-85
P Beckwith** Acting Director of Finance (from 10th March 2017)	75-80	1,100			0	75 - 80						

*The figure for Medical Director includes remuneration for duties that are not part of the director role. These duties comprise 50% of the individual's role.
** The pension related benefits figures for P Beckwith are not included due to the timing of appointment being after the required submission date to NHS Pensions of the 10th March 2017.

The Benefits in Kind covers the monetary value of the provision of a car and travel costs. The 2016-17 pension-related benefits figures have been adjusted for employee pension contributions.

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 2016/17 was £165,000. This was 7.5times the median remuneration of the workforce, which was £21,692.

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 4 below illustrates this calculation.

Table 4

	2016/17
Band of Highest Paid Director's Total Remuneration (£'000)	160 - 165
Median Total	21,692
Remuneration Ratio	7.5

Table 5: Pension Benefits of Trust Board and other senior managers (1 April 2016 – 31 March 2017) 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 2017 (bands of £5000) £000	Lump sum at 60 related to accrued pension at 31 March 2017 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension £000
D Hill Chief Executive	5.0 – 7.5	0	5.0 – 10	0	67	50	7	9
M Moran Chief Executive	0 – 2.5	5.0 – 7.5	55 – 60	175 - 180	1151	1019	132	3
A Snarr Director of Finance	0	0 – 2.5	40 – 45	115 – 120	726	658	64	17
E Thomas Director of Human Resources and Diversity	0 – 2.5	2.5 – 5.0	25 – 30	80 -85	638	588	50	13
D Michael Medical Director	0 – 2.5	2.5 – 5.0	35 - 40	110 - 115	736	671	65	23
T Cope Chief Operating Officer	5.0 – 7.5	10.0 – 12.5	30 – 35	75 – 80	428	346	82	14
H Gledhill Director of Nursing, Quality and Patient Experience	2.5-5.0	15.0 – 17.5	20 – 25	65 - 70	468	345	123	14
P Beckwith Acting Director of Finance	0	0	35 – 40	0	420	371	3	11

Table 6: Information on the remuneration of the directors and on the expenses of the governors and the directors

	Governors	Directors	Total
the total number of [governors / directors] in office	26	13	**29**
the number of [governors / directors] receiving expenses in the reporting period and	10	14	**24**
the aggregate sum of expenses paid to [governors / directors] in the reporting period.	**£2,382**	**£11,682**	**£14,064**

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 0.0%

MICHELE MORAN

Chief Executive

26 MAY 2017

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 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 of 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.

During the year, the committee appointed an interim Chief Executive and, following a rigorous process, a substantive Chief Executive. The Committee considers the approval of any new or replacement Board-level appointments, taking into account the job description/person specifications and proposed remuneration package using NHS benchmarks and relevant Very Senior Managers guidance. Appointments are made using robust recruitment and selection processes which include stakeholder sessions and a formal panel interview. Appointments are then ratified by the committee.

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.

Two meetings of the committee were held during the period of this report and details of attendance are presented in the Board of Directors' attendance table. The terms of reference for the committee are available from the Trust Secretary.

Staff Report

Staff costs

	Group			
			2016/17	2015/16
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	79,189	11,278	**90,467**	82,798
Social security costs	8,220	-	**8,220**	6,002
Employer's contributions to NHS pensions	10,377	-	**10,377**	9,953
Pension cost - other	355	-	**355**	126
Other post-employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	27
Agency/contract staff	-	4,094	**4,094**	4,769
NHS charitable funds staff	-	-	**-**	-
Total gross staff costs	**98,141**	**15,372**	**113,513**	**103,675**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**98,141**	**15,372**	**113,513**	**103,675**
Of which				
Costs capitalised as part of assets	94	14	**108**	-

Average number of employees (WTE basis)

	Group			
			2016/17	2015/16
	Permanent number	Other number	Total number	Total number
Medical and dental	65	-	**65**	57
Ambulance staff	-	-	**-**	-
Administration and estates	518	28	**546**	511
Healthcare assistants and other support staff	687	98	**785**	706
Nursing, midwifery and health visiting staff	914	37	**951**	951
Nursing, midwifery and health visiting learners	12	-	**12**	17
Scientific, therapeutic and technical staff	321	5	**326**	325
Healthcare science staff	-	-	**-**	-
Social care staff	60	-	**60**	28
Agency and contract staff	-	-	**-**	146
Bank staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**2,577**	**168**	**2,745**	**2,741**
Of which:				
Number of employees (WTE) engaged on capital projects	**3**	**1**	**4**	

Breakdown of male and female directors, senior managers and employees (as of 31/3/17)

	Male	Female
Directors	2	4
Other Senior Managers	10	13
Employees	560	2,059

Staff Sickness Absence

	2016/17 Number	2015/16 Number
Total FTE Days Lost	31,535	26,719
Total FTE Days Available (Years)	2,596	2,421
Average Sick Days per FTE	12	11

Staff Policies and actions applied during the Financial Year

- **Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities.**

  The Trust's policy is to give full and fair consideration to applications for employment received from disabled persons, having regard to their particular aptitudes and abilities. The Trust provides regular training to all recruiting managers ensuring the Recruitment and Selection Policy is adhered to.

  The Trust's Recruitment and Retention Strategy and plan will be launched in the new financial year with the aim of introducing new initiatives to attract and retain high quality staff.

- **Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period**
  The Trust has recently revised the Managing Attendance Policy and this reinforces support available to staff. Manager and supervisor training will be delivered over the forthcoming year and will provide advice to managers to support staff with long-term conditions, giving consideration to reasonable adjustments and redeployment when required.

- **Policies applied during the financial year for training, career development and promotion of disabled employees.**

  All policies are subject to an Equality Impact Assessment and trade unions are involved in the agreement and introduction of revised and new policies.

  In January the Trust introduced a bi-monthly trade union meeting with the sole purpose of reviewing new and existing HR policies.

  The Trust's Workforce and Organisational Development Policy was launched in October 2016 and the actions arising from the action plan will be embedded across the Trust in the 2017/18 financial year.

- **Actions taken in the financial year to provide employees on a systematic basis with information on matters of concern to them as employees**

  The Trust communicates with staff on a regular basis through Midday Mail, an email bulletin. There is also the monthly 'Board Talk' newsletter produced and there are regular face-to-face meetings.

  The Trust holds monthly trade union meetings through the Trust Consultation and Negotiation Committee (TCNC) and in January 2016 introduced an additional bi-monthly Policy Forum to review new and existing policies.

- **Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests**

  The Trust participates in the quarterly Staff Friends and Family survey and produces local surveys to establish the views of employees. The Trust also holds focus groups and provides additional support meetings through times of transformation and change with one-to-one meetings and face-to-face meetings following the implementation of change.

- **Actions taken in the financial year to encourage the involvement of employees in the NHS foundation Trust's performance**

  The Trust encourages staff to be active members of the Trust and promotes this through the intranet and through the induction process.

  Information on the findings and feedback of the Staff Friends and Family Survey is shared with staff.

  Information relating to the Trust's performance and Board information is shared with staff on the Trust's intranet site.

Additional policies applied during the financial year

- The Trust has developed a Personal Responsibility Framework to support a change in culture and to ensure staff understand their responsibility within the organisation and

recognise the valuable role and contribution they provide.

- The Trust has a well-established leadership forum and this has been refreshed to make the session more interactive and focussed on key priorities and challenges.
- The Trust's Leadership Programme was agreed in the 2016/2017 financial year and the first cohort of training will take place in May 2017.
- In advance of the introduction of the new Apprenticeship Levy, the Trust has developed a plan and created a steering group to identify opportunities for new apprenticeship roles.
- The Trust has developed a Staff Employee of the Month scheme.
- The Trust's Recruitment and Retention Strategy and plan will be launched in the new financial year with the aim of introducing new initiatives to attract and retain high quality staff.

Occupational Health

The Trust has an Occupational Health department and provides a service internally and externally to private sector organisations.

The service offers confidential and independent support on pre-employment health checks, health referrals, vaccinations, back care support and counselling.

To support the wellbeing of staff, the service also provides aromatherapy sessions through an external provider.

Health and Safety

The Trust's Health and Safety department supports the Employee Wellbeing agenda with regular stress audits across the Trust. The department also support the Trust's induction programme, providing health and safety training to staff.

Counter fraud and corruption

The Trust has a local counter-fraud specialist and there are policies in place to support counter fraud and corruption. It is the Trust's policy that all allegations of fraud must be referred to the Trust's Director of Finance.

Staff Survey

The Trust's new Workforce and Organisational Development Strategy along with the Communication Strategy supports continued improvement to staff engagement.

One of the Trust's key priorities is to ensure that all staff feel empowered and senior leaders are accessible and visible. Our new values of Caring, Learning and Growing support this priority.

The Trust acts upon the feedback from the National Survey and also uses the Staff Friends and Family Survey. In addition to this there are also local surveys issued to staff. The Trust also uses focus groups to engage with staff.

Employee engagement is a priority for the Trust and we are keen to ensure staff feel they have a voice and are able to contribute.

Summary of the Performance of the NHS Staff Survey

The information provided in the briefing are the findings of the 2016 National NHS Staff Survey which compares Humber NHS Foundation Trust with other combined mental health, learning disability and community trusts.

The summary of the findings for the 2016 National NHS Staff Survey is as follows:

- The overall staff engagement score for the Trust, which ranges from 1 to 5, with 1 indicating staff are poorly engaged with their work, team and their trust, and 5 indicating staff are highly engaged, is 3.64. The national average is 3.80 and the figure has not changed since the 2015 survey.
- The Trust's response rate was 43%. In 2015, the response rate was 48% and the 2016 survey reports a response rate from the Trust as below the average of 46%, with 35% being the lowest national score and 55% the highest.
- The total number of staff who responded to the survey is 526, which accounts for 17% of staff. The findings from the questions relating to the organisation are in the table opposite.

Q – Question KF – Key Finding	Humber NHS Foundation Trust - 2016	Humber NHS Foundation Trust - 2015	Average (median) for combined MH/ LD & Community Trusts - 2016
Q 'Care of patients /service users is my organisation's top priority'	64%	60%	73%
Q 'My organisation acts on concerns raised by patients / service users'	67%	63%	75%
Q 'I would recommend my organisation as a place to work'	45%	45%	57%
Q 'If a friend or relative needed treatment , I would be happy with the standard of care provided by this organisation'	58%	58%	66%
KF Staff recommendation of the organisation as a place to work or receive treatment.	3.47	3.46	3.71

Although the findings compared to the benchmarking data are below average, there has been no reduction in the figures compared to 2015.

The top five ranking areas compared to the national average for other scores for the Trust which compare more favourably with other trusts:

Area measured (Questions)	Humber NHS Foundation Trust Score - 2016	Humber NHS Foundation Trust Score - 2015	2016 Average National Score
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	94%	94%	93%
Percentage of staff witnessing potentially harmful errors ,near misses of incidents in the last month.	22%	20%	24%
Percentage of staff experiencing physical violence from staff in last 12 months.	2%	2%	2%
Percentage of staff appraised in the last 12 months	92%	79%	92%
Percentage of staff satisfied with the opportunities for flexible working patterns	57%	54%	58%

The bottom five ranking areas for the Trust and areas which would need further action to improve.

Area measured (Key findings)	Humber NHS Foundation Trust Score - 2016	Humber NHS Foundation Trust Score - 2015	2016 Average National Score
Effective team working	3.63	3.65	3.87
Support from immediate managers.	3.68	3.66	3.88
Recognition and value of staff by managers and the organisation	3.32	3.30	3.55
Percentage of staff able to contribute towards improvement at work	65%	69%	74%
Percentage of staff /colleagues reporting most recent experience of harassment, bullying or abuse.	52%	50%	58%

An action plan has been developed to address areas of concern highlighted within the staff survey including the following key areas:

- Appraisals and support for development
- Equality and diversity
- Errors and incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying

The key themes have been developed with clear objectives and expectations for improvements. This action plan will be monitored through the Health and Wellbeing Steering Group and the Workforce Development Group.

Future priorities and targets

- The Trust recognises there are a number of areas of improvement required and the key priorities will focus on improvements to effective team working, ability of staff to contribute towards improvements in work and the increase in the number of staff experiencing harassment, bullying or abuse.
- Performance against the priority areas will be monitored through the quarterly Friends and Family Survey and local surveys.

Exit packages

Reporting of compensation schemes - exit packages 2016/17

	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	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	-	-
Total resource cost (£)	**£0**	**£0**	**£0**

Reporting of compensation schemes - exit packages 2015/16

	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	2	-	2
£10,001 - £25,000	1	-	1
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	3	-	3
Total resource cost (£)	**£27,000**	**£0**	**£27,000**

Exit packages: other (non-compulsory) departure payments

	2016/17		2015/16	
	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	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**-**	**-**	**-**	**-**
Of which:	-	-	-	-
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Expenditure on consultancy	2016/17 £000	2015/16 £000
Consultancy costs	212	635

As part of its commitment to tackling tax avoidance and ensuring everyone pays their fair share, HM Treasury reviewed the tax arrangements of senior public sector employees and published its report in May 2012. The review recommended that, in central government departments and their arm's length bodies, for all new engagements and contract renewals that board members and senior officials with significant financial responsibility should be on the organisation's payroll, unless there are exceptional circumstances – in which case the Accounting Officer should approve the arrangements – and such exceptions should exist for no longer than six months.

The Trust's current position is presented below:

Off-payroll arrangements

To ensure adherence to HM Treasury requirements in respect of tax and national insurance for public sector appointees, we have arrangements in place for the appropriate use of external contractors where engagements last for six months or more and the daily rate exceeds £220. These arrangements apply when we contract with an individual through an intermediary company, and also where the contract is direct with an individual, and provides the appropriate assurances that the independent contractor is complying with their income tax and national insurance obligations.

	2016/17 Number of engagements
Number of existing engagements as of 31 Mar 2017	7
Of which:	
Number that have existed for less than one year at the time of reporting	6
Number that have existed for between one and two years at the time of reporting	1
Number that have existed for between two and three years at the time of reporting	-
Number that have existed for between three and four years at the time of reporting	-
Number that have existed for four or more years at the time of reporting	-

For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2016 and 31 Mar 2017, for more than £220 per day and that last for longer than six months

	2016/17 Number of engagements
Number of new engagements, or those that reached six months in duration between 01 Apr 2016 and 31 Mar 2017	7
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	7
Number for whom assurance has been requested	6
Of which:	
Number for whom assurance has been received	2
Number for whom assurance has not been received	4
Number that have been terminated as a result of assurance not being received	-

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2016 and 31 Mar 2017

	2016/17 Number of engagements
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". This figure should include both off-payroll and on-payroll engagements.	14

A senior official has been engaged to cover the secondment of the permanent staff member to a role within the Local Authority.

Code of Governance

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

The Board will reserve certain matters to itself and will delegate others to specific committees and executive directors. Details of this are set out in a document called Reservation of Powers to the Trust Board and Scheme of Delegation/Standing Orders and Standing Financial Instructions.

Copies of this document are available from our Trust Secretary.

During the financial year 2016/17 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 is 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 48
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 – page 53
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 61
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 27
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 – page 55
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. Comply – Board of Directors – page 38
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. Page 45 Comply – register of interest is publicly available for the chairman and all those on the Board of Directors. It is presented at each meeting 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 61
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 26
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 as required – Board of Directors – page 51
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 21 External Auditors responsibilities – page 51 Annual Governance Statement - page 70
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 70

Code of Governance Reference	Requirement
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 51
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 dependent on outcome of decision
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 51
D.1.3	Where an NHS foundation trust releases an executive director, for 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 – page 64
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 66

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

To comply with section four, 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 five, 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 six.

External Reviews

During the course of the year one review was commenced which is due to be completed in April 2017. This was the Well Led Review undertaken by Deloitte as a preliminary review against the Care Quality Commission (CQC) guidance. This review was commissioned from Deloitte at an in-year cost of £45,000 plus VAT. Deloitte is also the Trust's external auditor appointed by the Council of Governors. The current contract expired at the end of March 2017.

Board of Directors Sub Committees

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

- Remuneration and Nominations Committee - details can be found on page 31 of this report.
- Integrated Audit and Governance Committee

  The Integrated Audit and Governance 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 three non-executives directors and is chaired by Non-Executive Director Peter Baren. In accordance with NHS Improvement guidance, Mr Baren has relevant and recent financial experience. The committee met five times last year and included attendance from the Director of Finance, Infrastructure and Informatics, the Director of Nursing, Quality and Patient Experience, the external and internal auditors and the Counter-Fraud Manager. The committee approved the annual audit and counter-fraud plans and reviewed all internal and external audit reports. For assurance, reports were received from the Quality and Patient Safety Committee (QPaS) demonstrating the work that is being done to improve patient care, patient safety and patient experience.

The chair of the committee reports on its proceedings to the Board of Directors as soon as practicable after the meeting, raising any significant issues of concern.

The Integrated Audit and Governance Committee will be separated into the Audit Committee and a newly established Quality Committee from April 2017.

External Audit

For 2016/17, the Trust's external auditor was Deloitte. During the year a total of £66,337 was paid to Deloitte for audit services.

At its May 2016 meeting the Integrated Audit and Governance Committee received the Report of the External Auditors (ISA 260). The report provided the unqualified opinion on the accounts.

