Improving Health and Wellbeing

Humber NHS
NHS Foundation Trust

Humber NHS Foundation Trust Annual Report and Accounts 2015/16

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

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Contents

Welcome from Chairman and Chief Executive

It is often said that change is the only constant in life. Yet as humans we are predisposed to resist change because of the risk associated with it. Despite this resistance to change, it is more important than ever.

This year, probably more so than any other, has challenged us on several fronts as we along with others face the pressures of unprecedented levels of demand and financial constraint. However, despite the pressures on our services, we aim to maintain a sustainable business to ensure that we can continue to care in the future.

We have celebrated some important developments this year. We are entering into a new era of positive transformation marked by changes to our quality governance, leadership and improvements to how we deliver our services.

Looking ahead, we believe that there are exciting opportunities for us. The majority of our work and income comes from our two local CCGs and we are an organisation that has a strong connection with local people. As such we feel a deep responsibility to make sure we do as well as we can to contribute to the wellbeing of our local community.

Although our performance as a Trust will be covered later in this report, there are many moments that have made us both incredibly proud this year that are worthy of a mention here.

When we refreshed our vision last year, we said we want to be a leading Trust, known for the quality of our care and the staff who work for us. We want to be a trusted provider of local healthcare and a great place to work. We want to be a valued partner with a problem solving approach.

We launched our Recovery College late last year and were delighted to see all 12 courses (including mind mapping, wellbeing through creativity and managing anger) fill up within the space of a month. We offer a range of recovery-focused educational courses and workshops free of charge for people who use our services, their carers, supporters and Trust staff.

- The Royal Philharmonic Orchestra (RPO) worked closely with our Hull Integrated Community Stroke Service to use group creative music-making to drive patient-led rehabilitation work with stroke survivors and their carers. This work culminated in a moving performance of two original pieces ahead of the RPO's season opening concert at Hull City Hall. Following the successful pilot (funded by Hull City Council's Public Health department), the RPO are continuing this work to devise original pieces of music to perform live in a public concert as part of the national BBC Music Day celebrations on Friday 3 June, 2016.

- Hull City Council social care staff transferred to the Trust this year which meant we became a single point of contact for adults with mental health or learning disability needs. At the same time, we were awarded a major community services contract in Whitby and the surrounding area by a new commissioner to deliver community services.

- We celebrated ten years working in partnership to provide drug and alcohol services and the launch of a new image and performance enhancing drugs clinic. We were awarded all four lots of the recent retender of addictions services in the East Riding and are delighted to be working with criminal justice specialists Nacro. These examples also support our vision to be a leading, and integrated provider, trusted by our partners.

In the current economic environment, we realise that we do not exist in isolation as an organisation. Our future and our sustainability are tied to the sustainability of the health and care economy of which we are a part and we would like to thank our members and local partners for their support over the past year.

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

Performance Report

Overview

A statement from the chief executive

This year, probably more so than any other, has challenged us on several fronts as we along with others face the pressures of unprecedented levels of demand and financial constraint. However, despite the pressures on our services, we aim to maintain a sustainable business to ensure that we can continue to care in the future. We delivered a really challenging cost improvement programme and at the end of the year, have retained a good financial risk rating.

As a provider of health services, we are accountable to our commissioners who are responsible for designing, developing and buying local health services for local people.

We provide regular performance information to our commissioners; NHS East Riding of Yorkshire Clinical Commissioning Group, NHS Hull Clinical Commissioning Group, NHS Vale of York Clinical Commissioning Group, NHS England, Hull City Council and East Riding of Yorkshire Council and more recently Hambleton, Richmondshire and Whitby Clinical Commissioning Group. Our commitment to contract performance management is evidenced through monthly contract meetings, and sub groups with commissioners which are regularly attended and have full participation of senior staff. These meetings and groups focus on areas such as service quality, service development and finance.

This year, we joined our commissioners to outline a shared determination to transform emotional health and wellbeing services to make a difference to the lives of local children and young people. We made a commitment to work together on a number of Child and Adolescent Mental Health Service priorities including setting up the Crisis team we made operational in early 2016 and to improve waiting times against which we have made great progress.

We made changes to our Executive Management Team early in the new financial year with two new roles; Chief Operating Officer and Director of Nursing, Quality & Patient Experience. Following the Board's agreement to the creation of a new organisational structure we created four new care groups namely Children and Learning Disability Services; Adult Mental Health Services; Community and Older People Services and Specialist Services. These are managed by a triumvirate leadership team consisting of a Care Group Director, Clinical Care Director and Associate Medical Director all reporting to the Chief Operating Officer. The care groups will provide much greater clinical leadership and engagement opportunities. We designed them to help frontline staff see more clearly where they fit into the organisation and how we provide the governance, leadership and support for them and their services.

Following the new appointments, our Executive Management Team and Trust Board took the opportunity to review our strategic planning framework and have refreshed our Vision, Values and Strategic Aims after speaking with staff, members and governors at numerous engagement events.

When we refreshed the Trust's vision, we said we want to be a leading Trust, known for the quality of our care and the staff who work for us. We want to be a trusted provider of local healthcare and

a great place to work. We want to be a valued partner with a problem solving approach. On balance, the Trust is bigger and stronger than a year ago, with a higher turnover, and providing more services to more patients. There is a section dedicated to some of our most noteworthy achievements this year on pages 63-64.