The Trust's existing audit arrangements ceased on the 31st March 2017. The Trust has therefore run a procurement process to appoint a new external auditor with effect from 1st April 2017. The Trust opted to utilise the North of England Commercial Procurement Collaborative (NOECPC) Framework to undertake a further competition process. The advantages of the process adopted are that it maximises the NHS's collective leverage against NOECPC membership, offers full OJEU compliance and avoids duplication of the procurement process.

Following the procurement process a recommendation was made to the Council of Governors for the appointment of Deloitte for the three-year period commencing 1st April 2017. This recommendation was approved on 17th March 2017.

The non-audit service provided during 2016/17 was the Well Led Review.

To maintain auditor objectivity, independence and probity, these services were carried out by Deloitte staff who were not involved in the Trust statutory audits, nor did the audit staff have any involvement with the findings, which were reported directly to the Trust and not via the audit partner.

As part of its external audit plan, Deloitte tested risks relating to revenue recognition in respect of NHS income, property valuations and management override of controls as part of its review of the 2016/17 financial statements. All controls around these risks were found to be appropriate and in line with Deloitte's expectations. Recommendations following the audit have been made in relation to asset valuations, fixed asset register and contract variations. These have been accepted by management and actions will be put in place to address each of them.

Internal Audit

In public sector organisations, internal audit work is regulated by the Public Sector Internal Audit Standards, which became effective on 1st 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 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 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 committee 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 Non-Executive Director Peter Baren and comprises 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 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 and other related mental health legislation.
- To monitor, provide challenge and seek assurance of compliance with external standards relating to mental health legislation.
- To approve and review mental health legislation polices and protocols.

The committee is chaired by Non-Executive Director David Crick and has a core membership of one other non-executive director (who is also a designated Manager Panel member), the Medical Director, Director of Nursing, Quality and Patient Experience, and the Mental Health Legislation Manager (who is also the chair of the Mental Health Legislation Steering Group). An 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 care group director with nursing experience.

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

Consideration of this committee merging with the Integrated Audit and Governance Committee has been an area of focus during the year. However, no recommendation has yet been made to the Board of Directors.

- **Strategic Investment Committee**

The Strategic Investment Committee ensures that processes governing 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 Non-Executive Director Andrew Milner and has a core membership of two other non-executive directors, the Director of Finance, Infrastructure and Informatics and Assistant Director of Business Development and Relationship Management.

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

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 attended a committee meeting that they do not normally attend. The Chairman attends each committee during the year to observe.

Name	Position	Board (Inc Extra Ord Mtgs)	Rem	MHLC (Inc Extra Ord Mtgs)	CF	IAGC (Inc Extra Ord Mtgs)	StIC	CoG
Sharon Mays	Chairman	13/13	3/3		1/1			4/4
David Hill	Chief Executive (up to 31.8.16)	4/5	1/1			1/1		1/1
Michele Moran	Interim Chief Executive (from 1.9.16)	8/8	1/1	1/1		2/2	6/7	3/3

David Crick,	Non-Executive Director	12/13	1/1	5/5		5/5		4/4
Andrew Milner	Non-Executive Director (Senior Independent Director)	12/13	2/3		4/5		11/11	4/4
John Whitton up to 31.8.16	Non-Executive Director	4/5	2/2			3/3	4/5	1/1
Peter Baren	Non-Executive Director	12/13	2/3	4/4	5/5	5/5	6/11	2/4
Paula Bee	Non-Executive Director (from 1.10.16)	13/13	3/3		2/2	3/4		0/4
Mike Cooke	Non-Executive Director (from 1.9.16)	8/8	1/1			1/1	6/6	3/3
Mike Smith	Non-Executive Director (from 1.10.16)	7/7	1/1	1/2			2/3	0/2
Adrian Snarr (up to 9.3.17)	Director of Finance, Infrastructure and Informatics	12/13			5/5	4/5	8/10	3/3
Teresa Cope	Chief Operating Officer	13/13		5/5		2/5	7/9	3/4
Dasari Michael	Medical Director	13/12		4/5		2/5		3/4
Hilary Gledhill	Director of Nursing, Quality, and Patient Experience	10/13		3/5		4/5		1/4
Elizabeth Thomas (non- voting)	Director of Human Resources & Diversity	10/13	2/3			1/5		4/4
Peter Beckwith (from 10.3.07)	Acting Director of Finance	3/3				1/1	3/3	1/1

Rem = Remuneration Committee MHLC = Mental Health Legislation Committee CF = Charitable Funds IAGC = Integrated Audit and Governance Committee StIC = Strategic Investment Committee CoG = Council of Governors

Board of Directors: Expertise and Experience

Sharon Mays,
Chairman
(term of office expires 15 September 2020)

Prior to taking up the position of chairman, Sharon served as a governor, non-executive director, deputy chairman and senior independent director.

She joined the board of the Trust in July 2011 when she became the senior independent non-executive director and, subsequently, she became deputy chairman. 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 was a member of the joint independent audit committee of the Police and Crime Commissioner for Humberside and Humberside Police Force. 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.

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

John Whitton,
Non-Executive Director
(term of office expired 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.

John 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 the 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 30 September 2017)

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 and BHSF Group Limited.

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 Aspire Academy and chairman of Brantingham Village Hall Trustees.

Peter Baren,
Non-Executive Director
(term of office expires 31 January 2020)

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 serves as a 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 Crick,
Non-Executive Director
(term of office expires 31 May 2018)

David was a family doctor in Hull for more than 30 years, retiring in February 2011; he had training in psychiatry and counselling.

During his many years as a GP, David took on various roles with the local health authority and with the Primary Care Trust until October 2007, serving as executive committee vice chair and lead for mental health and musculo-skeletal services.

He teaches Whole Person Medicine (with an emphasis on Mental Health) in Eastern Europe with PRIME International.

Paula Bee,
Non-Executive Director
(term of office expires 28 February 2019)

Having originally trained as a physiotherapist, Paula has been involved in the wellbeing of older people throughout her career, which went on to encompass various community roles both in a voluntary and professional capacity. Throughout this time, she developed a passion for enabling people to fulfil their potential. As Chief Executive of Age UK Wakefield District and member of the Age England Association Executive Group, Paula has been fortunate to be at the forefront of local and national changes that have the potential to alter the experience of ageing for us all.

Paula is also currently the chair of the Wakefield Assembly (the local VCS Board for voice and influence), on the Board of Nova (the support agency for voluntary and community groups in Wakefield district), a member of the Health and Wellbeing Board and part of Wakefield Provider Alliance.

Mike Cooke,
Non-Executive Director
(term of office expires 31 August 2019)

Mike Cooke joined Humber NHS Foundation Trust on 1 September 2016 and is delighted to bring his NHS and wider leadership experience and to help in any way he can to benefit patients, service users and staff. Mike had a 32-year career in NHS provider leadership roles - half of this time spent as Chief Executive, most recently at Nottinghamshire Healthcare.

Mike was founder and first Chair of the Mental Health Foundation Trust Network and helped set up and then chaired the East Midlands Leadership Academy. He has a long held interest in health services research and was Special Professor in Healthcare Innovation and Leadership at the University of Nottingham, chaired several research collaborations and networks in the East Midlands and served two terms on The National Advisory Board of the National Institute of Health Research. He was heavily involved in the success of The Institute of Mental Health and is affiliated with the University of York since his move to the East Riding. Mike is a long-term service user and was lead chief executive for ImROC, an important recovery movement across sectors in mental health. He was in 2010 awarded a Commander of The Order of the British Empire for services to mental health.

Mike is a trustee of Yorkshire Wildlife Trust, a University of York consultant, executive mentor and coach and lives in Storwood on Pocklington Canal.

Mike Smith,
Non-Executive Director
(term of office expires 30 September 2019)

Mike was appointed in October 2016 having previously served as a non-executive director for Rotherham Doncaster and South Humber NHS Foundation Trust.

He has an Honours degree in law, a Master's in business administration and recently received his third degree - a Master's in mental health law for which he was given a commendation. He is also a Chartered Fellow of the Institute of Transport and Logistics.

Mike has extensive experience in the public and private sectors, has been the president of his local chamber of commerce and serves as a director of the Magna Science Adventure Centre in Rotherham, where he lives. When not working in the NHS, Mike is the Lord-Lieutenant's Officer for South Yorkshire, planning Royal visits and assisting in the presentation of honours and awards.

Michele Moran,
Chief Executive
(appointed January 2017)

Michele is a nurse, midwife and health visitor by background and has more than 30 years' experience of front-line roles in NHS management and care.

Michele was appointed to the role of chief executive at Humber on a permanent basis in February 2017. Prior to her four years as chief executive in Manchester, Michele served as deputy chief executive/chief operating officer/chief nurse at Leeds and York Partnership NHS Foundation Trust for seven years.

An ex-chair of the Foundation Trust Network Clinical Leads Network and a member and current non-executive director of the National Skills Academy for Health. Michele has extensive experience in the primary care and acute sectors.

A qualified nurse, mental health nurse and midwife, Michele also has a Master's degree in health services management from the University of Manchester.

David Hill,
Chief Executive
(appointed 1 July 2014, left 31 August 2016)

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

David served as Chief Executive of Guildford Borough Council for six years, leading a comprehensive transformation programme delivering financial sustainability and performance improvement. David has held senior strategic roles with three other local authorities. David is a Fellow of the Chartered Management Institute.
He has served as a trustee of the University of Surrey Students' Union and was a chair of trustees of two charities associated with poverty alleviation.

Adrian Snarr,
Director of Finance, Infrastructure and Informatics and Deputy Chief Executive
(left 31 March 2017)

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

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.

Dr Dasari Michael, Medical Director
(appointed 1 May 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.

He has been Training Programme Director for the East Riding Core Training Scheme in Psychiatry. He has played a key role in the development of the learning disability service in the organisation. His main areas of interests are patient-focused pathways of care with safety at their heart, bringing innovation into service delivery, encouraging a culture of learning and training, developing research and fostering collaborative working among professionals.

Elizabeth Thomas,
Director of Human Resources and Diversity
appointed 1 February 2014 (non- voting)

Elizabeth has been a deputy director since 2010. A Fellow of the Institute of Personnel and Development, Elizabeth has a Master's 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.

Teresa Cope, Chief Operating Officer
appointed 1 April 2015

Teresa joined Humber in April 2015 and has over 20 years' experience in the NHS, starting her career as a diagnostic radiographer before moving into management roles in the acute and mental health sectors and in provider and commissioning organisations. During her career, Teresa has worked across a number of functions including operations, strategy and planning, performance, and service transformation.

Prior to joining Humber, Teresa spent three years as the Director of Quality, Delivery and Contracting for Nottingham City Clinical Commissioning Group, which included commissioning mental health and community services for Nottinghamshire. Prior to this, Teresa worked for Nottinghamshire Healthcare NHS Foundation Trust as both a general manager and then as an associate director for forensic services.

Hilary Gledhill,
Director of Nursing, Quality and Patient Experience
appointed 1 June 2015

Hilary joined the Trust in June 2015 and has over 30 years' experience in the NHS. She qualified as a registered nurse in 1983 and worked as a nurse in acute hospital services and the community before moving into senior quality improvement and nurse leadership roles, gaining experience in community care and commissioning organisations.

Hilary has a working experience of many healthcare sectors and services including prison health, mental health services, ambulance services, hospital and community services.

Prior to joining the Trust, she spent two years as the Director of Quality and Integrated Governance and the Executive Nurse for East Riding of Yorkshire Clinical Commissioning Group, which included commissioning mental health and community services for residents of the East Riding of Yorkshire.

Peter Beckwith,
Acting Director of Finance
(from 10 March 2017)

Peter has been Deputy Director of Finance and Contracting with the Trust since December 2015. Prior to joining the Trust, Peter held various senior roles with local NHS organisations including NHS England and NHS Hull. Prior to joining the NHS, Peter accumulated 19 years' finance experience in local government across several different local authorities.

Peter is a Fellow of the Association of Chartered Certified Accountants.

Register of Directors' Interests

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 or through the website in the Board papers section. 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 works 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

Message from the Lead Governor, Julie Hastings

It is a governor's role to listen and engage with members of their constituencies, patients, carers, families and Trust staff. To further enhance their involvement, many governors also join one of the four sub groups. Governors attend the Annual Members' Meeting (AMM) which forms part of the Trust's annual review.

For the second successive year it was decided to hold the Trust's Staff Awards separately from the normal Annual Members' Meeting to give time to truly value and celebrate the compassion, innovation and dedication of all of Humber's staff. The Trust's skilled workforce showcased the innovative ways in which it continues to deliver and raise the quality and standard of care throughout the organisation.

The visits programme, in which a governor and one of the non-executive director team are invited to visit Trust service areas, continues to be a useful and proactive opportunity to talk to and gain insight into the experience of patients and staff.

Governor elections took place for nominations within the Hull and East Riding constituencies and for one staff governor role. This culminated in Helena Spencer securing an uncontested nomination in Hull, Robert Hunt being re-elected to continue to support his East Riding constituency, and Craig Enderby being elected as a staff governor. Following a recent resignation from the East Riding constituency, a vacancy remains.

Governors took up their seats from 1 February 2017. A valued and informative induction session was provided for the newly elected governors to enable them to learn more about their role.

The Council of Governors is comprised of people from many walks of life who have various skills and experience which they bring to the role, enhanced by their enthusiasm, dedication and commitment to really make a difference. The overarching aim of governors is to work with the Trust to enable continued improvement around the excellent quality of care, standards and innovations for patients, carers, families and to fully support staff.

Council of Governors

The Council of Governors is made up of individuals who have been elected by local people and staff who represent our constituencies. The Council 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. Julie Hastings was elected by the Council of Governors to fulfil this role.

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

- 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.

Non-executive directors are appointed for a term of three years up to the maximum specified in the Trust's constitution. Non-executive director appointments may be terminated in line with the requirements of the 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.

The Council of Governors comprises 28 Governors and two observers, (although not all seats are filled), 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 5 Governors	From various service areas in the Trust
Partner Organisations 7 Governors	East Riding of Yorkshire Council
	Hull and East Yorkshire MIND
	Kingston Upon Hull City Council
	Humberside Police
	HEY Smile Foundation
	University of Hull Faculty of Health and Social Care
	Hull and East Yorkshire NHS Hospitals
Observers	NHS East Riding Clinical Commissioning Group NHS Hull Clinical Commissioning Group

Council of Governors' Meetings

The Council of Governors met four times during 2016/17 and also held an Annual Members' Meeting. Council of Governors' public meetings are open for members of the public to attend and the meeting dates and papers are published on our website. Governor attendance at these meetings is provided in the table later in this section. Governors are involved in setting the agenda for the Council's meetings. Each meeting, when possible, begins with a patient story which is a presentation by a patients'/service area team which allows them to give their views on services and the challenges they may have had to face during their journey.

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, often to present their reports. A summary of their attendance is included in the table detailing attendance at Board and sub committee meetings. Further information about the work of the Board of Directors can be found in the Directors' Report.

Council of Governors' Sub Committee/ Groups

The Council of Governors may not delegate its responsibilities but can choose to carry out its duties through groups, committees or individuals. A sub committee (statutory requirement) and three governor groups hold meetings 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.

Appointments, Terms and Conditions Committee

The Appointments, Terms and Conditions Committee has undertaken five formal meetings during 2016/2017. This committee is chaired by Julie Hastings, elected governor for East Riding. The group consists of a team of governors and valued support and guidance from Senior Independent Director Andrew Milner, Director of Human Resources and Diversity Elizabeth Thomas, and, when required, invited guests who share their expertise and specialist knowledge. Any decisions made by this group are presented to the full Council of Governors for its approval.

During this year the committee has been involved in the recruitment process for two new non-executive directors. In considering these appointments the committee took into account the views of the Board of Directors regarding the skills, experience and qualifications required for these roles. The group enlisted the specialist skills of Penna (recruitment company) to enable it to identify high-calibre potential candidates to undertake these vital and challenging roles. The interview panel was chaired by a governor and included members of the Appointments, Terms and Conditions Committee supported by the Chairman, Senior Independent Director and the Director of Human Resources and Diversity. Following the rigorous interviews, a recommendation for appointment was made to the Council of Governors.

As part of a succession planning strategy by the committee it was unanimously agreed to reappoint the Chairman, Sharon Mays, for a further term of office. Although the Chairman still had time within her current term of office, it was felt that an early decision sent out a clear message regarding the immense appreciation for her dedication and continued hard work while also ensuring stability for the Trust. This decision was ratified by all governors during their Council of Governors' meeting. Further work is being undertaken by the committee around succession planning for the non-executive directors.

Communications and Membership Governor Group

Regular meetings of the group have taken place during the year. Discussions have included:

- Information technology issues including a secure site for governors on the website
- Membership and governors' issues
- Membership strategy

Non-Executive Director Paula Bee attends the meetings along with members of the Communications Team.

Finance and Audit Governor Group

The group meets on a quarterly basis to discuss the finances of Trust, paying particular attention to its financial performance against its own targets and those of the Government. These meetings are attended by the Chair of the Integrated Audit and Governance Committee and the Executive Director of Finance. The external audit contract for the Trust expired at the end of March 2017. The Finance and Audit Governor Group, in conjunction with the Integrated Audit and Governance Committee recommendation, considered all of the applications and made a recommendation to the Council of Governors. The Council of Governors approved the recommendation made by the Finance and Audit Governor Group and re-appointed Deloitte as the external auditor.