As for the quality of our staff and services, I regularly receive letters of praise and read patient experience feedback from the Friends and Families Test and there are simply too many positive comments for me to include, below is a selection:

“Seen within 30 mins. Nurse took time to listen."
Patient review of weekend visit to one of our Minor Injuries Units

“During a distressing and scary experience our fears were met with kindness and understanding by staff”
Family of a patient staying in one of our mental health inpatient units

"A fantastic Hospital on our doorstep - NHS at its best."
A patient that spent time at East Riding Community Hospital

"Thank you for providing me with a safe haven ... and giving me the chance to live again."
Patient at one of our mental health inpatient units

This sentiment is echoed in our Friends and Family Test results - 94.4% of patients and their carers would recommend us to their family and friends if they needed our support.

Our liaison psychiatry services featured in a new Kings Fund publication as a study of a high quality service, delivering great outcomes and diverting many, many patients away from in-patient admissions and our perinatal team was shortlisted for a Royal College of Midwifery Award.

We continue to forge strong working relationships with our local health and social care partners through collaborations including the Hull 2020 Programme, Better Care Plans with our CCGs and the Health and Wellbeing Board Strategic plans associated with our local authorities.

Like all parts of the NHS we do still face the challenge of transforming our services so that we can continue to meet the needs of a growing and aging population. We know that we also face the challenge of improving our ability to recruit and retain staff and ensuring that all staff feel able to make the most of their skills and maximise their contribution to the communities we serve.

To help address the gaps in our workforce, we have developed new and creative approaches to recruitment. We struggle to attract applicants from outside the area for example and have therefore started to run our own targeted social media campaigns using LinkedIn and Facebook. Along with other added financial incentive packages to join and stay with the Trust for a year, this has started to make a difference.

Recruitment opportunities were included as part of other events that took place throughout the year including World Mental Health Day, Hull Clinical Commissioning Group Annual Meeting and

Health Fair, a Time to Talk event, Hull University Career Fair, Recovery College events, Lawns Membership and the Bridlington World Café event.

We have also started to innovate with the roles we are creating and, in addition to our award winning apprentices another innovative way we are addressing the shortage is by placing psychology graduates to support nursing teams for six month periods.

We have been very fortunate to attract some highly experienced consultants to work with us over the year. At the other end of their careers, we have also seen some very good doctors looking to return to the Trust after completing their higher training.

I do know that we have a lot more work to do on speeding up recruitment and making sure we routinely attract more candidates, but there is no doubting the quality of the staff who do continue to join the Trust, or their passion and commitment to deliver high quality care.

We also know from our staff survey results that we still have more work to do to ensure we truly are a great place to work. One of the most heartening results in the survey however was that 89% of staff agreed that their role makes a difference to patients or service users. This is especially pleasing as it shows that we really do put our patients at the heart of what we do, right across the Trust. We will be running a series of workshops in the new year so that staff can tell us how you think we should respond to the survey findings.

However, I am pleased we can report that we are achieving our key Performance Appraisal and Development Review compliance target. We have changed the way we conduct employee appraisals to make sure they cover their wider role and contribution and allow time to discuss how they are feeling. 85 percent of staff completed an appraisal in the past 12 months and 93 percent have had one in the past 15 months.

Overall, I feel we are entering an era of positive transformation marked by changes to our quality governance, leadership and improvements to how we deliver our services. Our Trust membership continues to grow, we continue to be innovative in our approach and I am excited about what we have planned for 2016/17.

Signed:  **Date: 26 May 2016**

Chief Executive

About our Trust

We provide 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 3000 staff across more than 70 sites at locations throughout the East Riding, Hull and Whitby.

We became a Foundation Trust six 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 2015/16 was £130.5 million with the majority of this coming from our two main commissioners, NHS Hull and NHS East Riding of Yorkshire Clinical Commissioning Groups (CCGs).

Our services include:

- A&E liaison for working age adults and older people
- bladder and bowel specialist care
- child and adolescent mental health
- children's
- chronic fatigue
- 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
- palliative care
- perinatal mental health
- physiotherapy

- podiatry
- psychiatric liaison
- psychological interventions
- psychotherapy
- stroke
- therapy (physiotherapy, speech and language)
- tissue viability
- traumatic stress
- unscheduled care

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

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

People who use our 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 2015 - 2020

Our Vision

Caring, compassionate, committed
We aim to be recognised as a leading provider of integrated health services, recognised for the care, compassion and commitment of our staff. We want to be a trusted provider of local healthcare and a great place to work. We want to be a valued partner with a problem solving approach.

Our Values and what they mean

Putting the needs of others first

- We place our patients and their carers at the heart of everything we do.
- We listen to what the people who use our services tell us – and we act on it.
- We accept that this requires acting with courage at times.

Acting with compassion and care at all times

- We treat patient and carers with dignity, respect and compassion at all times.
- We deliver our services to the highest standards of safety and in safe environments.

Aspiring to excellence and be the best that we can be

- We believe in the need to innovate and develop new models of care based on evidence, research and best practice.
- We are a teaching Trust and seek to improve standards of care and clinical effectiveness.

Continuously seeking improvement

- We focus on learning and developing an open culture.
- We aim to provide the best services we can and constantly look at how we can improve them.

Value each other and develop teamwork

- We believe in multi-disciplinary work, bringing together the right people, with the right skills, to care for our patients.
- We work across boundaries to deliver seamless service provision on behalf of our patients and their carers.
- We recognise, reward and celebrate success.

Our Strategic Aims

- We will prioritise prevention, early intervention, recovery and rehabilitation.
- We will deliver care closer to home to avoid hospital admissions.
- We will deliver high quality, safe and effective care services.
- We will integrate health and social care, mental and physical health and wellbeing involving service users.
- We will work with communities, partners and members to design the services that will best serve their needs.
- We will listen and actively engage our patients, service users, carers and families in development and delivery of services.
- We will maintain a sustainable business ensuring we can continue to care in future.

Development and Performance

Our performance management framework track 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

Our Staff Awards recognise and celebrate the inspiring and innovative work our staff do across the Trust every day to improve the lives of our patients and service users.

We invited staff from across the Trust to nominate their colleagues and teams in any one of the following categories:

- Outstanding Team of the Year
- Outstanding Individual of the Year
- Innovation and Progress
- Improving Patient Dignity and Respect
- Improving Patient Safety
- Working in Partnership with other Agencies
- Delivering Compassionate Care
- Behind the Scenes
- Rising Star
- Championing Health and Wellbeing

In addition, we awarded a Chairman's Award and Chief Executive's Award.

We announced the winners and runners up at a special ceremony on 2 December 2015. Our Trust's very own Strokestra, an amazing collaboration between our Hull Integrated Community Stroke Service and the Royal Philharmonic Orchestra, opened the ceremony with a moving performance that included a song they had written specially for the awards ceremony.

We were joined by a special guest, local BBC Health Reporter Vicky Johnson, who helped present the awards to the winners.

This year, our event was sponsored by Citycare, along with Sewell and Safe at Home who each sponsored an award.

Principal Risks and Uncertainties

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

- Failure to recruit, retain, deploy and develop a workforce that is sufficient in number, capable, skilled and fit for purpose to deliver business plans.
- That income declines through loss of contracts, implementation of tariff, national and local commissioner targets.
- Potential financial and quality implications of not delivering national and local Commissioning for Quality and Innovation (CQUIN) indicators.
- Lack of development of new strategic partnerships with existing and emerging stakeholders.
- Risk of contract losses resulting from failure to compete effectively for provision of services.
- Failure to appropriately engage with patients and carers resulting in services that do not meet the patients' needs.
- Adverse impact of inadequate IT systems failing to effectively support management decisions, performance management or contract compliance.
- Non-compliance with The National Institute for Health and Care Excellence (NICE) and other national guidance due to a lack of provision of relevant funding, lack of process and recording of data.
- Failure to ensure all patient environments are safe and provide privacy and dignity.
- Staff do not own the culture required to ensure trust values and goals and NHS principles are at the heart of service delivery.
- Failure of integrated governance processes which could lead to poor performance ratings, registration failures and/or damage to the trust in relation to commissioners, regulators and the public.
- Expenditure is not contained within budget levels.
- Unable to deliver short, medium and long term Cost Improvement Programme and service transformation to ensure costs are contained within available income.
- Risk of failure of communications/ marketing activities, both internal and external, resulting in the failure to promote the trust as a professional and trusted partner and identifying new service ideas through the input of clinicians and others.

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

Going Concern

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

Performance analysis

Summary of the Financial Year

This report covers our financial position for the year April 2015 to March 2016. We are reporting a deficit of £5.1m on income of £130.5m in the year. This position reflects asset revaluations across the Trust and an associated impairment charge. Excluding this charge, our underlying financial position is a £1.2m deficit which is a deterioration on last year's performance.

Operationally, we have continued to work very hard to achieve this result. However, there is a level of underachievement on our efficiency programme and we have continued to consider non recurrent savings which although successful will impact on next year's financial plan.

Income received to deliver core services has decreased by 1.9% in 2015/16 - this is known as the national efficiency requirement and follows on from the 1.7% reduction in 2014/15. In addition, we have faced reductions due to the decommissioning of some services, most notably the provision of prison services in Wakefield. We received some targeted investment in year most notably CAMHS and NCT Nurses and a new contract has commenced to deliver community services in Whitby.

Efficiency reductions will continue to be required at a similar level for the foreseeable future. Coupled with the effect of cost inflation, this has placed increasing emphasis on the need to deliver financial efficiencies throughout the organisation. £4.2m of cost efficiencies were generated; this has enabled us to come close to delivering our underlying financial targets for 2015/16.

The closing cash balance increased to £14.7m in the year, careful management of all capital expenditure has protected this position. However, this balance is likely to continue to reduce whilst we fail to generate year end surpluses.

Our total capital spend in the year was £3.1m. This level of expenditure is as expected.

We have an expected year end risk rating of 3. The scale is from 1 to 4, with 4 being the lowest risk. This is primarily based on our strong liquidity position (cash balance). We are expecting our Governance risk rating to remain at Green at the end of the year, at the time of publication this has not been confirmed by our regulator, Monitor.

Financial results 2015/16

Headlines

- Income of £130.5m a reduction of £1.6m
- Deficit of £5.1m after impairment adjustment
- Deficit of £1.2m excluding impairment adjustment above.
- The cash balance was £14.7m compared to £12.3 at March 2015
- Net current assets of £15.8m compared to £12.2m at March 2015
- Total net assets of £67.3m compared to £70.4m at March 2015

Income and expenditure

Income in the period was £130.5m compared to £131.8m in the prior year. We incurred a reduction in income from commissioners of 1.9%. Additional income was received in March due to the trust commencing service delivery of the Whitby community services contract.

Despite it being a difficult year in terms of receiving a further 1.9% reduction in income, incurring cost inflation as well as other financial pressures; our deficit of £1.2m was only £0.2m higher than anticipated.

Section 43 (2a) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the Health

Service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust met this requirement during 2015/16.

Capital Expenditure

Capital expenditure totalled £3.1m during the year. This level of expenditure is as expected. The schemes we supported included IT infrastructure projects including the implementation of the total mobile system and teleconferencing and estate projects including the completion of work to increase bed capacity at Newbridges and improvements to the seclusion suites in the Humber Centre (our secure inpatient unit). Our total net assets decreased to £70.4m compared to £76m a year ago.

The other most notable expenditure covered a range of projects and facilities including addressing backlog maintenance issues.