Strategy and Business Development Governor Group

Governors were involved in developing the Trust's Strategy and Operational Plan and had the opportunity to discuss the content at a specially arranged session with Board members. Regular updates on implementation and specific aspects of the plan are provided through the Strategy and Business Development Governor Group, the outcomes of which were reported to the Council of Governors. Regular meetings of the group are held which are attended by a non-executive director and representatives of the Strategy and Performance Department. Views of the group are reported to the Board via the non-executive director who attends and via the chairman, who meets on a regular basis with the group chair.

Governors other activities

During the year governors were involved with the Patient-Led Assessment of the Care 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. Visits for 2017 have started and governors are again involved.

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. Governor champions have been identified to be part of the Patient Experience Group which will take forward the Patient and Carer Experience pledges outlined in the Patient and Carer Experience Strategy.

Governors have taken part in the recruitment processes for the Chief Executive, Director of Finance and non-executive directors during the year. This has been as part of the panel or on the stakeholder groups. Governors have taken part in the non-executive directors' appraisal process both via the review panels and by submitting their views on their performances.

Governors have been involved in the development of the Quality Report and representatives attended an event 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 promoted 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 raising concerns/whistleblowing, a presentation from external auditors on their findings of the Trust's audit and presentations from various services areas including Positive Assets and the Recovery College. Training for governors was also provided during these sessions.

To help improve communication between the Board of Directors and Council of Governors, sessions with the Board of Directors are built into the governor development day as required. Governors set the agenda for the development days by identifying areas they wish to receive more information on including presentations from specific teams/services. This year, at the governors' request, non-executive directors attended a full development day session to discuss how they interact with them. Members of the Board of Directors engage with governors in various ways including:

- attendance at Council of Governors' meetings
- attendance and membership of Governor groups/committee
- joint Board and governor sessions for budgets, cost improvement programme and quality accounts
- attendance at development days
- involvement in visits by governors to patient areas
- attending Patient-Led Assessment of the Care Environment (PLACE) inspections

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. Governors have an established governor forum event, where only governors are present. The agendas for these meetings are set by the governors themselves and the actions from these meetings are shared with the chairman so appropriate action can be taken.

Governors are invited to attend the Trust's public Board meetings and observe at Board 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 meets on a monthly basis (with the exception of January and August), with every meeting held in public. From March 2017, meeting dates changed to the last Wednesday of the month, resulting in two meetings being held in March 2017. The agenda and supporting papers for the public meetings are published on our website. Details of attendance at these meetings for the period of this report are detailed in another section of this report. Confidential and commercially sensitive matters are discussed in part II (private) meetings and matters which are not confidential or commercially sensitive are discussed at meetings held in public. Governors are sent a link to the website for the public papers, the agenda for the part II meeting and also have access to the part II minutes.

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 Eight 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.

Name	Constituency	No of Council Meetings attended / possible total	Term of Office ended/s
Current Governors			
Rodney Evans (elected)	Hull Public	3/4	Jan 2019
Robert Hunt (elected)	Hull Public	2/4	Jan 2020
Eric Bennett (elected)	Hull Public	2/4	Jan 2018
Gary Wareing (elected) resigned 16.9.16	Hull Public	0/2	Jan 2019
Martin Clayton (elected)	Hull Public	3/4	Jan 2019
Ron Morgan (elected)	East Riding Public	4/4	Jan 2018
Neel Kamal (elected)	East Riding Public	1/4	Jan 2019
Sam Muzaffar (elected)	East Riding Public	4/4	Jan 2019
Pat Collard (elected)	East Riding Public	0/4**	Jan 2019
Julie Hastings (elected) – Lead Governor	East Riding Public	4/4	Jan 2019
Ros Jump (elected)	East Riding Public	3/4	Jan 2018
Marie Nicoll (elected)	East Riding Public	1/4	Jan 2018
Nicholas Alexander (elected) resigned 1 March 2017	East Riding Public	2/3	Jan 2018
Mike Oxtoby (elected)	East Riding Public	1/4	Jan 2018
Peter Lacey (-elected)	Wider Yorkshire and Humber Public	3/4	Jan 2019
Vanessa Colman (elected)	Staff	0/4**	Jan 2018
Sarah Tyreman (elected) left 8.6.16	Staff	0/0	Jan 2018
Natalie Belt (elected) up to 31.1.17	Staff	2/3	Jan 2017
Anne Gorman (elected)	Staff	4/4	Jan 2019
Mandy Dawley (elected)	Staff	3/4	Jan 2019

Jezz Farmer (elected) took over from S Tyreman 9.6.16	Staff	3/4	June 2018
David Smith (appointed)	Hull and East Yorkshire Mind	2/4	Aug 2017
John Thirkettle (appointed)	Humberside Police	2/4	Feb 2019
Elaine Aird (appointed)	East Riding of Yorkshire Council	4/4	Jan 2019
Helena Spencer (appointed) left 6.5.16 replaced by Gwen Lunn	Kingston upon Hull City Council	0/0	Jun 2016
Gwen Lunn (appointed) from 6.5.16	Kingston upon Hull City Council	1/4	May 2019
Jonathan Beckerlegge (appointed)	NHS East Riding Clinical Commissioning Group	1/4	Aug 2016
Kirsty Fishburn (appointed)	University of Hull Faculty of Health and Social Care	3/4	Feb 2018
Andy Barber (appointed)	HEY Smile Foundation	0/4	Feb 2018
Craig Enderby (elected 1.2.17)	Staff	1/1	Jan 2020
Helena Spencer (elected 1.2.17)	Hull Public Governor	1/1	Jan 2020
Governors who left during 2016/17			
Sarah Tyreman	Staff		June 2016
Gary Wareing	Hull Public		Sept 2016
Nicholas Alexander	East Riding Public		March 2017
Helena Spencer	Appointed Governor		May 2016

** non-attendance through exceptional circumstances endorsed by the Chairman

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 2016 to 31 March 2017, a total of ten 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 £2,382.49.

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 on 01482 389132 or by emailing **HNF- TR.governors@nhs.net.**

Governor Elections

Elections were held in November/December 2016 for four governor seats covering two constituencies. The details are below:

- Public – Hull: Three seats were available and two candidates were elected uncontested.
- Staff: One seat was available which was filled through an election process.

Membership

A total of 126 new public members joined our Trust during 2016/17, taking our membership total (excluding staff members) to 12,820. This number aligned to our Membership Strategy to recruit at least the number of members that were lost due to bereavement, due to moving out of the area or for other reasons.

As of 31 March 2017, the Trust had 6,291 members in the East Riding, 5,632 in Hull, 695 in the wider Yorkshire and Humber area, 2,976* staff members and 202 members living outside our catchment area. Our Trust membership is fairly static; however, there are plans to hold more recruitment events within the constituencies to ensure our membership is as representative as possible of the communities we serve. Our staff are broadly representative of the Trust's public membership in numerical terms.

Membership Size and Movement		
Public Constituency (at 31.3.17)	2016/17	2017/18 (est)
At year start 1 April	13,245	12,820
New Members	126	750
Members Leaving	551	500
At year end 31 March	12,820	13,070

Staff Constituency (at 31.3.17)	2016/17	2017/18 (est)
At year start 1 April	2,993	2,976
New Members	0	750*
Members Leaving	17	1,250*
At year end 31 March	2,976	2,476

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 wish.

During 2016/17 recruitment opportunities were included as part of other events that took place throughout the year including World Mental Health Day, Hull Clinical Commissioning Group's Annual Meeting and Health Fair, a Time to Talk event, Hull University's Careers Fair, Recovery College events, Lawns Membership and the Bridlington World Café event.

The charts below show how membership is made up and the ethnicity profile up to 31.3.17

Analysis of Current Membership		
Public Constituency	Number of Members	Eligible Membership
Age (years)		
0 – 16	1	1,087,178
17 – 21	308	353,951
22+	11,561	3,972,173
Ethnicity		
White	12,152	4,692,156
Mixed	51	84,561
Asian or Asian British	171	835,964
Black or Black British	116	80,346
Other	29	40,910
Gender Analysis		
Male	4,632	2,672,306
Female	8,170	2,740,994

Membership is about community engagement and developing our organisation in partnership with the community. Through our membership we want our members to be truly interested in making a difference and getting involved.

One of the greatest benefits of being a foundation trust (FT) 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, puzzles and competitions.

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 organisations 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 illnesses associated with these conditions.

Contact details

The Membership Office is the initial contact point for new and existing members. Details of how to contact the Membership Office and our Governors are as follows:

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

Tel. 01482 389132

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 provided.

Single Oversight Framework

The Trust has an Integrated Performance Tracker which reports performance against identified key performance indicators to the Board on a monthly basis. Indicators reported are based around both the Monitor Risk Assurance Framework (Access and Outcomes Measures) and the Care Quality Commission's Intelligent Monitoring Framework (Caring, Effective, Safe, Responsive and Well Led).

Segmentation

Humber NHS Foundation Trust is recorded as being in segment 2 by NHS Improvement at the time of preparing this annual report. This indicates that the provider has been offered targeted support to address concerns around one or more of the framework's themes.

This segmentation information is the Trust's position as at 7 April 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and Use of Resources

The Finance and Use of Resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that Finance and Use of Resources is but one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score opposite.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	2	2
	Liquidity	1	1
Financial efficiency	I&E margin	2	2
Financial controls	Distance from financial plan	1	1
	Agency spend	2	2
Overall Scoring		**2**	**2**

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Humber NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of 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 Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance 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 the *NHS Foundation Trust Accounting Officer Memorandum.*

MICHELE MORAN

Chief Executive

26 MAY 2017

Annual Governance Statement

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, while 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.

The Trust Board through its Integrated Audit and Governance Committee agreed the Trust's 2016/17 Internal Audit Plan with its internal auditors which consisted of 18 reviews that have all been undertaken. The results of these audits culminated in the Head of Internal Audit's opinion on the system of internal control which has been incorporated as part of this statement.

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 2017 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. To support this, we have introduced the Corporate Risk Manager post into the Trust structure to develop and implement the Risk Management Strategy and framework across the Trust. This role also provides dedicated leadership and coordination to develop and deliver the Risk Management Strategy Implementation Plan and will lead in the development of information technology solutions required to support the move to an intelligent risk management environment.

Ultimate responsibility for the management of the risks facing the organisation sits with the Trust Board. The Board considers the strategic and high level Trust-wide operational risks facing the organisation as part of its routine business in order to satisfy itself collectively that risks are being managed appropriately. The Trust Board continuously strives to strengthen the culture of risk management throughout the organisation. Each Board Committee and its sub-groups has a collective responsibility to ensure effective risk management to ensure good governance as they discharge their duties, and this is reflected in their respective Terms of Reference. Through their work plans they will contribute towards reducing the organisation's exposure to risk. Risks identified by Committees and reporting groups will be communicated and recorded on the appropriate directorate risk registers and subject to overview, monitoring and intervention by the Risk Manager, providing assurance to the Audit Committee (AC) and Trust Board.

Following a review in 2016/17 the Integrated Audit and Governance Committee will be separated for 2017/18 business and the Trust will have an Audit Committee and a Quality Committee. Risks identified by committees and reporting groups will be communicated and recorded on the appropriate directorate risk registers and subject to overview, monitoring and intervention by the Risk Manager, providing assurance to the Audit Committee and Trust Board.

An independent review against NHS Improvement's well-led governance framework was conducted at the end of 2016/17 with the report expected at the start of the new year. Any recommendations arising from the review will be progressed upon receipt.

As the Chief Executive, I am accountable for having effective risk management systems and internal controls in place and for achieving statutory requirements. I have delegated overall duty to ensure risk management is discharged appropriately, to the Director of Nursing, Quality & Patient Experience, who is responsible for the implementation of Risk Management Strategy. Financial risk management has been delegated to the Director of Finance.

All Executive Directors, Care Group Directors, Clinical Care Directors, Associate Medical Directors and Managers are responsible for identifying, communicating and managing the risks associated with their portfolios in accordance with the Trust's risk management framework. They are responsible for understanding the approach towards risk management of all key clients, contractors, suppliers and partners and mitigate where necessary, where gaps are found. They are responsible for identifying risks that should be escalated to and from the Trust-wide Risk Register.

Guidance on populating risk registers and managing risk is available to all staff electronically via the Trust intranet. Roles and responsibilities in terms of risk management are incorporated into the Trust Risk Management Policy and Strategy and are also displayed via the intranet on the dedicated Risk pages. All staff employed by the Trust are required to attend the mandatory and statutory training that is relevant to their role and to ensure they meet their own continuous professional development requirements. Training covers mandatory requirements and elements that are dependent on the job role.

A risk management training needs analysis will be conducted in the early 2017/18 to identify training needs for staff groups across the Trust and a training plan developed and delivered. This will be incorporated into the strategy implementation plan, being recorded and monitored at an individual level.

The Risk and Control Framework

Humber NHS Foundation Trust is committed to embedding an integrated approach to managing risk, and recognises that the proactive and continuous management of risk is essential to the efficient and effective delivery of services. In year, the Trust Board has approved a three-year Risk Management Strategy which sets out the Trust's commitment to embedding this approach to managing risk and it is recognised that a proactive approach to risk management can enable a reduction in harm to patients and staff, assist in creating safer care environments and is essential for the achievement of the organisation's strategic goals as well as the Trust's corporate and clinical objectives.

The Trust has undertaken a self-assessment to identify areas for improvement within risk management and has developed a plan for implementing its Risk Management Strategy. Risk management objectives have also been developed, which are based on the outcome of the risk maturity assessment carried out by the Trust in line with national guidance and best practice.

An exercise has also been completed to define the Trust's risk appetite or the level of risk that it is prepared to accept, tolerate, or be exposed to. A risk appetite statement has been developed that was agreed by the Board of Directors, which defines the level of risk that can be accepted against key domain areas as well as the Trust's strategic goals.

The management of risks is a key factor in achieving the provision of the highest quality care, requiring the identification, management and minimising of activities or events which could result in unnecessary risks to service users, staff and visitors/members of the public. All of 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.

Current risks confronting the organisation are identified as part of a 'top down' assessment process and a 'bottom up' risk identification process involving analysis of incidents, claims and complaints and other tools such 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.

To ensure risk management is robust, we have used the 'Alarm National Model for Risk Management' to undertake a self-assessment of our 'risk maturity'. We will use this as a development tool, identifying areas for improvement, as well as setting and implementing clear plans. Risk management objectives have also been developed, which are based on the outcome of the risk maturity assessment carried out by the Trust and are in line with national guidance and best practice.

CQC Compliance

An announced scheduled inspection was carried out by the Care Quality Commission (CQC) in year, from 11th – 14th April 2016.

Immediately following the inspection, Humber NHS Foundation Trust was issued warning notices in three areas: lack of effective governance arrangements around the use of rapid tranquilisation (RT); lack of an effective procedure and process to support the use of seclusion; and the use of blanket restrictions within the Trust specifically in relation to the monitoring of patient mail within the Forensic Services.

Following the issuing of the aforementioned notices, the Trust took immediate action and provided a comprehensive response to the CQC on 14th June, 2016. All CQC reports were received by the Trust in early August and were published on 10th August, 2016 with the Trust's Quality Summit held on 7 October, 2016.

A comprehensive Improvement Plan was developed to address the concerns raised via the warning notices, regulation breaches and the 'must' and 'should' do actions that were detailed in the final inspection reports. The Improvement Plan was presented to the Trust Board in November 2016 and has been implemented throughout the remainder of 2016/17. Actions requiring direct commissioner involvement to be completed were identified within the plan.

Trust-wide Risks

The Trust-wide risk register holds risk that should they occur would have implications at a Trust-level and are referenced below: The current mitigating controls in place as well as the further areas for action are also detailed to indicate the level of mitigating control currently in place and additional actions planned for completion.

Risk Description

Failure to implement the Trust's Workforce Plan and Strategy may result in an inability to achieve the changes to culture and reputation which are aspired to by the organisation.

Mitigating Controls	*Further Mitigating Actions*
• Workforce and Organisational Development Strategy and implementation plan approved by Board • Organisational Development resource in place. • Investment in Leadership Programme. • Structures regularly reviewed to ensure levels of leadership are appropriate. • Plan for Leadership programme developed.	• Deploy plan and develop reporting. • Leadership Programme to commence in 2017.

Risk Description

Risk of a serious fire as a result of patients starting fires within their rooms and or 'other' parts of the premises. This may result in the fire developing and lead to death, injury, and significant building damage. The subsequent issues post fire would have a bearing and impact on service delivery

Mitigating Controls	*Further Mitigating Actions*
• Search policy and procedures in place. • Clinical risk assessments undertaken. • All units display poster on banned contraband items. • Property search on admission and banned items removed. • Patients returning from leave asked regularly above lighters. • Where permitted under current policy searches carried out on patients returning from leave. • Fire controls in place including risk assessments, alarms and Fire Wardens. • Event analysis undertaken in all incidents of fire. • Feedback delivered to all inpatient units following review of fires. • Briefing developed to inform required actions in event of fire. • Training packages updated to include full process for Trust staff in event of fire as well as the dangers of smoking/ ignition sources.	• Search policy to be amended to meet the needs of the Trust's complex client base. • All incidents to be reported via single reporting template. • Request for clinical system update to include specific alert for individuals with history of starting fires. • Risk assessment and MDT review to include recommendations in relation to fire for each patient with history of starting fires.