During 2015/16 we commissioned an estates capital revaluation exercise. This resulted in a net impairment of £3.9m due to changes in the value of the properties.

Management costs

Management costs for the year amounted to £7.5m which equates to 5.79% of income. This shows a small increase in both value and percentage of total costs when compared to the previous year. Details of directors' remuneration are provided on page 24-26.

Better payments practice code

In accordance with the Confederation of British Industry's (CBI) Better Payment Practice Code, our payment policy is to pay non-NHS trade creditors within 30 days of receipt of goods or services, or a valid invoice (whichever is the later) unless other payment forms have been agreed with the supplier. The figures for non NHS creditors improved from 96% to 98% in terms of the value paid within 30 days. The number of invoices paid within this time frame also maintained at 98%. We will continue to focus on this important performance measure.

	2015/16		2014/15	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	27,140	25,363	29,385	27,682
Total non-NHS trade invoices paid within target	26,705	24,913	27,978	26,648
Percentage of non-NHS trade invoices paid within target	98%	98%	95%	96%
Total NHS trade invoices paid in the year	340	2,594	332	2,376
Total NHS trade invoices paid within target	322	2,483	318	2,284
Percentage of NHS trade invoices paid within target	95%	95%	96%	96%

Financial Outlook

We have responded well to the financial challenges we and the wider NHS have faced over the last three years in particular. Over £11.3m of cost-efficiency savings have been generated over the course of the past three years. For 2016/17 contract inflation will increase values by 3.1% but this masks another national efficiency target of 2% as there will be a significant cost increase to fund national pay awards and increased pension costs of 1.1%. To offset these issues, further cost efficiency improvements of approximately £5.5m are required.

Medium term plans demonstrate the need to continue to deliver this level of efficiency improvement over the next four years. Given the amount already saved it is naturally more difficult

to identify further savings. We continue to operate a very robust process for identifying and implementing cost savings projects. All projects must be approved by both the Medical Director and Director of Nursing to ensure there is no negative impact on patient safety or quality of care. The programme of work for identifying savings initiatives for 2016/17 is largely complete and will continue to be reviewed on an ongoing basis.

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

As reported last year, there is no doubt the difficult economic environment will remain for some time. We have maintained a solid financial base but will need to continue to improve financial management to remain in a healthy financial position. All staff are encouraged to identify where any waste occurs and a series of workshops were held to consider all suggestions put forward. These workshops will be repeated in 2016/17.

We continue to perform well against achievement of our Commissioning for Quality and Innovation (CQUIN) framework, we accomplished a high level of achievement of these indicators in 2015/16. We continue to focus on these indicators in 2016/17 to ensure this level of income remains in place.

Conclusion

We delivered our expected financial performance last year despite national efficiency requirements being applied and the loss of income from some commissioned services. This was a positive achievement given that it was the fifth year of receiving a reduction in income and that it is becoming increasingly difficult to identify cost efficiency improvements. As ever, it was very much a team effort across the whole organisation to deliver this financial performance. Even more importantly, the delivery of the financial results did not compromise patient care. We achieved the vast majority of our performance targets for the year.

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

Since the end of the financial year, a number of important events have taken place that will affect the Trust. These include a Care Quality Commission inspection of our services and taking over the running of a GP practice in Market Weighton, with plans to turn it into a ‘one stop shop’ with the ability to combine traditional GP services with some hospital services.

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

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 the our Trust’s performance, business model and strategy.

Performance Analysis

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 to the end of March 2016 for the Monitor Risk Assurance Framework is summarised in the table below:

Monitor's Risk Assurance Framework : Access & Outcome Measures

Indicator Definition	Threshold / Target	Current RAG Definition		Frequency	Q1	Q2	Q3	Q4
Referral to Treatment - Non Admitted 18 weeks (Alfred Bean only)	90.0%	✓	Good	Mthly	99.0%	no data	92.3%	97.2%
Referral to Treatment - Incomplete 18 Weeks (Alfred Bean only)	92.0%	✓	Good	Mthly	99.4%	no data	97.3%	99.1%
Total Time in A&E - spent waiting less than 4 hours	95.0%	✓	Good	Mthly	100.0%	100.0%	100.0%	99.9%
Care Programme Approach (CPA) Formal Review within 12 months	95.0%	✓	Good	Mthly	96.2%	96.4%	97.0%	96.4%
Admissions to inpatients services - Access via Crisis (gate-keeping)	95.0%	✓	Good	Mthly	100.0%	99.5%	98.5%	100.0%
Early Intervention in Psychosis (EIP) - First episode treated within 2 weeks	50.0%	✗	Weak	Mthly	10.5%	53.6%	41.7%	37.5%
Improved Access to Psychological Therapies (IAPT) - Treated in 6 weeks of referral	75.0%	✓	Good	Mthly	86.1%	88.8%	89.4%	84.0%
Improved Access to Psychological Therapies (IAPT) - Treated in 18 weeks of referral	95.0%	✓	Good	Mthly	98.3%	99.0%	100.0%	100.0%
Care Programme Approach (CPA) Follow Up within 7 days of discharge	95.0%	✓	Good	Mthly	97.9%	96.7%	95.4%	96.6%
Clostridium Difficile Objective	4	✓	Good	Mthly	0	1	3	3
Minimising Mental Health Delayed Transfers of Care	7.5%	✓	Good	Mthly	4.9%	3.5%	1.7%	3.0%
Mental Health Data Completeness - Identifiers	97.0%	✓	Good	Mthly	99.3%	99.4%	99.6%	99.7%
Mental Health Data Completeness - Outcomes for patients on CPA	50.0%	✓	Good	Mthly	87.8%	88.6%	89.5%	89.0%
Certification against Compliance - Access to healthcare for people with Learning Disability	Y/N	✓	Good	Qtrly	100.0%	100.0%	100.0%	100.0%
Community Services Data Completeness - Referral to treatment information	50.0%	✓	Good	Qtrly	100.0%	100.0%	100.0%	100.0%
Community Services Data Completeness - Referral to treatment	50.0%	✓	Good	Qtrly	66.0%	66.0%	66.0%	66.0%
Community Services Data Completeness - Treatment activity information	50.0%	✓	Good	Qtrly	75.0%	75.0%	75.0%	75.0%