Risk Description

A national shortage of Medical Staff presents the Trust with difficulties in the recruitment of Medical Staff particularly for inpatient Units, resulting in the high use of Locums which may impact on service delivery and quality of care due to the lack of continuity.

Mitigating Controls	*Further Mitigating Actions*
• Recruitment of highly-trained Consultants to Community and Liaison posts. • Medical deployment reviewed and reflected in new job plans. • Newbridges and Westlands Units have a Specialty Doctor in place. • Appointment of two Community Consultants. • Marketing campaign and marketing pack issued. • Meetings completed regarding use of IR35 guidelines and recruitment incentives. • Transfer of some agency consultants onto Trust Locum contracts.	• Trust Enhanced Advert for various posts. • Development of a Trust-wide Non-Medical Prescribing Strategy to support medical staff. • Trust-wide Medical Workforce Strategy to be developed. • Care Group specific workforce plans to be produced. • Development of joint posts with local Universities and Hull York Medical School.

Risk Description

Risk to the safety and wellbeing of patients and staff as a result of the continued delay in identifying a suitable, safe alternative to Maister Lodge for the care and treatment of patients with dementia.

Mitigating Controls	*Further Mitigating Actions*
• Executive and senior management are sighted on the risk and looking for alternative solutions. • Environmental risk and issues are recorded and controls as far as possible applied within the confines of the environment and service provision. • Chief Operating Officer chairing meeting to identify and develop plans for inpatient services which addresses the needs identified. • De-cant option identified. • Operational plan in place to address premises fire risk.	• Identification of and approval to proceed with an affordable plan to provide a safe and suitable alternative for Maister Lodge accommodation. • Agreement to proceed with major refurbishments to make good the remedial works necessary for safety and to improve the environment for those in receipt of care. • Review of fire risk to be held with estates / fire safety officer to provide assurance on the adequacy of current measures. • Lease negotiations for de-cant premises.

Risk Description

Failure to recruit and retain appropriately qualified, skilled and experienced workforce will directly impact on the trusts ability to meet its objectives.

Mitigating Controls	*Further Mitigating Actions*
• Organisational Development and Workforce Strategy Implementation Plan. • Performance and Development Review process. • Leadership and management development programmes. • Human Resources process review group in place. • Staff engagement though Trust Consultation and Negotiation Committee. • Staff Health & Wellbeing Group and action plan. • Transformation programme includes staff engagement sessions. • Recruitment strategy.	• Prevention and Recovery Strategy. • Consistent approach to use of a recovery tool. • Align to Staff & Wellbeing agenda. • Further review to implement a robust recruitment process that attracts and appoints talented staff. • Brand development with Communications Team. • R & R packages were developed for key risk areas. • Delivery of Workforce and Organisational Development strategy and improvement plan deployed. • Leadership and development programmes • Full implementation of e- rostering.

A governance framework was put in place to ensure effective monitoring of the delivery of the Improvement Plan, and the Rapid Improvement Team (RIT), which was established in early October to ensure that required improvements in clinical practice were fully embedded.

The CQC made an unannounced visit to the Trust on 1 and 2 December, 2016 and visited the Humber Centre and Adult Mental Health units to assess compliance against the areas identified in the warning notice. The CQC reports from this Inspection were published on 17 February, 2017 and confirmed that the Trust had made the required improvements and consequently the warning notices were withdrawn.

However, the report identified areas where the Trust needed to improve, including:

- ensuring that physical health monitoring was carried out in line with the Trust policy, following the use of rapid tranquilisation;
- ensuring that all qualified staff were up to date with immediate life support training;
- ensuring that clinicians carried out reviews for patients in seclusion within the timeframes specified in their policy and that seclusion ended at the earliest opportunity.

The Improvement Plan is monitored as part of the overall CQC Improvement Plan and remains a key area of focus. CQC indicators are reported as part of the Trust Integrated Performance Tracker and are recorded in Care Group Dashboards. KPIs that are failing to either meet a target or are showing a continued downward trajectory and at risk of breaching a target are reported by exception on Performance Indicator returns (PIs). PIs are discussed with operational staff to understand the issues and problems and current action plans are agreed that would support the development of services and make improvements that will enable the Trust to meet its contractual obligations.

Trust-wide risks

The Trust-wide risk register holds risk that should they occur would have implications at a Trust-level and are referenced below: The current mitigating controls in place as well as the further areas for action are also detailed to indicate the level of mitigating control currently in place and additional actions planned for completion.

The Trust Board maintains overarching responsibility for risk management throughout the Trust and considers the Trust-wide Risk Register and Board Assurance Framework four times a year.

Governance structure

Each Board committee and its sub-groups has a collective responsibility to ensure effective risk management to ensure good governance as they discharge their duties, and this is reflected in their respective terms of reference. Through their work plans they will contribute towards reducing the organisation's exposure to risk. Risks identified by committees and reporting groups will be communicated and recorded on the appropriate directorate risk register and subject to overview, monitoring and intervention by the Corporate Risk Manager, providing assurance to the Audit Committee and Trust Board.

Integrated Audit and Governance Committee 2016/17 - is the Board committee with overarching responsibility for risk. The role of the committee is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It seeks regular assurance on the Trust's risk management arrangements to enable it to review the organisation's approach to risk management as well as reviewing the Trust-wide risk register and Board Assurance Framework regularly. The committee reviews the adequacy of all risk and control related disclosure statements together with any accompanying Head of Internal Audit statement, external auditor opinion or other appropriate independent assurances. On occasion it will commission internal or external auditors to review and report on aspects of risk management or on the management of significant risks.

Strategic Investment Committee - is a Board committee whose remit it is to conduct independent and objective review and oversight of the Trust's trading and commercial investment activities on behalf of the Board, and to ensure compliance with investment policy and strategic objectives.

Mental Health Legislation Committee - is a Board committee whose remit it is to provide strategic leadership pertaining to the Mental Health Act, the Mental Capacity Act and their respective codes of practice and other mental health related

legislation, as well as to monitor, provide challenge and seek assurance of compliance with external standards relating to mental health legislation and approve and review mental health legislation policies and protocols.

Executive Management Team (EMT) - involves all Executive Directors and is chaired by the Chief Executive. The Executive Management Team provides the leadership for risk management across the Trust, considering and approving the development of systems and processes, as well as championing risk management within their areas of responsibility. This group is the lead for managing the Trust-wide Risk Register, monitoring the management of risk. They consider and accept new items on to the Trust-wide Risk Register and reviewing and revising risk entries on a regular basis, as well as the approval/removal of any risks from the register at the request of the Corporate Risk Manager. The Trust-wide risk register and Board Assurance Framework are reviewed by the EMT on a monthly basis.

Operational Management Group - is accountable to EMT and established to oversee all aspects of operational planning, performance and delivery. This is a multidisciplinary group chaired by the Chief Operating Officer. They receive care group risk registers for information and assurance purposes.

Operational 'Performance and Risk' Group - is chaired by the Chief Operating Officer and considers the care group risk registers, as well as thematic risks from directorate risk registers. This group is responsible for ensuring that risk assessments are consistent, timely and appropriate actions to manage and mitigate risks are being taken, and that similar risks across the Trust are identified, cross-referenced and considered as a whole.

Directorate Business meetings - are held within each directorate, and are responsible for ensuring that appropriate risk registers are in place, risks are being effectively captured and appropriate mitigating actions are being taken. They are also responsible for highlighting risks for escalation/ de-escalation, based on the current risk score and perceived business impact for the Trust, to/ from the Trust-wide risk register via the Executive Management Team.

Care Group Business meetings - are held within each care group, and are responsible for ensuring that appropriate risk registers are in place, risks are being effectively captured and appropriate mitigating actions are being taken. They are also responsible for highlighting risks for escalation/ de-escalation, based on the current risk score and perceived business impact for the Trust, to/ from the Trust-wide risk register via the Executive Management Team.

Quality & Patient Safety Committee (QPAS) - is accountable to the Executive Management Team (EMT). It oversees and coordinates all aspects of quality improvement (patient experience/ patient safety & clinical effectiveness), assurance and clinical governance activity and delivery. The committee has responsibility to escalate any issues which may have a potential impact on the delivery of the organisational objectives to the Executive Management Team.

Clinical Risk Management Group (CRMG) - reports to QPAS and has responsibility for ensuring clinical risk management systems, processes and related clinical risk management strategies and policies are regularly reviewed and implemented Trust-wide. The group ensures that systems and processes are developed and maintained to enable Trust-wide monitoring and review of all clinical risks to ensure appropriate investigation, and maximisation of learning from incidents.

Infrastructure, Safety and Compliance Committee - receives updates from multiple infrastructure, safety and compliance related sub groups, ensuring that strategic decisions are made and appropriate action taken to either resolve, mitigate or appropriately escalate issues and risks. Accountable to QPAS, it also feeds into the CPB, CRMG, and EMT.

Emergency Preparedness Resilience and Response (EPRR) - reports to the Operational Management Group on the delivery of the objectives of the sub-group, including the identification, management and reporting of EPRR risks.

Capital Programme Board - reports to EMT following the assessment and prioritising of capital applications based on underlying risk.

Information Governance Committee – reporting to Integrated Governance and Audit Committee in 2016/17 the Committee ensures that the Trust has effective policies and management arrangements covering all aspects of Information Governance. The Committee ensures robust systems of internal control are established and maintained.

The key to effective governance within the Trust is a robust integrated committee structure and management process, which gives the Board 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 governance structure in place within the Trust and referenced in this section of this statement is subject to ongoing review to ensure that it is effective and provides appropriate scrutiny and oversight.

Annual Governance Statement / Board Assurance

The requirement to produce an Annual Governance Statement as part of the Annual Report and Accounts, enable the Trust Board to demonstrate that risks with the potential to impact upon the delivery of the Trust's principal strategic objectives are being appropriately managed. The validity of the information detailed within the statement can be evidenced in practice through the use of the Board Assurance Framework (BAF) within the Trust. The framework is used to monitor the principal risks to the corporate objectives which underpin the Trust strategic goals, as well as monitoring mitigating controls and actions, sources of assurance and positive/negative assurances contributing to the overall rating assigned to the strategic objective. Through the established assurance processes implemented within the Trust, the Board maintain oversight of systems and standards regarded as appropriate for a supplier of healthcare services in the NHS.

Development of the Board Assurance Framework has continued throughout 2016/17, and the format of the framework has been updated with input from the Trust Board. The BAF has been further developed in line with review of other NHS organisation's frameworks and the identification of positive elements from those reviewed. Information is presented with a focus on actual assurances received, as well as the risks to the key objectives that sit under each of the strategic goals. The BAF aims to allow the Board to monitor progress against the Trust's strategic goals in 2016/17, as well as progress against individual identified risks, with the framework highlighting the movement of current risk ratings from the previous quarter's position. This format allows for clear consideration to be given to the risks, controls and assurances, which will enable a focused review and discussion of the challenges to delivery of the organisational objectives.

The framework also provides a comprehensive evidence base for compliance against internal and external standards, as well as targets and requirements including CQC registration. The Framework is monitored closely by the Executive Management Team on a monthly basis. Individual meetings also take place with each of the Trust Executives on a quarterly basis to undertake a review of their allocated strategic goal(s) and aligned risks. This process ensures that there is robust confirm and challenge prior to submission to the Trust Board and Audit Committee each quarter.

Risk management activities undertaken within the Trust operate at a number of levels: for example, a health or social care professional creating a risk management plan for a service user; health and safety assessments of local facilities, incident reporting and organisational learning, corporate planning around the organisational response to a major incident; or risk assessment and mitigation for business expansion and development. The Trust risk management strategy and its related procedures serve to set these various risk management activities within a broader corporate framework and to identify a consistent approach to risk management across the Trust. Risk management is also embedded throughout the committee and organisational structure of the Trust with clear escalation routes of risks between units and the board ranging from operational sub-groups up to the Trust Board.

Public stake-holders involvement is sought where appropriate by the Trust and is managed through the Patient and Carer 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 Healthwatch and Overview and Scrutiny Committees is being pursued. The Patient Advice and Liaison Service (PALS) is well established within the Trust and there is effective reporting quarterly to the Trust's Audit Committee and Board meetings. The Trust Board holds a meeting in public on a monthly basis and stakeholder attendance is encouraged.

Humber NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC) as at the 31 March 2017.

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

Control measures are in place to ensure 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.

Trust Achievements

Below are some of our most important Trust achievements during 2016/17 by Trust Care Group.

Adult Mental Health Services

- Implemented a new model for access into services and for mental health crisis by establishing the Rapid Response Service across Hull and East Riding.
- Secured funding for the new 'crisis pad' through a business case which was the top priority of the multi-agency Crisis Care Concordat group.
- Changed from care cluster mental health teams in Hull to a new locality community mental health team service structure.
- Developed a rehabilitation/recovery model which released money to reinvest in community-based services.

Specialist Services

- Secured the addictions contract for East Riding of Yorkshire, including criminal justice services, in partnership with The Alcohol and Drugs Service (ADS) and NACRO, a national social justice charity;
- Successfully implemented complete electronic patient information systems in Forensic and Addictions services (Lorenzo and SystmOne);
- Patients and staff from across the organisation collaborated on design and painting of Street mural to coincide with service going 'smoke free'.

Children's and Learning Disability Services

- Continued focus on access to all of our services, progress has continued across all service areas in improving waiting times.
- Retained key services and achieved income growth. Specifically, we have retained 0- 19, which is currently being re-designed. We have also secured services at Millside.
- Learning Disability services have won awards throughout the year for My Health App, regional leadership awards and most recently the Health Education England talent awards for our approach to apprenticeships. The service remains central to the implementation of the local Transforming Care agenda;

Community and Older People's Mental Health Services

- Mobilised community and out-of-hours services in Whitby. Implementation of Physio Direct, which gives residents access to our musculoskeletal service - or outpatient physiotherapy service - is just one example of how we have improved patient care.
- STROKESTRA – a pioneering project between our Hull Integrated Community Stroke Service (HICSS) and the Royal Philharmonic Orchestra (RPO) established that creative music-making can be used to support the rehabilitation of stroke patients. The initiative gained national media attention.
- Smoking cessation – work is under way to further reduce the number of smoking- related deaths in East Riding. The current figure matches the national average. Our holistic approach attempts to change behaviour via interventions which are patient- centred, face-to-face and responsive and supports the public health strategy.
- Enabled the smooth transition of our community services in East Riding to a new provider

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 and its sub-committee structure have a clear role in providing assurance and governance leadership within the Trust, particularly around the achievement of efficiency and effectiveness, which is a key area of focus under the Trust's governance arrangements supported by internal and external audit reviews.

Integrated Audit and Governance Committee (2016/17) 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 committee 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.

Findings and recommendations from audits are monitored and reported through this committee. The Trust's external auditors are required as part of their annual audit to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the Trust has not.

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 Committee also provides an overview of tenders.

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.

Trust performance is monitored by the Board on a monthly basis. Finance reporting is undertaken, which informs the Board of the Trust's current financial position and provides a comparison with the planned position for the reporting period. Regular reports are also provided in relation to the Trust's Cost Improvement Programme (CIP) and its level of achievement.

Performance against key indicators is reported via the Integrated Performance Report which provides data in regards to finance, clinical and workforce indicators alongside national or local targets and objectives.

Any areas of concern or poor performing area are highlighted and mitigating actions are determined as appropriate by the Board. Specific reporting of service waiting times and regular updates for the Trust's care groups are also considered through the Trust Board to ensure that resources are being used effectively within the Trust and that any areas of concerns can be addressed quickly.

Information Governance

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 as satisfactory with respect to the IG toolkit assessment for 2016/17.

In order to provide assurance that information governance practices are compliant with Trust policy, legal and regulatory requirements and are embedded in the Trust culture, a programme of random 'spot check' audits is conducted throughout the Trust. This ensures that information governance policies, process and operational activities are effective on the ground and compliant with Information Governance Toolkit requirements and CQC outcomes 2 and 21 – Consent to Care and Treatment and Records. If this is not the case, corrective action is recommended by the Information Governance department. The results of these audits confirm that information governance practices are well established and are compliant with Trust policy, legal and regulatory requirements.

The Trust has encrypted laptops, encrypted data devices and desktop computers and has reviewed the security of all bulk data in transit and personal identifiable data flows identified and mitigated against any risks. The Trust has undertaken a refresh and review of its critical information assets. Its key information assets have been identified and approved by the IG Committee this year and each has an Information Asset Owner assigned. Each asset has been updated in the Information Asset Register which has been approved by the Information Governance Committee. 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 previously migrated to NHS Mail for additional security for data transfers.

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. NHS Improvement (in exercise of the powers conferred on 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.

Annual Quality Accounts are published as part of the Trust Annual Report and in their development for 2016/17, the Trust has worked with key stakeholders such as: governors; HealthWatch; local authority members; members of the overview and scrutiny committees; patients/ carers and their representatives as well as commissioners, to ensure that the priorities selected for review were appropriate and that the publication fairly represented the quality of our service delivery. Stakeholders are sent a draft version of the accounts for comment prior to publication, and where these partners have commented on the quality accounts, feedback in printed verbatim within the final version.