Performance against the CQC Intelligent Monitoring Framework:

Indicators	Assurance Level - CQC Caring			
Total Entries	Total Assurance	Limited Assurance	No Assurance	Being Developed
11	10	0	1	0
	Period Ending:		Mar-16	
	Quarter Ending:		Q4	

Indicators	Assurance Level : CQC Effectiveness			
Total Entries	Total Assurance	Limited Assurance	No Assurance	Being Developed
19	12	3	2	2
	Period Ending:		Mar-16	
	Quarter Ending:		Q4	

Indicators	Assurance Level : CQC Safe			
Total Entries	Total Assurance	Limited Assurance	No Assurance	Being Developed
13	10	2	0	1
	Period Ending:		Mar-16	
	Quarter Ending:		Q4	

Indicators	Assurance Level : CQC Responsiveness			
Total Entries	Total Assurance	Limited Assurance	No Assurance	Being Developed
6	6	0	0	0
	Period Ending:		Mar-16	
	Quarter Ending:		Q4	

Indicators	Assurance Level : CQC Well-Led			
Total Entries	Total Assurance	Limited Assurance	No Assurance	Being Developed
18	10	3	3	2
	Period Ending:		Mar-16	
	Quarter Ending:		Q4	

Areas of limited/No Assurance relate to:

- 7 day follow ups
- Bed Occupancy
- Mental Health Access Times
- Safer Staffing
- Sickness
- Mandatory and Statutory Training compliance

Social, community and human rights issues

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 people we serve from being treated equally
- Treating all people as individuals respecting and valuing with 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 service, or any one of the protected characteristics.

Signed:  **Date: 26 May 2016**

Chief Executive

Accountability Report

Directors' Report

The Board of Directors, sets the strategic goals and objectives of the Trust and monitors its 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, ensuring financial control and monitoring performance of the Trust.

During the year, there were some changes to our Board.

- Vanessa Walker, Non Executive Director, resigned on 7 July 2015. Paula Bee was appointed as her replacement from 1 March 2016. The Governor Appointments, Terms and Conditions Committee oversaw the process and details are provided within the Council of Governors section of the report.

- Hilary Gledhill joined the Trust in June 2015 as the Director of Nursing, Quality and Patient Experience taking over from Philip King, Interim Director of Nursing.

- Teresa Cope was appointed as the Chief Operating Officer from 1 April 2015.

- The Director of Strategy and Performance Simon Hunter also left the Trust following a review of the corporate structure.

The Board of Directors is chaired by Sharon Mays and comprises of six non executive directors (including the chairman) and five executive directors (including the chief executive). Andrew Milner, Non Executive Director is 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 review and evaluate its performance. 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 Board of Directors' priorities is reported on a quarterly basis.

Each Board of Directors' Sub Committee produces an annual report on their activities, achievements and plans for the year ahead. This 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 and involvement of non executive directors and governors. The Chairman led the evaluation of the non executive directors with appropriate consultation and involvement of governors.

The chief executive and executive directors are subject to formal appraisal by the chairman and chief executive respectively. This is based on the agreement of objectives linked to the key components of the Trust's annual plans and Board of Directors' priorities. Progress is monitored throughout the year. 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**
Sharon Mays	Trust Chairman and Chairman of Council of Governors and Remuneration and Nomination Committee	16 September 2014	15 September 2017
David Hill	Chief Executive	1 July 2014	N/A
John Whitton	Independent Non Executive Director	1 February 2010	31 August 2016
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 and Charitable Funds Committee	1 December 2013	31 January 2020
Paula Bee	Independent Non Executive Director	1 March 2016	28 February 2019
Vanessa Walker - until 7 July 2015	Independent Non Executive Director	1 March 2014	28 February 2017
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
Simon Hunter	Director of Strategy and Performance	1 August 2011	8 May 2015
Adrian Snarr	Director of Finance, Informatics and Infrastructure	9 December 2013	N/A
Elizabeth Thomas (non voting)	Director of HR and 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 Monitor's 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 the chair of the Council of Governors meetings and is responsible for providing leadership to both the Board of Directors and the Council of Governors. She 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. 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 delegate the day to day management of the Trust's operational services to the Executive Directors with the non executive directors sharing corporate responsibility for ensuring the Trust is run in an economically, effective and efficient way. The Operational, Management Group (OMG) meet on a monthly basis to ensure delegated duties are discharged.

Executive and non executive directors led a visibility programme to sites and teams within the organisation during the year including shadowing staff to gain a better understanding of the services being provided and any issues that staff may be faced with.

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.

The Risk Management Strategy expired during this reporting period.

As the care group structures were in the early stages of implementation at this point and the corporate structures were still in development, the decision was made to have an internal audit review of our existing risk structures, systems and processes to see if they are still fit for purpose to support the new operational structure of the Trust.

The audit, gave us a limited assurance rating on the current risk strategy, structures and systems and has led to a review of corporate risk structures and systems to create a new role for a risk management specialist within the Trust.

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

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

Information regarding the register of interests for our Board of Directors and Governors can be found on page 50 and 56 respectively.

The Trust made no political donations in 2015/16.

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Enhanced quality governance reporting

A Quality Improvement and Clinical Governance Development Plan for 2015/16 was produced by the Director of Nursing with input from professional leads and senior managers. The plan captures key quality improvement and clinical governance work programmes that are either existing or are required to be undertaken during the year. The plan identifies development and improvement work across six priority areas in line with the proposed strategic framework:

Priority Area 1: Patient Safety - Ensure our services are safe

Priority Area 2: Patient Experience - To actively listen and engage with our patients, services users, carers and other stakeholders in the planning, design, development, delivery and evaluation of the services we provide.

Priority Area 3: Clinical Effectiveness - To optimise our clinical effectiveness by best use of innovation, clinical audit and research

Priority Area 4: Leadership - Ensure we have a workforce that is caring, responsive and well led.

Priority Area 5: Work collaboratively - Promote a culture of openness, transparency and inclusiveness to drive the delivery of high quality care across all care settings.

Priority Area 6: Quality & Clinical Governance - Embed a systematic approach to clinical governance and quality improvement.

To ensure there is a corporate ownership and leadership of the Quality & Clinical Governance agenda, during 2015/16 the Director of Nursing established a Quality & Patient Safety Committee which will is responsible for ensuring there is a Quality Improvement and Clinical Governance programme developed for the Trust in line with national and local requirements; that there is appropriate clinical and managerial engagement and ownership of the plan and that the performance against the plan is monitored and performance managed.

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

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are

complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

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

Humber NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC) as at the 31 March 2016.

How We Measure Performance - Meeting Monitor targets

Our Trust uses a 'traffic Light' or 'RAG Rating' system to report on performance and quality against our selected priorities and Key Performance Indicators (KPIs), eg Red = Weak, Amber = Fair and Green = Good. This is translated to reflect the organisation's performance on the selected priorities and initiatives.

We also report externally to our Commissioners via:

- Contract Activity Report (CAR)
  Completed monthly by the Information Management team jointly with the Performance team.

  This system ensures that we can:
  - Monitor critical clinical processes and activities using measures of clinical and corporate performance that trigger alerts when potential problems arise.
  - Analyse the root cause of problems by exploring relevant and timely information from different sources and at various levels of detail.
  - Manage people and processes to improve decisions, be more effective, enhance performance, and steer the organisation in the right direction.

  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.

- Performance Indicator returns (PIs)
  All Monitor and CQC indicators are reported in the IPT 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.

Quality governance and quality are discussed in more detail in our Annual Governance Statement on page 59 of this report and in our Quality Accounts.

Directors' Statement

As far as each Director is aware there is no relevant audit information that the NHS Foundation Trust's auditor is unaware of. Each Director has taken all the required steps in order to make themselves and the NHS Foundation Trust's auditor aware of any relevant audit information need to let all directors have sight of this statement before it is finalised.

Remuneration Report

Annual statement on remuneration

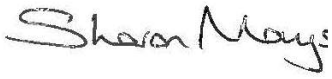
The Remuneration Committee determines the salaries of the Chief Executive and the other Executive Directors by considering market rates. All Directors are on permanent contracts with the Chief Executive and other Directors having a six month notice period. There is no performance related pay and no compensation for early termination.

The Council of Governors determines the pay for the Chairman and Non-Executive Directors and in so doing take 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 no cost of living award for the Chief Executive and Executive Directors with effect from 1 April 2015.

There were no other changes relating to senior managers' remuneration made during the year and the Council of Governors did not review the salaries for the Chair and Non-Executive Directors during 2015/16.

Sharon Mays  **26 May 2016**
Chairman

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 2014/15 and 2015/16 are provided in Table 3. The information included in this table is subject to audit. These allowances are not pensionable remuneration.

TABLE 1 Non Executive Director Remuneration Policy

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. Details of the salaries and allowances of the Chief Executive and other executive directors during 2014/15 and 2015/16 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 these or any other senior managers currently employed within the Trust. All current senior managers are on permanent contracts with three-month notice periods and standard NHS terms and conditions. The remuneration of these senior managers is based on the NHS-wide job evaluation scheme (known as Agenda for Change), which is uplifted annually by the Executive Management Group in line with the national uplift advised by the Department of

Health.

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

Senior Managers Remuneration Policy

TABLE 3 Salaries and allowances of Trust Board and other senior managers (1 April 2015 – 31 March 2016)

Chair and non-executive directors

Name and Title	2015/16						2014/15					
	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)
S Mays Chairman	40-45					40-45	25-30					25-30
V Walker Non Executive	0-5					0-5	10-15					10-15

Director (up to July 2015)												
J Whitton Non Executive Director	10-15					10-15	10-15					10-15
P Baren Non Executive Director	15-20					15-20	10-15					10-15
A Milner Non Executive Director	10-15					10-15	10-15					10-15
D Crick Non Executive Director	10-15					10-15	10-15					10-15

Executive directors

Name and Title	2015/16						2014/15					
	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	145-150	7,500			0	150-155	110-115	3.3			0	110-115
A Snarr Director of Finance	105-110	4,500			32.5-35	145-150	105-110	3.8			0	110-115
E Thomas Director of Human Resources & Diversity	85-90	5,100			20-22.5	115-120	85-90	3.5			2.5-5	90-95
D Michael* Medical Director	155-160			10-15	2.5-5	175-180	165-170			10-15	0	180-185
T Cope Chief Operating Officer (from 1 April 2015)	100-105	1,900			0	100-105						
H Gledhill Director of Nursing, Quality & Patient	80-85				0	80-85						

Experience (from 1 June 2015)											
S Hunter Director of Strategy and Performance (up to 8 May 2015)	10-15	400		22.5-25	35-40	95-100	3.1			0	95-100

*****The figure for Medical Director includes remuneration for duties that are not part of the director role. These duties comprise 50% of the individuals' role.