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

- Impact on improving quality through considering the likely improvement in safety, clinical outcomes and experience
- 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:

Quality Accounts Priorities 2017/18
We will work with partners to reduce the stigma of mental illness by delivery a recovery focussed approach to achieve social inclusion.
We will implement the Trust Organisational Development Plan to support staff with their development, health and wellbeing.
We will work with our staff, patients, carers and the public to co-design improvements to the Trust's inpatient facilities.

Each of the identified priorities has a set of clear key performance indicators to ensure delivery.

A number of public consultations took place for our key stakeholders, governors, staff and patient group representatives. During the events, presentations were delivered on the key areas for development, and following group discussion, those present were asked to prioritise their top focus areas to the other attendees. The Trust was given feedback that some of the priorities initially identified should be amended to better reflect the needs of our patients and staff. The required changes were subsequently made and the final priorities were then agreed by our Board members.

Data Quality

The Trust has continued to take necessary steps to assure itself of the robustness of its data quality. Processes are in place within the Trust for the monitoring of performance information, both centrally through the Trust's Performance team and at operational level within the care groups, such as regular meetings to review waiting time data.

During 2016/17, the Trust has further developed the Integrated Performance Tracker which serves as useful tool for bringing together all aspects of Trust performance and allows for effective identification of trends, as well as the escalation of key issues to the Trust Executive Management Team and Trust Board as required. The report format has undergone review during 2016/17, and suggested indicators for future reporting have been discussed by the Executive Management Team to further enhance the reporting arrangements and quality of data used.

A monthly Quality Report is presented to the Trust Board outlining the Trust's performance against key quality objectives including comparative data, and a safer staffing dashboard is presented highlighting key staffing indicators. New weekly return forms have been introduced to allow for consistent entry submissions limiting the choices to the nationally set criteria. This process also allows for more accurate data quality in terms of clinical effectiveness at care group level.

Partnership Working

The Trust is engaged in wide partnership working within the local health economy and the wider geographical area. Some examples of partnership working can be found below:

Humber Transforming Care Partnership

The Humber Transforming Care Partnership was established to work on a wider footprint than our usual learning disability planning partnerships, with consequent increased scope for economies of scale and greater opportunities for learning from the experience of other areas and organisations.

This three year transformation plan is written in response to 'Building the right support' and the national service model published in October 2015, which set out a national vision for a radical shift in the delivery of care and support for people with learning disabilities and/or autism.

Priorities have been defined locally and will be reviewed by the transforming Care Partnership Operational Group. These are:

- Short term accommodation options including Crisis and Short Breaks Support
- Positive Behavioural Support Team/Complex care behaviour distress pathway
- Enhanced complex care service for people with Profound and Multiple Learning Disabilities (PPMLD)
- Acute liaison
- Advocacy
- Increased availability of communication techniques and sensory profiling to support individuals with complex neurological impairments including Autism
- Supported Living capacity which can safely manage individuals with highly complex needs and challenging behaviour, including offending histories

Humber Coast and Vale Sustainability Transformation Plan

The Humber Coast and Vale STP footprint covers 6 Clinical Commissioning Groups (CCGs), North East Lincolnshire, North Lincolnshire, Hull, East Riding, Vale of York and Scarborough and Ryedale. The footprint covers a population of 1.4million.

The STP is required to address, the Health and Wellbeing Gap, the Care and Quality Gap and the funding and Efficiency Gap.

Six priorities have been identified which are:

- Helping people stay well
- Place based care
- Creating the best hospital care
- Supporting people with mental health problems
- Helping people through cancer
- Strategic commissioning

The Trust has been asked to take a lead role in this work to help to influence across the STP footprint.

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 Integrated Audit and Governance Committee 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 on 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 Integrated Audit and Governance Committee 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 committee 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 Integrated Audit and Governance Committee. 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 Audit Committee.

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 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 of the internal auditor's opinion above, and the audits of communication and engagement arrangements, health and safety management and arrangements for implementation of NICE guidance undertaken in year where limited assurance was provided. Weaknesses were identified in these areas, indicating additional work required, but were not considered to have a potential impact on the achievement of the Trust's objectives. Work is ongoing within the organisation to address the recommendations made by internal audit and to strengthen the systems and processes in place.

MICHELE MORAN

Chief Executive

26 MAY 2017

Equality and diversity

Progress against our objectives for 2016/2017 and proposed core objectives for 2017/2018 are detailed below.

Staff objectives for 2016/2017

- To act on the analysis of the NHS Workforce Race Equality Standard (WRES) and take steps to close the gap between the treatment of white and BME staff.
- To repeat the review of NHS job applications and HR case work activity.

Key achievements and outcomes

To act on the analysis of the WRES and take steps to close the gap between the treatment of white and BME staff

Hull and East Riding remains a challenging area due to its ethnicity demographic and geographical positioning. The 2011 census statistics show that the non-white population of East Riding and Hull to be 3.8% and 4.5% respectively.

The WRES analysis of the relevant questions from the 2016 National NHS Staff Survey shows the following data/information.

Staff Attitude Survey (SAS) question	2016 score of those surveyed	
KF25 % of staff experiencing harassment, bullying or abuse from patients relatives or the public in the last 12 months	White	30%
	BME	33%
KF26 % of staff experiencing harassment, bullying or abuse from staff in last 12 month	White	25%
	BME	7%
KF21 % of staff believing the organisation provides equal opportunities for career progression or promotion	White	87%
	BME	91%
Q17b in the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleague	White	6%
	BME	6%

Actions taken against the WRES objectives for 2016/17:

WRES objectives 2016/17	Key achievements/objectives
To analyse the ratio of number of applications made to shortlisted candidates from NHS jobs 2 in relation to protected characteristics including ethnicity	This data is currently being analysed
To review the equality and diversity training offered and make this a mandatory requirement for staff	A review has been undertaken of the equality and diversity training currently offered to staff and the e-learning module is considered to be relevant and accessible for most staff. This was made mandatory for staff, there has also been a leaflet developed for staff who have not got regular access to a computer
To consider using national promotion days for local staff engagement and well being	2016/17 has been a developmental year for health and wellbeing with activities for staff involvement to promote mental, physical and emotional wellbeing. A specific E&D event is planned for May 2017
To continue to promote equal access to career opportunities	The Trust continues to score positively (87%) in this area of the SAS. The WRES report shows that 91% of BME staff who completed the SAS reported positively in this area, and this is above the national average
To re-launch the Equality and Diversity Steering Group	This group was re-launched in 2016 and contributed to the completion of the EDS scheme on behalf of the Trust

Review of information of NHS job applications, HR case work activity and Trust workforce information shows the following data/information.

Our Trust profile shows a ***Gender*** split of approximately 79% female and 21% male. NHS job applications are broadly proportionate in that 77% were from females and 23% were from males in the year to 31 March 2017. These figures show that as at 31.3.17 we employed slightly less women and slightly more men than last year.

Age profile of the Trust remains an ageing one with the highest headcount in the age ranges 40-59 (59%) and 9.4% of the workforce are aged 60 and above. NHS job applications show the highest number of applications come from age ranges 18-34 (56%) which is an encouraging sign for future workforce planning needs.

The vast majority of applicants through NHS Jobs declared that they had no ***Disability*** (92.5%) however the Trust currently reports that of staff employed, 4% declared a disability, which is proportionately similar to the of applicants that do declare a disability (6%), which could suggest the Trust is positive about employing staff with a disability. It is worth noting that of staff employed, 35% of staff have chosen to either not declare a disability or have chosen to select undefined.

Ethnicity of the Trust is reported as 82% white British/white other, with 3.2% BME and 12.5% choosing not to declare an ethnic background. These figures are in line with the ethnicity data reported from applications on NHS Jobs which is detailed as 88.5% white British/White other. Ethnicity data for the East Yorkshire and Hull region is detailed respectively at 96.2% and 95.5% white British/white other. It is difficult to accurately assess if we are representative of the local communities when 12.5% remain undisclosed.

Christianity is the highest ***Religion*** recorded in the Trust (38%), however 27.7% of staff did not disclose their religion or it remains unspecified. NHS job applications show 45.9% declared themselves as Christians, 20.5% declared themselves atheists, 14.8% were undisclosed and 15.1% stated other. So the Trust profile remains broadly proportionate with regard to applicants and Trust profile.

Sexuality disclosure in the Trust remains predominantly heterosexual (63.6%) or undisclosed or unspecified (35.2%). NHS jobs applications report 89.7% heterosexual and 6.6% were undisclosed. These figures imply that individuals feel comfortable declaring that they are heterosexual, whilst those who are not heterosexual feel less comfortable declaring their sexuality.

Marital status in the Trust is reported as 53.5% married and 29.9% single whilst NHS job applications report single as the most recorded status at 56.2% followed by married at 30.4%. This may suggest a correlation in relation to the age profile of the Trust.

Active ***HR casework*** during this period reports show that there have been nine bullying and harassment cases which is an increase of seven from last year. Capabilities have increased by four to 17 and there has been an increase of 16 (58 from 42) in disciplinary cases. Five formal flexible working requests were received (a reduction of five from last year) and 59 grievances which is an increase from 26 last year. We have not received any Whistleblowing cases during this period, which is an improvement from one last year.

Of those individuals involved in HR casework just over a quarter (26%) were male and three quarters (74%) were female staff, which indicates a higher proportion of male staff are involved in formal HR cases when compared to the Trust figure of male staff employed by the Trust.

Of the formal flexible working requests one was from a male, and four were from females, this shows a significant reduction from ten formal requests last year, but the split is similar as there was one request from a male last year. This demonstrates a slightly higher proportion of requests from women as opposed to men when compared to Trust workforce data; four of these requests were approved.

Modern Slavery Act 2015

Humber NHS Foundation Trust takes a number of steps to ensure slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business. We do this by:

- Working towards full compliance with the relevant legislation and regulatory requirements.
- Working to promote the requirements of the legislation, making our approach known to our suppliers and service providers.
- Building on our existing workforce awareness of human trafficking and modern slavery, through our safeguarding policies/protocols and commercial learning.
- Considering human trafficking and modern slavery issues when making procurement decisions.

Independent Auditor's Report to the Council of Governors and Board of Directors of Humber NHS Foundation Trust

Opinion on financial statements of Humber NHS Foundation Trust

In our opinion the financial statements:

- give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2017 and of the Group and Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement - 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 that we have audited comprise:

- the Consolidated Statements of Comprehensive Income;
- the Group and Trust Statements of Financial Position;
- the Group and Trust Statements of Cash Flow;
- the Statement of Changes in Equity; and
- the related notes 1 to 46.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement - 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 Code of Audit Practice.

Key Risks	The key risks that we identified in the current year were: • NHS Revenue and Provisions • Property Valuations Within this report, the risks which are the same as the prior year identified with ⟩⟩
Materiality	The materiality that we used in the current year was £2.86m which was determined on the basis of 2% of total operating income.
Scoping	All testing of the Group was performed by the main audit engagement team performed at the Trust's head offices in Beverley, led by the audit partner.
Significant changes in our approach	In 2015/16 we used 1.5% of operating income as the basis for materiality. We reassessed the percentage used to 2% of operating income in the context of our cumulative knowledge and understanding of the audit risks faced by the Trust for this year.

Going concern

We have reviewed the Accounting Officer's statement that the Group 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 Group'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 Group's ability to continue as a going concern.

Independence

We are required to comply with the Code of Audit Practice and Financial Reporting Council's Ethical Standards for Auditors, and confirm that we are independent of the group and we have fulfilled our other ethical responsibilities in accordance with those standards.

We confirm that we are independent of the group and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.

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.

NHS revenue and provisions

Risk Description

As described in note 1.2, Accounting Policies and note 1.21, Critical Accounting Judgements and Key Sources of Estimation Uncertainty, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes.

Details of the Group's income, including £116.6m of Commissioner Requested Services, are shown in note 3.1 to the financial statements. NHS debtors of

£6.6m are shown in note 27.1 to the financial statements

The Group earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position. The majority of the Group's income comes from NHS East Riding of Yorkshire Clinical Commissioning Group (£56.Sm), increasing the significance of associated judgements. The settlement of income with Clinical Commissioning Groups continues to present challenges, leading to disputes and delays in the agreement of year end positions.

This risk is discussed by the Audit Committee on page 43.

How the scope of our audit responded to the risk

We have evaluated the design and implementation of the controls around the senior sign off of contract variations. We have tested income recognised in the year to final signed contracts and variations.

We considered the management paper summarising any contract variations that are in dispute, challenges from commissioners and the rationale for accounting treatments adopted.

Continued overleaf...

We have assessed the appropriateness of the judgements made regarding recognising revenue and provisions for any disputes on the basis of discussion with the staff involved and review of correspondence with commissioners and other relevant documentation.

Key observations

From the testing performed we are satisfied that NHS revenue has been appropriately recognised.

Property valuations

Risk Description

The Group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £67m. The valuations are by nature assumptions (including the floor areas for a Modern Equivalent Asset, the basis significant estimates which are based on specialist and management for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value.

As detailed in note 1.5, there are significant judgements in property valuations due to the specialist knowledge required to conduct the valuation and assumptions used.

In 2016/17 the Trust revalued its estate resulting in a £7.2m revaluation gain offset by a £2.4m impairment. These movements are disclosed in notes 6 and 20 to the Financial Statements. The movements are recognised in the Statement of Comprehensive Income.

This risk is discussed by the Audit Committee on page 43.

How the scope of our audit responded to the risk

We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Group to the valuer.

We used Deloitte internal valuation specialists to review and challenge the properties, including through benchmarking against revaluations performed by appropriateness of the key assumptions used in the valuation of the Group's other Groups at 31 March 2017.

We have reviewed the disclosures in notes 1.5 and 17 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation.

We assessed whether the valuation and the accounting treatment of this was compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.

Key observations

'From the testing performed, we are satisfied that the valuation of Property, Plant and Equipment has been appropriately recognised.

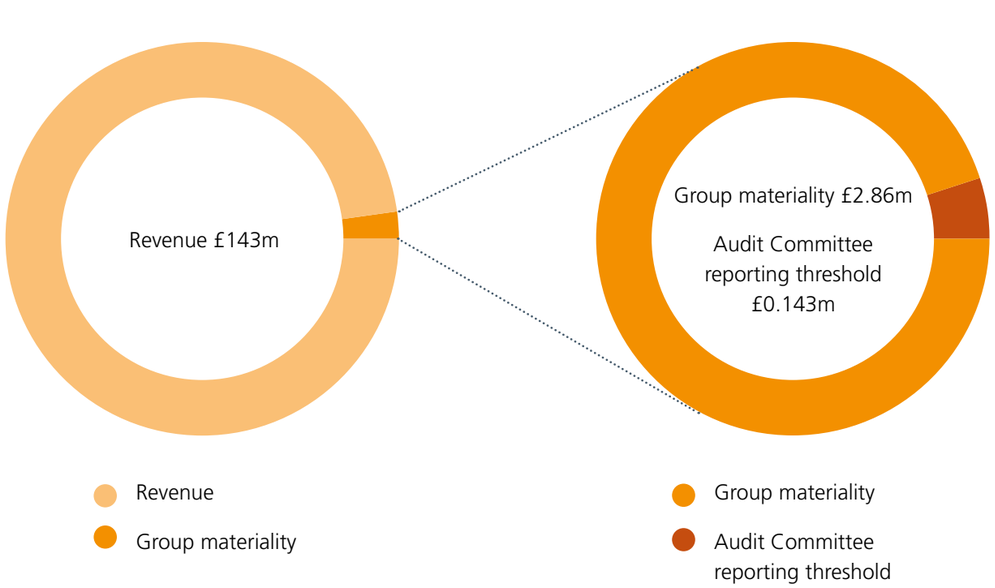
These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

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.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Group materiality	£2.86m (2015/16: £1.95m)
Basis for determining materiality	2% of operating income (2015/16: 1.5% of operating income) We reassessed the percentage used in the context of our cumulative knowledge and understanding of the audit risks at the Trust and our assessment of those risks for this year as well as the materiality's adopted for other foundation trusts nationally. This level of materiality represents an increase from that used in the prior year and is in line with the basis adopted across other Foundation Trusts within our portfolio who exhibit similar levels of risk.
Rationale for the benchmark applied	Operating income was chosen as a benchmark as the Trust is a non profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £143k (2015/16: £98k), 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 group audit was scoped by obtaining an understanding of the Group and its environment, including internal controls, and assessing the risks of material misstatement at the Group level.

The focus of our audit work was on the Trust, with work performed at the Trust's head offices in Hull directly by the audit engagement team, led by the audit partner.

Our audit covered the primary Trust entity within the Group which accounts for 99% of the Group's net asset and 100% of the group deficit for the year.

At the Group level we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information of the remaining components not subject to audit or audit of specified account balances.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems.

All testing was performed by the main audit engagement team, led by the audit partner.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the part of the Directors' Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability 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 Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- 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 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.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

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

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

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 Group acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to consider 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 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 Code of Audit Practice and International Standards on Auditing (UK and Ireland). 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 and independent partner reviews.

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 Group's and 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 H Hewitson

PAUL HEWITSON (FCA)

for and on behalf of

Deloitte LLP

Chartered Accountants and Statutory Auditor Newcastle Upon Tyne

26 MAY 2017

2016/17 Audited Accounts

Annual accounts for the year ended 31 March 2017

Foreword to the Accounts

These accounts, for the year ended 31 March 2017, have been prepared by Humber NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

MICHELE MORAN

Chief Executive

26 MAY 2017

Consolidated Statement of Comprehensive Income

		Group	
		2016/17	2015/16
	Note	£000	£000
Operating income from patient care activities	3	132,918	122,868
Other operating income	4	10,073	6,614
Total operating income from continuing operations		**142,991**	**129,482**
Operating expenses	5, 7	(142,584)	(132,692)
Operating surplus / (deficit) from continuing operations		**407**	**(3,210)**
Finance income	10	35	37
Finance expense - financial liabilities	11	(193)	(196)
Finance expense - unwinding of discount on provisions	35.1	(29)	(21)
PDC dividends payable		(1,998)	(1,860)
Net finance costs		**(2,185)**	**(2,040)**
Gains/ (losses) on disposal of non-current assets	12	-	-
Gains/ (losses) arising from transfers by absorption	42	-	86
Movement in the fair value of investment property and other investments		-	-
Corporation tax expense		-	-
Deficit for the year from continuing operations		**(1,778)**	**(5,164)**
Surplus/(deficit) on discontinued operations and the gain/ (loss) on disposal of discontinued operations		-	-
Deficit for the year		**(1,778)**	**(5,164)**

	Note	2016/17 £000	2015/16 £000
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(2,405)	(807)
Revaluations	20,17	7,175	3,554
Remeasurements of the net defined benefit pension scheme liability/asset	38	(173)	4
Other reserve movements		-	-
Total comprehensive income / (expense) for the period		**2,819**	**(2,413)**
Deficit for the period attributable to:			
non-controlling interests; and		-	-
the Foundation Trust		(1,778)	(5,164)
Total comprehensive income / (expense) for the period attributable to:			
non-controlling interests; and		-	-
the Foundation Trust		2,819	(2,413)

Statement of Financial Position

	Note	Group 31 March 2017 £000	Group 31 March 2016 £000	Trust 31 March 2017 £000	Trust 31 March 2016 £000
Non-current assets					
Intangible assets	15, 16	1,117	594	1,117	594
Property, plant and equipment	17, 18	68,412	66,146	68,412	66,146
Other investments	24	6	6	-	-
Total non-current assets		**69,535**	**66,746**	**69,529**	**66,740**
Current assets					
Inventories	26	125	99	125	99
Trade and other receivables	27	10,678	7,173	10,678	7,173
Cash and cash equivalents	29	9,877	15,135	9,426	14,659
Total current assets		**20,680**	**22,407**	**20,229**	**21,931**
Current liabilities					
Trade and other payables	30	(12,742)	(14,496)	(12,706)	(14,476)
Other liabilities	31	(468)	(508)	(468)	(508)
Borrowings	32	(255)	(255)	(255)	(255)
Provisions	35	(414)	(527)	(414)	(527)
Total current liabilities		**(13,879)**	**(15,786)**	**(13,843)**	**(15,766)**
Total assets less current liabilities		**76,336**	**73,367**	**75,915**	**72,905**
Non-current liabilities					
Other liabilities	31	(405)	(58)	(405)	(58)
Borrowings	32	(4,214)	(4,468)	(4,214)	(4,468)
Provisions	35	(827)	(1,020)	(827)	(1,020)
Total non-current liabilities		**(5,446)**	**(5,546)**	**(5,446)**	**(5,546)**
Total assets employed		**70,890**	**67,821**	**70,469**	**67,359**
Financed by					
Public dividend capital		43,943	43,693	43,943	43,693
Revaluation reserve		12,959	8,489	12,959	8,489
Other reserves		(169)	4	(169)	4
Income and expenditure reserve		13,736	15,173	13,736	15,173
Charitable fund reserves	25	421	462	-	-
Total taxpayers' and others' equity		**70,890**	**67,821**	**70,469**	**67,359**

The notes on pages 11 to 62 form part of these accounts.

MICHELE MORAN Chief Executive

26 MAY 2017

Statement of Changes in Equity for the year ended 31 March 2017

Group	Note	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	NHS charitable funds reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward		**43,693**	**8,489**	**4**	**15,173**	**462**	**67,821**
Surplus/(deficit) for the year		-	-	-	(1,737)	(41)	(1,778)
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits		-	(300)	-	300	-	-
Impairments	6	-	(2,405)	-	-	-	(2,405)
Revaluations	17	-	7,175	-	-	-	7,175
Remeasurements of the defined net benefit pension scheme liability/asset	38	-	-	-	(173)	-	-	(173)
Public dividend capital received		250	-	-	-	-	250
Taxpayers' and others' equity at 31 March 2017		**43,943**	**12,959**	**(169)**	**13,736**	**421**	**70,890**

Statement of Changes in Equity for the year ended 31 March 2016

Group	Note	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	NHS charitable funds reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2015 - brought forward		**44,293**	**5,933**	**-**	**20,139**	**469**	**70,834**
Surplus/(deficit) for the year		-	-	-	(5,157)	(7)	(5,164)
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits		-	(191)	-	191	-	-
Impairments	6	-	(807)	-	-	-	(807)
Revaluations	17	-	3,554	-	-	-	3,554
Remeasurements of the defined net benefit pension scheme liability/asset	38	-	-	4	-	-	4
Public dividend capital received		-	-	-	-	-	-
Public dividend capital repaid		(600)	-	-	-	-	(600)
Taxpayers' and others' equity at 31 March 2016		**43,693**	**8,489**	**4**	**15,173**	**462**	**67,821**

Statement of Changes in Equity for the year ended 31 March 2017

Trust	Note	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2016		**43,693**	**8,489**	**4**	**15,173**	**67,359**
Surplus/(deficit) for the year		-	-	-	(1,737)	(1,737)
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits		-	(300)	-	300	-
Impairments	6	-	(2,405)	-	-	(2,405)
Revaluations	17	-	7,175	-	-	7,175
Remeasurements of the defined net benefit pension scheme liability/asset	38	-	-	(173)	-	(173)
Public dividend capital received		250	-	-	-	250
Public dividend capital repaid		-	-	-	-	-
Taxpayers' and others' equity at 31 March 2017		**43,943**	**12,959**	**(169)**	**13,736**	**70,469**

Statement of Changes in Equity for the year ended 31 March 2017

Trust	Note	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2015		**44,293**	**5,933**	**-**	**20,139**	**70,365**
Surplus/(deficit) for the year		-	-	-	(5,157)	(5,157)
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits		-	(191)	-	191	-
Impairments	6	-	(807)	-	-	(807)
Revaluations	17	-	3,554	-	-	3,554
Remeasurements of the defined net benefit pension scheme liability/asset	38	-	-	4	-	-
Public dividend capital repaid		(600)	-	-	-	(600)
Taxpayers' and others' equity at 31 March 2016		**43,693**	**8,489**	**4**	**15,173**	**67,359**

Information on reserves

NHS charitable funds reserves

This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are classified as restricted or unrestricted.

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 Humber NHS Foundation Trust is payable to the Department of Health as the PDC 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.

Other reserves

The balance of this reserve is the movement in the East Riding of Yorkshire Council Pension scheme relating to the membership of Humber NHS Foundation Trust.

Income and expenditure reserve

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

Statement of Cash Flows

		Group		Trust	
		2016/17	2015/16	2016/17	2015/16
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus/(deficit)		407	(3,210)	407	(3,210)
Non-cash income and expense:					
Depreciation and amortisation	5	2,844	2,730	2,844	2,730
Net impairments and reversals of impairments	6	2,942	3,940	2,942	3,940
Income recognised in respect of capital donations	4	(402)	(36)	(402)	(36)
Non-cash movements in on-SoFP pension liability		174	62	174	62
(Increase)/decrease in receivables and other assets		(3,688)	90	(3,688)	90
(Increase)/decrease in inventories		(26)	10	(26)	10
Increase/(decrease) in payables and other liabilities		(1,891)	2,811	(1,891)	2,811
Increase/(decrease) in provisions		(335)	(216)	(335)	(216)
Tax (paid)/received		-	-	-	-
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		16	16	-	-
Other movements in operating cash flows		-	-	-	-

Statement of Cash Flows continued

		Group		Trust	
		2016/17	2015/16	2016/17	2015/16
	Note	£000	£000	£000	£000
Net cash generated from/(used in) operating activities		**41**	**6,197**	**25**	**6,181**
Cash flows from investing activities					
Interest received		27	35	27	35
Purchase and sale of financial assets		-	-	-	-
Purchase of intangible assets		(308)	(212)	(308)	(212)
Sales of intangible assets		-	-	-	-
Purchase of property, plant, equipment and investment property		(3,027)	(2,351)	(3,027)	(2,351)
Sales of property, plant, equipment and investment property		-	1,809	-	1,809
Receipt of cash donations to purchase capital assets		-	-	-	-
Investing cash flows of NHS charitable funds		-	-	-	-
Net cash generated from/(used in) investing activities		**(3,308)**	**(719)**	**(3,308)**	**(719)**
Cash flows from financing activities					
Public dividend capital received		250	-	250	-
Public dividend capital repaid		-	(600)	-	(600)
Movement on loans from the Department of Health		(255)	(255)	(255)	(255)
Movement on other loans		-	-	-	-
Other capital receipts		-	-	-	-
Other interest paid		(178)	(185)	(178)	(185)
PDC dividend paid		(1,802)	(2,120)	(1,802)	(2,120)
Financing cash flows of NHS charitable funds		-	469	-	-
Cash flows from (used in) other financing activities		(6)	-	(6)	-
Net cash generated from/(used in) financing activities		**(1,991)**	**(2,691)**	**(1,991)**	**(3,160)**
Increase/(decrease) in cash and cash equivalents		**(5,258)**	**2,787**	**(5,274)**	**2,302**
Cash and cash equivalents at 1 April		**15,135**	**12,348**	**15,135**	**12,348**
Cash and cash equivalents transferred under absorption accounting	42	-	-	-	-
Cash and cash equivalents at 31 March	**29.1**	**9,877**	**15,135**	**9,861**	**14,650**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow International Finanical Reporting Standards (IFRS) and HM Treasury's FReM 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 Consolidation

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

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

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

Note 1.2 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 the trust is contracts with commissioners in respect of the provision 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."

Note 1.3 Expenditure on employee benefits

Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme. Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

Local Government Pension Scheme

Since December 2016, some employees are members of the Local Government Pension Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'."

Note 1.4 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 1.5 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
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg plant and equipment, then these 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 valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5. Humber NHS Founation Trust, does not have any surplus assets."

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 its Estate by an independent valuer, District Valuers Office on 31 March 2017. 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.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.
Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to Humber NHS Foundation Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

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

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

Impairments

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

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

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated, government grant and other grant funded assets

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

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	89
Plant & machinery	-	10
Transport equipment	-	7
Information technology	-	5
Furniture & fittings	-	10

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 1.6 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.

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- intention to complete the asset and sell or use it
- ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- ability to can measure reliably the expenses attributable to the asset during development

Software

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

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

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

Amortisation

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

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	-	5
Goodwill	-	-

Note 1.7 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.

Note 1.8 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 1.9 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 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.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or all of the risks and rewards of ownerships have been substantially transferred.

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; 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'
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Humber NHS Foundation Trust does not have any embedded derivatives that have different risks and characteristics to their host contract.

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.

Financial liabilities

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

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

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

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

Impairment of financial assets

At the Statement of Financial Position date, Humber NHS Foundation Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision.

Note 1.10 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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

Note 1.11 Provisions

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

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which Humber NHS Foundation Trust pays an annual contribution to the NHS Litigation Authority, who then, settle all clinical negligence claims. Although NHS Litigation Authority is administratively responsible for all clinical negligence cases, the legal liability remains with Humber NHS Foundation Trust. The total value of clinical negligence provisions carried by NHS Litigation Authority on behalf of the Humber NHS Foundation Trust is disclosed at note 35.2 but is not recognised in Humber NHS Foundation Trust 's accounts.

Non-clinical risk pooling

Humber NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which an annual contribution is paid to NHS Litigation Authority who provide 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 1.12 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 38 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 36, 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 Humber NHS Foundation Trust'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 1.13 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. 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 (ii) 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 of the audit of the annual accounts.

Note 1.14 Value added tax (VAT)

Most of the activities of Humber 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 tax is recoverable, the amounts are stated net of VAT.

Note 1.15 Corporation tax

Under current regulations Humber NHS Foundation Trust is not liable to corporation tax.

Note 1.16 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

- 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 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since Humber 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 1.18 Losses and special payments

Losses and special payments, being non routine expenditure, are subject to additional control procedures, and recorded in a register, and routinely reported to the Integrated Audit and Governance Committee. Expenditure incurred, or provisions made for future obligations, are charged to the SoCI.

Note 1.19 Transfers of functions to and from other NHS bodies

"For functions that have been transferred to and from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in Humber NHS Foundation Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, Humber NHS Foundation Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Note 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers –– Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

Note 1.22 Critical accounting estimates and judgments

In the application of Humber NHS Foundation Trust's accounting policies, management is required to make judgments, 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.

Humber NHS Foundation Trust applies estimates for the pension provision, injury provision based on average life expectancy and the property plant and equipment valuation.

Note 2 Operating Segments

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

The consolidated charity is not a separate segment due to its size.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	Group	
	2016/17	2015/16
	£000	£000
Mental health services		
Cost and volume contract income	1,566	1,794
Block contract income	72,158	66,624
Clinical partnerships providing mandatory services (including S75 agreements)	1,246	3,432
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	3,847	3,718
Community services		
Community services income from CCGs and NHS England	48,450	42,956
Community services income from other commissioners	-	861
All services		
Additional income for delivery of healthcare services	-	600
Private patient income	33	-
Other clinical income	5,618	2,883
Total income from activities	**132,918**	**122,868**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	Group 2016/17 £000	Group 2015/16 £000
CCGs and NHS England	116,577	110,800
Local authorities	8,178	8,379
Department of Health	20	-
Other NHS foundation trusts	1,981	148
NHS trusts	832	1,445
NHS other	-	-
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	-	-
NHS injury scheme (was RTA)	33	40
Non NHS: other	5,297	1,456
Additional income for delivery of healthcare services	-	600
Total income from activities	**132,918**	**122,868**
Of which:		
Related to continuing operations	132,918	122,868
Related to discontinued operations	-	-

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

Humber NHS Foundation Trust had no overseas visitors income in the year 2016/17 (2015/16: £Nil).

Note 4 Other operating income

	Group 2016/17 £000	Group 2015/16 £000
Research and development	422	496
Education and training	3,676	3,668
Receipt of capital grants and donations	402	36
Charitable and other contributions to expenditure	-	-
Non-patient care services to other bodies	2,094	1,859
Support from the Department of Health for mergers	-	-
Sustainability and Transformation Fund income	2,496	-
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	896	245
Incoming resources received by NHS charitable funds	87	142
Other income	-	168
Total other operating income	**10,073**	**6,614**
Of which:		
Related to continuing operations	10,073	6,614
Related to discontinued operations	-	-

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, 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 licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group 2016/17 £000	Group 2015/16 £000
Income from services designated (or grandfathered) as commissioner requested services	139,307	128,537
Income from services not designated as commissioner requested services	3,752	945
Total	**143,059**	**129,482**

Note 5 Operating expenses

	Group	
	2016/17	2015/16
	£000	£000
Services from NHS foundation trusts	76	44
Services from NHS trusts	163	179
Services from CCGs and NHS England	-	-
Services from other NHS bodies	-	-
Purchase of healthcare from non NHS bodies	1,945	1,090
Employee expenses - executive directors	779	812
Remuneration of non-executive directors	119	102
Employee expenses - staff	112,233	102,409
Supplies and services - clinical	5,420	4,157
Supplies and services - general	1,607	1,504
Establishment	2,543	3,494
Research and development	393	486
Transport	2,368	2,605
Premises	3,168	3,009
Increase/(decrease) in provision for impairment of receivables	9	(1)
Drug costs	1,025	785
Rentals under operating leases	2,841	2,708
Depreciation on property, plant and equipment	2,657	2,577
Amortisation on intangible assets	187	153
Depreciation and amortisation on charitable fund assets	-	-
Net impairments	2,942	3,940
Audit fees payable to the external auditor		
audit services - statutory audit	66	67
other auditor remuneration	45	20
Clinical negligence	533	358
Legal fees	203	243
Consultancy costs	212	615
Internal audit costs	102	93
Training, courses and conferences	818	1,024
Patient travel	-	40
Redundancy	-	27
Losses, ex gratia & special payments	2	1
Other resources expended by NHS charitable funds	128	151
Other	-	-
Total	**142,584**	**132,692**
Of which:		
Related to continuing operations	142,584	132,692
Related to discontinued operations	-	-

Note 5.1 Other auditor remuneration

	Group	
	2016/17	2015/16
	£000	£000
Other remuneration paid to the external auditor:		
Other non-audit services	45	20
Total	**45**	**20**

Note 5.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

Note 6 Impairment of assets

	Group	
	2016/17	2015/16
	£000	£000
Net impairments charged to operating surplus/deficit resulting from:		
Changes in market price	2,942	3,940
Other	-	-
Total net impairments charged to operating surplus/deficit	**2,942**	**3,940**
Impairments charged to the revaluation reserve	2,405	807
Total net impairments	**5,347**	**4,747**

Humber NHS Foundation Trust revalued its Land and Buildings during the period, resulting in an impairment charge to revaluation reserve of £2,405k (2015/16 £807k), £6,752k as an operating expense (2015/16 £5,141k) and £3,810k reversal of impairments credited to operating income in the statement of comprehensive income (2015/16 £1,201k). This resulted in a net impairment loss of £5,347k (2015/16 loss £4,747k)

Note 7 Employee benefits

	Group	
	2016/17	**2015/16**
	£000	**£000**
Salaries and wages	90,467	82,798
Social security costs	8,220	6,002
Employer's contributions to NHS pensions	10,377	9,953
Pension cost - other	355	126
Other employment benefits	-	-
Termination benefits	-	27
Temporary staff (including agency)	4,094	4,769
NHS charitable funds staff	-	-
Total gross staff costs	**113,513**	**103,675**
Recoveries in respect of seconded staff	-	-
Total staff costs	**113,513**	**103,675**
Of which		
Costs capitalised as part of assets	108	-

Note 7.1 Retirements due to ill-health

During 2016/17 there were 2 early retirements agreed on the grounds of ill-health (1 in the year ended 31 March 2016). The estimated additional pension liabilities arising from these ill-health retirements amount to £21k (£32k in 2015/16). The cost will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

Note 8.1 NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not operated in a manner that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

"The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed 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. "

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 8.2 Local government superannuation scheme

East Riding of Yorkshire Council Pension Scheme

Further disclosure of the East Riding of Yorkshire Council Pension scheme relating to the Trust is shown in note 38.