The Benefits in Kind covers the monetary value of the provision of a car and travel costs. The 2015/16 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 2015/16 was £145,000. This was 6.7 times 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 2 above illustrates this calculation.

Table 4

	2015/16
Band of Highest Paid Director's Total Remuneration (£'000)	155-160
Median Total	21,692
Remuneration Ratio	7.3

Table 5 Pension benefits of Trust Board and other senior managers (1 April 2015 – 31 March 2016)

Executive directors

Name and Title	Real increase in pension at age 60 (bands of £2500)	Lump sum at age 60 related to real increase in pension (bands of £2500)	Total Accrued pension at 60 at 31 March 2016 (bands of £5000)	Lump sum at 60 related to accrued pension at 31 March 2016 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2015	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	£000	£000	£000	£000	£000	£000	£000	£000
D Hill Chief Executive	0	0	0-5	0	22	21	0	19
A Snarr Director of Finance	0-2.5	0	40-45	115-120	658	654	0	15
E Thomas Director of Human Resources and Diversity	0-2.5	0-2.5	25-30	75-80	588	557	24	13
D Michael Medical Director	0-2.5	0-2.5	35-40	105-110	671	657	4	23
T Cope Chief Operating Officer	0	0-2.5	20-25	65-70	346	322	20	14
H Gledhill Director of Nursing, Quality and Patient Experience	0	2.5-5	15-20	50-55	345	311	25	12
S Hunter Director of Strategy and Performance	0-2.5	0-2.5	30-35	100-105	659	643	1	1

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 1.2%

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

David Hill, Chief Executive

Signature:  **Date: 26 May 2016**

Remuneration and Nominations Committee

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

The role of the committee is to advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees on a Very Senior Managers contract and conditions including all aspects of salary (including any performance-related elements/bonuses) and provisions for other benefits, including pensions and cars.

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.

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 on the Trust's website or from the trust secretary.

For full details on the number of meetings and individuals' attendance at each can be found on page 43.

Each time an Executive Director is appointed there is debate and discussion at the Trust Remuneration and Nominations Committee about the appropriate salary to be agreed. We use the Foundation Trust Network benchmark salaries for similar Trusts.

Staff Report

Below is an analysis of average staff numbers in the Trust:

Average number of employees (WTE basis)

			2015/16	2014/15
	Permanent Number	Other Number	Total Number	Total Number
Medical and dental	57	-	57	63
Ambulance staff	-	-	-	-
Administration and estates	480	32	511	492
Healthcare assistants and other support staff	611	95	706	707
Nursing, midwifery and health visiting staff	915	36	951	964
Nursing, midwifery and health visiting learners	17	-	17	20

Scientific, therapeutic and technical staff	321	3	325	352
Healthcare science staff	-	-	-	-
Social care staff	28	-	28	9
Agency and contract staff	-	146	146	111
Bank staff	-	-	-	-
Other	-	-	-	-
Total average numbers	2,429	312	2,741	2,718
Of which:				
Number of employees (WTE) engaged on capital projects	3	-	3	3

Breakdown of male and female directors, senior managers and employees

	Male	Female
Directors	3	3
Other Senior Managers	2	8
Employees	544	2,044

Staff Sickness Absence

	2015/16 Number	2014/15 Number
Total FTE Days Lost	26,719	27,671
Total FTE Days Available (Years)	2,421	2,414
Average Sick Days per FTE	11	11

Staff sickness absence figures are calculated on a calendar year basis.

Staff policies and actions applied during the financial year

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

The Joint Consultation and Negotiating Committee continue to meet on a bi-monthly basis. The chairmanship of the committee rotates between the Chief Executive and the staff side Chairman. Secretariat support to the committee is provided by the Director of Human Resources and Diversity. There is also a separate negotiating forum for medical staff.

The following consultation documents and policies have been agreed at the Trust's Consultation and Negotiating Committee between 1 April 2015 and 31 March 2016:

Consultation documents	Policies
• Care Group Operational Management Structure	• Disciplinary
• Children's Services	• Special Leave
• Operational Restructure Band 8a	• Working Time Regulations
• Wakefield Prison	• Flexible Working
• 24 Hour Service Hospital Mental Health Team	• Retirement
• Introduction of short shifts to support the existing shift pattern within the Humber	• Nursing revalidation

Centre
- East Riding Community Alcohol and Drug Service
- Intensive Home Treatment Team (IHTT) and Intensive Home Care Team (IHCT)
- Corporate Services Structure
- Equality and Diversity
- Reckonable Service

We use a variety of communication methods to ensure that we involve our staff in all Trust activity which include:

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

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

Occupational Health
Our Consultant in Occupational Health Medicine retired at the end of the year and we now provide an occupational health service for managers and staff which is delivered by General Practitioners (GPs) who are qualified in occupational health and qualified occupational health nurses. Services provided include screening, immunisation programmes, health and stress assessments, counselling, advice and guidance on infection control and back care and ergonomic advice. Staff can refer themselves to the service. Managers are also assisted in managing staff attendance with expert guidance on adjustments and back to work programmes.

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

Counter Fraud
The Trust has embedded arrangements to counter fraud, bribery and corruption in line with NHS

Protect Standards. The Fraud, Bribery and Corruption Policy informs staff of what a potential criminal act of fraud is and how staff can report any concerns or suspicions to our Fraud Team.

The Fraud Team reports directly to the Director of Finance, Informatics and Infrastructure and is composed of a Fraud Manager and a Local Counter Fraud Specialist who will investigate all referrals: they are able to deal with potential fraudsters whether it be in a criminal court, through civil redress or assisting in disciplinary cases. The fraud officers also deal with other aspects of countering fraud including fraud awareness, prevention and deterrence.