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

This note discloses costs and commitments incurred in operating lease arrangements where Humber NHS Foundation Trust FT is the lessee.

Following NHS reforms under the Health and Social Care Act 2012 (Commencement No.4, Transitional, Savings and Transitory Provisions Order 2013), the costs of properties leased through NHS Property Services are disclosed in the accounts, as substance of form dictates, as operating leases, though there are no formal lease agreements in place. Minimum lease payments represent the recharge by NHS Property Services in year.

	Group	
	2016/17	2015/16
	£000	£000
Operating lease expense		
Minimum lease payments	2,841	2,708
Total	**2,841**	**2,708**

	31 March 2017	31 March 2016
	£000	£000
Future minimum lease payments due:		
not later than one year	2,421	2,799
later than one year and not later than five years	1,357	1,517
later than five years	3,261	3,304
Total	**7,039**	**7,620**

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2016/17	2016/17
	£000	£000
Interest on bank accounts	27	35
Investment income on NHS charitable funds financial assets	-	2
Other	8	-
Total	**35**	**37**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2016/17	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health	193	195
Total interest expense	**193**	**195**
Other finance costs	-	1
Total	**193**	**196**

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

Humber NHS Foundation Trust had no amounts relating to the late payment of commercial debts in the year 2016/17 (2015/16: £Nil).

Note 12 Gains/losses on disposal/ derecognition of non-current assets

Humber NHS Foundation Trust had no gains or losses on the disposal or derecognition of non-current assets in the year 2016/17 (2015/16: £Nil).

Note 13 Foundation trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, Humber Foundation Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's deficit for the period was £2,438k (2015/16 - £5,157k). Total comprehensive income for the period was £142,972k (2015/16 £129,340k).

Note 14 Corporation tax

Humber NHS Foundation Trust is not subject to Corporation Tax during 2016-17 (2015/16: £Nil).

Note 15

Note 15.1 Intangible assets - 2016/17

Group	Software licences	*Other	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016	**1,387**	**-**	**-**	**1,387**
Additions	596	114	-	710
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	-	-	-	-
Revaluations	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-
Gross cost at 31 March 2017	**1,983**	**114**	**-**	**2,097**
Amortisation at 1 April 2016 -	**793**	**-**	**-**	**793**
Provided during the year	187	-	-	187
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	-	-	-	-
Revaluations	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-
Amortisation at 31 March 2017	**980**	**-**	**-**	**980**
Net book value at 31 March 2017	**1,003**	**114**	**-**	**1,117**
Net book value at 1 April 2016	**594**	**-**	**-**	**594**

*The other intangibles figure relates to the purchase of a lease with the future obligations

Note 15.2 Intangible assets - 2015/16

Group	Software licences	*Other	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016	**956**	**-**	**219**	**1,175**
Additions	-	-	212	212
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	431	-	(431)	-
Revaluations	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-
Gross cost at 31 March 2017	**1,387**	**-**	**-**	**1,387**
Amortisation at 1 April 2016 -	**640**	**-**	**-**	**640**
Provided during the year	153	-	-	153
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	-	-	-	-
Revaluations	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-
Amortisation at 31 March 2017	**793**	**-**	**-**	**793**
Net book value at 31 March 2017	**594**	**-**	**-**	**594**
Net book value at 1 April 2016	**316**	**-**	**219**	**535**

Note 16.1 Intangible assets - 2016/17

Trust	Software licences	*Other	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016	**1,387**	**-**	**-**	**1,387**
Additions	596	114	-	710
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	-	-	-	-
Revaluations	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-
Gross cost at 31 March 2017	**1,983**	**114**	**-**	**2,097**
Amortisation at 1 April 2016	**793**	**-**	**-**	**793**
Provided during the year	187	-	-	187
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	-	-	-	-
Revaluations	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-
Amortisation at 31 March 2017	**980**	**-**	**-**	**980**
Net book value at 31 March 2017	**1,003**	**114**	**-**	**1,117**
Net book value at 1 April 2016	**594**	**-**	**-**	**594**

*The other intangibles figure relates to the purchase of a lease with the future obligations

Note 16.2 Intangible assets - 2015/16

Trust	Software licences	*Other	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015	**956**	**-**	**219**	**1,175**
Additions	-	-	212	212
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	431	-	(431)	-
Revaluations	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-
Valuation/gross cost at 31 March 2016	**1,387**	**-**	**-**	**1,387**
Amortisation at 1 April 2015	**640**	**-**	**-**	**640**
Provided during the year	153	-	-	153
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	-	-	-	-
Revaluations	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-
Amortisation at 31 March 2016	**793**	**-**	**-**	**793**
Net book value at 31 March 2016	**594**	**-**	**-**	**594**
Net book value at 1 April 2015	**316**	**-**	**219**	**535**

Note 17.1 Property, plant and equipment - 2016/17

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016	**8,010**	**53,281**	**1,894**	**1,939**	**121**	**9,705**	**1,128**	**76,078**
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	-	2,045	-	34	-	946	70	3,095
Impairments	(349)	(3,735)	-	-	-	-	-	(4,084)
Reversals of impairments	503	1,176	-	-	-	-	-	1,679
Reclassifications	-	1,573	(1,573)	-	-	-	-	-
Revaluations	-	4,545	-	-	-	-	-	4,545
Transfers to/from assets held for sale	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2017	**8,164**	**58,885**	**321**	**1,973**	**121**	**10,651**	**1,198**	**81,313**
Accumulated depreciation at 1 April 2016	(198)	609	-	1,200	112	7,654	555	9,932
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	1,713	-	191	5	616	132	2,657
Impairments	3,162	3,590	-	-	-	-	-	6,752
Reversals of impairments	(649)	(3,161)	-	-	-	-	-	(3,810)
Reclassifications	-	-	-	-	-	-	-	-
Revaluations	(529)	(2,101)	-	-	-	-	-	(2,630)
Transfers to/from assets held for sale	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2017	**1,786**	**650**	**-**	**1,391**	**117**	**8,270**	**687**	**12,901**
Net book value at 31 March 2017	**6,378**	**58,235**	**321**	**582**	**4**	**2,381**	**511**	**68,412**
Net book value at 1 April 2016	**8,208**	**52,672**	**1,894**	**739**	**9**	**2,051**	**573**	**66,146**

Note 17.2 Property, plant and equipment - 2015/16

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015	**9,915**	**50,234**	**3,955**	**1,292**	**121**	**8,402**	**1,128**	**75,047**
Transfers by absorption	-	-	-	579	-	-	-	579
Additions	-	-	2,810	36	-	-	-	2,846
Impairments	(1,955)	(3,993)	-	-	-	-	-	(5,948)
Reversals of impairments	-	-	-	-	-	-	-	-
Reclassifications	-	3,536	(4,871)	32	-	1,303	-	-
Revaluations	50	3,504	-	-	-	-	-	3,554
Transfers to/from assets held for sale	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2016	**8,010**	**53,281**	**1,894**	**1,939**	**121**	**9,705**	**1,128**	**76,078**
Accumulated depreciation at 1 April 2015	(193)	93	-	429	106	7,206	422	8,063
Transfers by absorption	-	-	-	493	-	-	-	493
Provided during the year	-	1,712	-	278	6	448	133	2,577
Impairments	-	-	-	-	-	-	-	-
Reversals of impairments	(5)	(1,196)	-	-	-	-	-	(1,201)
Reclassifications	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2016	**(198)**	**609**	**-**	**1,200**	**112**	**7,654**	**555**	**9,932**
Net book value at 31 March 2016	**8,208**	**52,672**	**1,894**	**739**	**9**	**2,051**	**573**	**66,146**
Net book value at 1 April 2015	**10,108**	**50,141**	**3,955**	**863**	**15**	**1,196**	**706**	**66,984**

Note 17.3 Property, plant and equipment financing - 2016/17

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned	6,280	57,822	321	510	-	2,381	511	-	67,825
Finance leased	-	-	-	-	-	-	-	-	-
Donated	98	413	-	72	4	-	-	-	587
Net book value at 31 March 2017	**6,378**	**58,235**	**321**	**582**	**4**	**2,381**	**511**	**-**	**68,412**

Note 17.4 Property, plant and equipment financing - 2015/16

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016									
Owned	8,128	52,185	1,894	649	-	2,051	572	-	65,479
Finance leased	-	-	-	-	-	-	-	-	-
Donated	80	487	-	90	9	-	1	-	667
Net book value at 31 March 2016	**8,208**	**52,672**	**1,894**	**739**	**9**	**2,051**	**573**	**-**	**66,146**

Note 18.1 Property, plant and equipment - 2016/17

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016	**8,010**	**53,281**	**1,894**	**1,939**	**121**	**9,705**	**1,128**	**76,078**
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	-	2,045	-	34	-	946	70	3,095
Impairments	(349)	(3,735)	-	-	-	-	-	(4,084)
Reversals of impairments	503	1,176	-	-	-	-	-	1,679
Reclassifications	-	1,573	(1,573)	-	-	-	-	-
Revaluations	-	4,545	-	-	-	-	-	4,545
Transfers to/from assets held for sale	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2017	**8,164**	**58,885**	**321**	**1,973**	**121**	**10,651**	**1,198**	**81,313**
Accumulated depreciation at 1 April 2016	**(198)**	**609**	**-**	**1,200**	**112**	**7,654**	**555**	**9,932**
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	1,713	-	191	5	616	132	2,657
Impairments	3,162	3,590	-	-	-	-	-	6,752
Reversals of impairments	(649)	(3,161)	-	-	-	-	-	(3,810)
Reclassifications	-	-	-	-	-	-	-	-
Revaluations	(529)	(2,101)	-	-	-	-	-	(2,630)
Transfers to/from assets held for sale	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2017	**1,786**	**650**	**-**	**1,391**	**117**	**8,270**	**687**	**12,901**
Net book value at 31 March 2017	**6,378**	**58,235**	**321**	**582**	**4**	**2,381**	**511**	**68,412**
Net book value at 1 April 2016	**8,208**	**52,672**	**1,894**	**739**	**9**	**2,051**	**573**	**66,146**

Note 18.2 Property, plant and equipment - 2015/16

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015	**9,915**	**50,234**	**3,955**	**1,292**	**121**	**8,402**	**1,128**	**75,047**
Transfers by absorption	-	-	-	579	-	-	-	579
Additions - purchased/ leased/ grants/ donations	-	-	2,810	36	-	-	-	2,846
Impairments	(1,955)	(3,993)	-	-	-	-	-	(5,948)
Reversals of impairments	-	-	-	-	-	-	-	-
Reclassifications	-	3,536	(4,871)	32	-	1,303	-	-
Revaluations	50	3,504	-	-	-	-	-	3,554
Transfers to/from assets held for sale	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2016	**8,010**	**53,281**	**1,894**	**1,939**	**121**	**9,705**	**1,128**	**76,078**
Accumulated depreciation at 1 April 2015	**(193)**	**93**	**-**	**429**	**106**	**7,206**	**422**	**8,063**
Transfers by absorption	-	-	-	493	-	-	-	493
Provided during the year	-	1,712	-	278	6	448	133	2,577
Impairments	-	-	-	-	-	-	-	-
Reversals of impairments	(5)	(1,196)	-	-	-	-	-	(1,201)
Reclassifications	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2016	**(198)**	**609**	**-**	**1,200**	**112**	**7,654**	**555**	**9,932**
Net book value at 31 March 2016	**8,208**	**52,672**	**1,894**	**739**	**9**	**2,051**	**573**	**66,146**
Net book value at 1 April 2015	**10,108**	**50,141**	**3,955**	**863**	**15**	**1,196**	**706**	**66,984**

Note 18.3 Property, plant and equipment financing - 2016/17

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned	6,280	57,822	321	510	-	2,381	511	67,825
Finance leased	-	-	-	-	-	-	-	-
Donated	98	413	-	72	4	-	-	587
Net book value at 31 March 2017	**6,378**	**58,235**	**321**	**582**	**4**	**2,381**	**511**	**68,412**

Note 18.4 Property, plant and equipment financing - 2015/16

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016								
Owned	8,128	52,185	1,894	649	-	2,051	572	65,479
Finance leased	-	-	-	-	-	-	-	-
Donated	80	487	-	90	9	-	1	667
Net book value at 31 March 2016	**8,208**	**52,672**	**1,894**	**739**	**9**	**2,051**	**573**	**66,146**

Note 19 Donations of property, plant and equipment

During 2016/17 Humber NHS Foundation Trust received £402k of software licences from NHS Digital.

Note 20 Revaluations of property, plant and equipment

Humber NHS Foundation Trust's Land and Buildings were fully revalued at 31 March 2017 by independent valuers The District Valuers Office.]

The valuation of buildings has been undertaken with reference to the buildings' current condition and agreed obsolescence and assumed that over its life it will be maintained to its current condition. The valuation has been undertaken on a modern equivalent asset basis and reflects the current service potential of the Trust. A full revaluation of the Trusts estate was undertaken by the District Valuer, which including inspecting all of the Trust buildings.

The previous valuation in 2015/16 was undertaken by Clark Weightman using an existing use basis.

Note 21 Investment Property

Humber NHS Foundation Trust held no investments in 2016/17 (2015/16: £Nil).

Note 22 Investment property income and expenses

Humber NHS Foundation Trust held no investment property in 2016/17 (2015/16: £Nil).

Note 23 Investments in associates (and joint ventures)

Humber NHS Foundation Trust held no investments in associates in 2016/17 (2015/16: £Nil).

Note 24 Other investments

	Group		Trust	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Carrying value at 1 April	**6**	**-**	**-**	**-**
Transfers by absorption	-	6	-	-
Acquisitions in year	-	-	-	-
Movement in fair value	-	-	-	-
Disposals	-	-	-	-
Carrying value at 31 March	**6**	**6**	**-**	**-**

Note 25 Analysis of charitable fund reserves

Humber NHS Foundation Trust Charitable Funds have been consolidated in these accounts

	31 March 2017	31 March 2016
	£000	£000
Unrestricted funds:		
Unrestricted income funds	248	251
Revaluation reserve	-	-
Other reserves	-	-
Restricted funds:		
Restricted income funds	167	205
Permanent endowment funds	6	6
	421	**462**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (eg endowments) where the assets are required to be invested, or retained rather than expended.

Note 26 Inventories

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Consumables	125	99	125	99
Total inventories	**125**	**99**	**125**	**99**

Inventories recognised in expenses for the year were £1,936k (2015/16: £1,803k). Write-down of inventories recognised as expenses for the year were £Nil (2015/16: £Nil).

Note 27.1 Trade and other receivables

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Current				
Trade receivables due from NHS bodies	6,444	3,939	6,444	3,939
Receivables due from NHS charities	-	-	-	-
Other receivables due from related parties	683	691	683	691
Capital receivables	273	273	273	273
Provision for impaired receivables	(48)	(42)	(48)	(42)
Deposits and advances	-	-	-	-
Prepayments (non-PFI)	805	787	805	787
Accrued income	1,530	401	1,530	401
Interest receivable	-	-	-	-
PDC dividend receivable	-	183	-	183
VAT receivable	45	73	45	73
Other receivables	946	868	946	868
Trade and other receivables held by NHS charitable funds	-	-	-	-
Total current trade and other receivables	**10,678**	**7,173**	**10,678**	**7,173**

Non-current

Humber NHS Foundation Trust held no non-current receivables in the year 2016/17 (2015/16: £Nil).

Note 27.2 Provision for impairment of receivables

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
At 1 April	**42**	**63**	**42**	**63**
Transfers by absorption	-	-	-	-
Increase in provision	9	26	9	26
Amounts utilised	(3)	(20)	(3)	(20)
Unused amounts reversed	-	(27)	-	(27)
At 31 March	**6**	**(21)**	**6**	**(21)**

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

Note 27.3 Analysis of financial assets

Group	31 March 2017	31 March 2016
	£000	£000
	Trade and other receivables	Trade and other receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	-	-
0 - 30 days	-	-
60 - 90 days	-	-
90 - 180 days	-	-
Over 180 days	48	42
Total	**48**	**42**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	699	572
30 - 60 Days	987	810
60 - 90 days	230	167
90 - 180 days	378	75
Over 180 days	391	325
Total	**2,685**	**1,949**

Trust	31 March 2017	31 March 2016
	Trade and other receivables	Trade and other receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	-	-
30 - 60 Days	-	-
60 - 90 days	-	-
90 - 180 days	-	-
Over 180 days	48	42
Total	**48**	**42**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	699	572
30 - 60 Days	987	810
60 - 90 days	230	167
90 - 180 days	378	75
Over 180 days	391	325
Total	**2,685**	**1,949**

Note 28.1 Non-current assets for sale and assets in disposal groups

Humber NHS Foundation Trust held no non-current assets for sale and assets in disposal groups in 2016/17 (2015/16: £Nil).

Note 29

Note 29.1 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.

	Group		Trust	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
At 1 April	**15,135**	**12,817**	**15,135**	**12,817**
Net change in year	(5,258)	2,318	(5,258)	2,318
At 31 March	9,877	15,135	9,877	15,135
Broken down into:				
Cash at commercial banks and in hand	525	356	429	235
Cash with the Government Banking Service	8,997	14,424	8,997	14,424
Deposits with the National Loan Fund	-	-	-	-
Other current investments	355	355	-	-
Total cash and cash equivalents as in SoFP	**9,877**	**15,135**	**9,426**	**14,659**
Bank overdrafts (GBS and commercial banks)	-	-	-	-
Drawdown of committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**9,877**	**15,135**	**9,426**	**14,659**

Note 29.2 Third party assets held

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

	Group and Trust	
	31 March 2017	31 March 2016
	£000	£000
Bank balances	372	312
Total third party assets	**372**	**312**

Note 30

Note 30.1 Trade and other payables

	Group		Trust	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Current				
NHS trade payables	2,043	1,676	2,043	1,676
Amounts due to other related parties	26	-	26	-
Other trade payables	923	2,187	923	2,187
Capital payables	1,997	1,929	1,997	1,929
Taxes payable	2,136	1,839	2,136	1,839
Other payables	1,396	1,373	1,396	1,373
Accruals	4,172	5,472	4,172	5,472
PDC dividend payable	13	-	13	-
Trade and other payables held by NHS charitable funds	36	20	-	-
Total current trade and other payables	**12,742**	**14,496**	**12,706**	**14,476**

Non-current

Humber NHS Foundation Trust held no non-current payables in the year 2016/17 (2015/16: £Nil).

Note 30.2 Early retirements in NHS payables above

Humber NHS Foundation Trust made no payments for early retirements in 2016/17 (2015/16: £Nil).

Note 31 Other liabilities

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Current				
Other deferred income	468	508	468	508
Total other current liabilities	**468**	**508**	**468**	**508**
Non-current				
Net pension scheme liability	405	58	405	58
Total other non-current liabilities	**405**	**58**	**405**	**58**

Note 32 Borrowings

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Current				
Loans from the Department of Health	255	255	255	255
Total current borrowings	**255**	**255**	**255**	**255**
Non-current				
Loans from the Department of Health	4,214	4,468	4,214	4,468
Total non-current borrowings	**4,214**	**4,468**	**4,214**	**4,468**

Note 33 Other financial liabilities

Humber NHS Foundation Trust had no other financial liabilities in the year 2016/17 (2015/16: £Nil).

Note 34 Finance leases

Humber NHS Foundation Trust had no finance leases in the year 2016/17 (2015/16: £Nil).

Note 35

Note 35.1 Provisions for liabilities and charges analysis

Group	Pensions - early departure costs	Other legal claims	Redundancy	Other	NHS charitable fund provisions	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2016	**527**	**68**	**28**	**924**	**-**	**1,547**
Change in the discount rate	-	-	-	-	-	-
Arising during the year	-	87	-	14	-	101
Utilised during the year	(77)	(7)	(28)	(46)	-	(158)
Reversed unused	-	-	-	(278)	-	(278)
Unwinding of discount	12	4	-	13	-	29
Movement in NHS charitable funds provisions	-	-	-	-	-	-
At 31 March 2017	**462**	**152**	**-**	**627**	**-**	**1,241**
Expected timing of cash flows:						
not later than one year	81	152	-	181	-	414
later than one year and not later than five years	335	-	-	120	-	455
later than five years	46	-	-	326	-	372
Total	**462**	**152**	**-**	**627**	**-**	**1,241**

Trust	Pensions - early departure costs	Other legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2016	**527**	**68**	**28**	**924**	**1,547**
Change in the discount rate	-	-	-	-	-
Arising during the year	-	87	-	14	101
Utilised during the year	(77)	(7)	(28)	(46)	(158)
Reversed unused	-	-	-	(278)	(278)
Unwinding of discount	12	4	-	13	29
At 31 March 2017	**462**	**152**	**-**	**627**	**1,241**
Expected timing of cash flows:					
not later than one year	81	152	-	181	414
later than one year and not later than five years	335	-	-	120	455
later than five years	46	-	-	326	372
Total	**462**	**152**	**-**	**627**	**1,241**

Note 35.1 Provisions for liabilities and charges analysis (Cont.)

Pensions relating to other staff – these provisions relate to the expected pension payments to former employees. The total value is based upon a standard life expectancy of the former employee. Should this life expectancy be different the value and timings of the payments will be affected. The value of the pension payment is also affected by annual pension increases determined by the NHS Pensions Agency.

Other Legal claims – this provision relates to public and employer's liability claims. The value and timing of these claims is uncertain until the claims have been fully investigated and any settlements agreed.

Other – injury benefits are payable by the NHS Pensions Agency. The total value of the provision is based upon standard life expectancy of the former employees. Should this life expectancy not be achieved, the value and the timing of payments will be affected. The value of the pension payment is also affected by annual pension increases, determined by the NHS Pensions Agency.

Merger Provision – exit costs associated with a merger of the hosted internal audit service;

Sunshine House Insurance - relates to any potential outstanding invoices arising from Sunshine House flood damage.

The other figure of £627k include the following provisions:

	£000
Injury provision	529
Merger provision	85
Unwinding of discount (Other)	13
Total other provisions	**627**

Note 35.2 Clinical negligence liabilities

At 31 March 2017, £150k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Humber NHS Foundation Trust (31 March 2016: £68k).

Note 36 Contingent assets and liabilities

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Litigation Authority legal claims	(56)	(32)	(56)	(32)
Employment tribunal and other employee related litigation	-	-	-	-
Redundancy	-	-	-	-
Other	-	-	-	-
Gross value of contingent liabilities	**(56)**	**(32)**	**(56)**	**(32)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(56)**	**(32)**	**(56)**	**(32)**
Net value of contingent assets	**-**	**-**	**-**	**-**

NHS Litigation Authority legal claims relate to legal claims that have been identified as a contingent liability by NHS Litigation

Note 37 Contractual capital commitments

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Property, plant and equipment	615	1,214	615	1,214
Intangible assets	-	-	-	-
Total	**615**	**1,214**	**615**	**1,214**

Contractual capital commitments relate to capital schemes which are not completed in the year but which Humber NHS Foundation Trust have contracts to complete.

Note 38 Defined benefit pension schemes

East Riding of Yorkshire Council Pension Scheme

In 2015/16 49 members of staff transferred employment from Kingston upon Hull Council with active membership of the East Riding of Yorkshire Council Pension Fund, which is a defined benefits scheme.

Humber NHS Foundation Trust's obligations in respect of pension liabilities for these staff transferring is with effect from 1 December 2015 and not the period of employment before this date.

The Trust commissioned Hymans Robinson to prepare an actuarial report to provide full pension details in accordance with IAS19.

In the financial year 2016/17 Humber NHS Foundation Trust contributed £355k to the fund (2015/16: £126k).

A pension deficit of £405k is included in the Statement of Financial Position as at 31 March 2017 (2015/16: £58k)

Note 38.1 The main actuarial assumptions used at the date of the Statement of Financial Position in measuring the present value of the defined benefit scheme liabilities are:

Financial Assumptions

	31 March 2017	1 December 2015
Pension Increase Rate	2.40%	2.20%
Salary Increase Rate	2.60%	3.70%
Discount Rate	2.60%	3.60%

Note 38.2 The estimated Fund asset allocation is as follows:

	31 March 2017	1 December 2015
	£000	£000
Equities Securities	151	41
Debt Securities	43	9
Private Equity	19	5
Real Estate	48	11
Investment Funds & Unit Trusts	135	25
Cash & Cash Equivalents	12	3
	408	**93**

Note 38.3 Changes in the defined benefit obligation and fair value of plan assets during the year

	Group		Trust	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Present value of the defined benefit obligation at 1 April	**(151)**	**-**	**(151)**	**-**
Current service cost	(355)	(126)	(355)	(126)
Interest cost	(13)	(1)	(13)	(1)
Contribution by plan participants	(82)	(28)	(82)	(28)
Remeasurement of the net defined benefit (liability)/asset:			-	-
Actuarial gain / (losses)	(212)	4	(212)	4
Benefits paid	-	-	-	-
Past service costs	-	-	-	-
Present value of the defined benefit obligation at 31 March	**(813)**	**(151)**	**(813)**	**(151)**
Plan assets at fair value at 1 April	**93**	**-**	**93**	**-**
Interest income	8	1	8	1
Remeasurement of the net defined benefit (liability)/asset:			-	-
Return on plan assets	39	-	39	-
Actuarial gain/(losses)	-	-	-	-
Contributions by the employer	186	64	186	64
Contributions by the plan participants	82	28	82	28
Benefits paid	-	-	-	-
Plan assets at fair value at 31 March	**408**	**93**	**408**	**93**
Plan surplus/(deficit) at 31 March	**(405)**	**(58)**	**(405)**	**(58)**

Note 38.4 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	Group		Trust	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Current service cost	(355)	(126)	(355)	(126)
Interest expense/income	(5)	-	(5)	-
Past service cost	-	-	-	-
Total net (charge)/gain recognised in SOCI	**(360)**	**(126)**	**(360)**	**(126)**

Note 39 On-SoFP PFI, LIFT or other service concession arrangements

Humber NHS Foundation Trust does not have any PFI or LIFT schemes.

Note 40 Financial instruments

Note 40.1 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 it in undertaking its activities.

Humber NHS Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within standing financial instructions and policies agreed by the board of directors. 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,has no overseas operations and 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

The majority of income derives from contracts with other public sector bodies, and therefore there is low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the Trade and other receivables note. (See Note 27.1)

Liquidity risk

Humber NHS Foundation Trust's operating costs were incurred under contracts with Clinical Commissioning Groups in 2016/17. 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 40.2 Financial assets

Group	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					
Trade and other receivables excluding non financial assets	8,410	-	-	-	**8,410**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	9,426	-	-	-	**9,426**
Financial assets held in NHS charitable funds	-	-	-	-	**-**
Total at 31 March 2017	**17,836**	**-**	**-**	**-**	**17,836**
Assets as per SoFP					
Trade and other receivables excluding non financial assets	5,729	-	-	-	**5,729**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	14,659	-	-	-	**14,659**
Financial assets held in NHS charitable funds	-	-	-	-	**-**
Total at 31 March 2016	**20,388**	**-**	**-**	**-**	**20,388**

Trust	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					
Trade and other receivables excluding non financial assets	8,410	-	-	-	**8,410**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	9,426	-	-	-	**9,426**
Total at 31 March 2017	**17,836**	**-**	**-**	**-**	**17,836**

Trust	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					
Trade and other receivables excluding non financial assets	5,729	-	-	-	**5,729**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	14,659	-	-	-	**14,659**
Total at 31 March 2017	**20,388**	**-**	**-**	**-**	**20,388**

Note 40.3 Financial liabilities

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	4,469	-	**4,469**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	10,557	-	**10,557**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Financial liabilities held in NHS charitable funds	-	-	**-**
Total at 31 March 2017	**15,026**	**-**	**15,026**
Liabilities as per SoFP			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	4,723	-	**4,723**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	11,447	-	**11,447**
Other financial liabilities	-	-	**-**
Provisions under contract	1,547	-	**1,547**
Financial liabilities held in NHS charitable funds	-	-	**-**
Total at 31 March 2016	**17,717**	**-**	**17,717**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	4,469	-	**4,469**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	10,557	-	**10,557**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2017	**15,026**	**-**	**15,026**
Liabilities as per SoFP			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	4,723	-	**4,723**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	11,447	-	**11,447**
Other financial liabilities	-	-	**-**
Provisions under contract	1,547	-	**1,547**
Total at 31 March 2016	**17,717**	**-**	**17,717**

Note 40.4 Maturity of financial liabilities

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
In one year or less	10,812	17,717	10,812	17,717
In more than one year but not more than two years	4,214	-	-	-
In more than two years but not more than five years	-	-	-	-
In more than five years	-	-	-	-
Total	**15,026**	**17,717**	**10,812**	**17,717**

Note 41 Losses and special payments

Group and Trust	2016/17		2015/16	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Bad debts and claims abandoned	4	3	10	1
Stores losses and damage to property	5	2	-	-
Total losses	**9**	**5**	**10**	**1**
Special payments				
Extra-contractual payments	-	-	-	-
Compensation payments	-	-	-	-
Special severance payments	-	-	-	-
Ex-gratia payments	4	2	-	-
Total special payments	**4**	**2**	**-**	**-**
Total losses and special payments	**13**	**7**	**10**	**1**
Compensation payments received	-	-	-	-

During 2016/17 Humber NHS Foundation Trust had four bad debts written off totalling £3k (2015/16: 10 totalling £1k) and five other cases totalling £2k (2015/16: 0 totalling £Nil).There have been no special payments made in 2016/17 (2015/16: £Nil)

Note 42 Transfers by absorption

In 2015/16, as part of the commencement of the contract on 1 March 2015 for community services in Whitby, plant and machinery assets of £86k from York Teaching Foundation Trust transferred to Humber NHS Foundation Trust via transfer by absorption.

Note 43 Events after the reporting date

With effect from 1 April 2017, the principal contractual arrangement through which community services were provided to NHS East Riding of Yorkshire Clinical Commissioning Group have terminated. These services were provided throughout 2016/17, and represented £28.2m income for Humber NHS Foundation Trust. Application of the results of a comprehensive review of future structure, income and costs, conducted prior to the year end, during the service transfer phase, has reassured the Board as to the future financial viability. NHS Improvement have adjusted the 2017/18 control total to take account of a small predicted reduction in financial results. Staff employed to deliver these services have successfully transferred to the new provider under TUPE Regulations.

With effect from 1 June 2017, staff will be transferring from East Riding Council as part of the Granville Court service. The transfering staff will be members of the East Riding of Yorkshire Pension scheme, which is a defined benefit scheme. This transfer may affect the pension liability of the Trust from 2017/18 onwards.

Note 46 Related parties

During the year one one board member and one Non Executive board member of the NHS Foundation Trust Board had a related party interests in an entity which has undertaken transactions with the NHS Foundation Trust. Elizabeth Thomas has a family member working at City Healthcare Partnership and Mike Smith provided services to Rotherham, Doncaster and South Humber Foundation Trust as an Associate Hospital Manager. Andrew Milner is a Trustee and Director at Hull and East Yorkshire Smile Foundation.

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 overleaf.

	2016/17				2015/16			
	Income	Expenditure	Receivables	Payables	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000	£000	£000	£000	£000
City Health Care Partnership	4,080	5	1,160					
Health Education England	3,667		887		3,328		414	
Hull & East Yorkshire Hospitals NHS Trust	1,109	1,221	400	550	1,291	1,118	263	281
Humber NHS Trust Charitable Funds			23		36			
NHS East Riding Of Yorkshire CCG	56,734		2,208		55,594		895	
NHS England	18,341		787	23	15,599	1	412	
NHS Hull CCG	34,794	37	777		36,014		592	43
NHS Pensions Agency		10,377		1,396		9,953		1,373
NHS Property Services	5	1,983		644	522	752	612	941
NHS Vale of York CCG	1,099		33		2,147		42	
Rotherham, Doncaster and South Humber Foundaiton Trust	211	0	35					
Northern Lincolnshire & Goole Hospitals NHS Foundation Trust	0	4	83	5		34	83	8
Tees, Esk and Wear Valleys NHS Foundation Trust	1,381	44	296					
York Teaching Hospital NHS Foundation Trust	427	911	134	84	60	810	45	152
Yorkshire Ambulance Service NHS Trust	199	137	62		177	155	77	13
Local Government Bodies								
Kingston Upon Hull City Council	401	87	180	7	1,613	556	285	
East Riding of Yorkshire Council	8,627	192	503	19	6,789	1,027	406	49
Charitable Fund Transactions								
Hull and East Yorkshire Smile Foundation		60		10				

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 other related party transactions.