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

Staff Survey results

It was clear from the results of the 2015 NHS staff survey that we still have a lot of work to do to ensure that our staff feel properly supported and managed.

During 2015 we created a new operational structure with four care groups to improve the availability and visibility of managers across our services and many of these changes were still underway or only just bedding in when the survey took place.

We are planning a variety of ways to engage staff in what needs to change to improve their experience of working for the Trust.

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

- response rate for 2015/2016 compared with previous years;
- top four ranked scores in comparison with other trusts;
- bottom four ranked scores in comparison with other trusts.

In previous years the Trust has been assessed as a Mental Health and Learning Disabilities Trust only. In 2015 the Trust was assessed as a Mental Health, Learning Disabilities and Community Services Trust for the first time.

Response Rates

	2012/2013		**2013/14**		**2014/15**		**2015/16**		**Trust Improvement or Deterioration**
	Trust	National Average	Trust	National Average	Trust	National Average	Trust	National Average	
Response Rate	57%	51%	56%	49%	44%	44%	48%	44%	4% increase

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

	2014/15		2015/16		Trust Improvement or Deterioration
Category	Trust	National Average	Trust	National Average	
Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	92%	86%	92%	89%	Same
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	91%	91%	94%	92%	3% improvement
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	18%	27%	20%	22%	2% deterioration
Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	41%	-	50%	48%	9% improvement

Bottom Four Ranking Scores
Where the Trust Score was lower than the national average

	2014/15		2015/16		Trust Improvement or Deterioration
Category	Trust	National Average	Trust	National Average	
Support from immediate managers	3.69	3.81	3.66	3.86	0.03% deterioration
Effective team working	3.86	3.84	3.65	3.86	0.21% deterioration
Recognition and value of staff by managers and the organisation	3.52	-	3.30	3.52	0.22% deterioration
Effective use of patient / service user feedback	3.41	-	3.36	3.69	0.05% deterioration

Expenditure on consultancy

Expenditure on Consultancy	2015/16	2014/15
	£	£
Consultancy Costs	615	307

Off payroll arrangements

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months.

	2015/16 Number of engagements
Number of existing engagements as of 31 March 2016	9
Of which:	
Number that have existed for less than one year at the time of reporting	9
Number that have existed for between one and two years at the time of reporting	-
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	-

Humber NHS Foundation Trust has a policy to ensure that assurance is sought for all off-payroll assignments.

For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months.

	2015/16 Number of engagements
Number of new engagements, or those that reached six months in duration between 01 April 2015 and 31 March 2016	9
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	9
Number for whom assurance has been requested	9
Of which:	
Number for whom assurance has been received	5
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 April 2015 and 31 March 2016.

	2015/16 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.	6

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

Exit packages

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

Reporting of compensation schemes - exit packages 2014/15

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

Exit packages: other (non-compulsory) departure payments

	2015/16		2014/15	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	2	22
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	1	8
Non-contractual payments requiring HMT approval	-	-	-	-
Total	-	-	3	30
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

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**.**

Code provision A 1.1 states there should be a clear statement defining the roles and responsibilities of the Council of Governors. This is included in the Schedule of Matters Reserved to the Board of Directors and is part of the Standing Orders/Standing Financial Instructions and Reservation of Powers to the Board of Directors and Scheme of Delegation documents. It also explains the process to be taken in the event of a disagreement between the Board of Directors and Council of Governors. In the event of any directors having concerns that cannot be resolved about the running of the Trust or a proposed action, these concerns will be recorded in the Board of Directors minutes.

During the financial year 2015/16 the principles of the code were applied and requirements met. Schedule A of the Code of Governance sets out the requirements in six areas and the response and declaration from the trust for each area are included in the table below.

As per section 1 of Schedule A of the Code of Governance, all statutory requirements have been complied with, if appropriate.

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

Code Ref	Summary of Disclosure Requirement	Page(s)
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.	Pages 20 and 36
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) • the chairperson and members of the nominations, audit and remuneration committees; • the number of meetings of the board and those committees and individual attendance by directors.	Pages 17, 18, 24, 29, 44 - 50
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.	Pages 49, 54, 55 and 56
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.	Page 18
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.	Pages 44 - 50
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.	Pages 29
B.3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the Annual Report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next Annual Report. Comply – register of interest is publicly available for the chairman	Page 50

Code Ref	Summary of Disclosure Requirement	Page(s)
	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.	Page 57
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.	Page 17
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.	Page 39
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).	Pages 14, 19 and 59
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.	Page 59
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.	Page 41
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.	N/A
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:	Page 40

Code Ref	Summary of Disclosure Requirement	Page(s)
	• 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.	
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.	N/A
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.	Pages 19, 42 and 53
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.	Pages 56 - 57

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

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

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

The Trust complies with all provisions of section 6.

External Reviews

During the course of the year 5 reviews have been completed. These were primarily to support the Trust in the development and delivery of its cost improvement programme covering areas which include programme management, productivity reviews (including the benefits of mobile working across both community and mental health) and development of partnership framework agreements.

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 29 of this report

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

  The committee comprises of three non executives directors and is chaired by Peter Baren, Non Executive Director. In accordance with Monitor's guidance, Peter Baren has relevant and recent financial experience. The committees met six 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. Four assurance reports from the Quality and Patient Safety Committee (QPaS) were received demonstrating the work that is being done to improve patient care, patient safety and patient experience.

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

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

  A proposal was made to merge the Mental Health Legislation Committee into the IAGC, which is still being considered.

  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.

  A self-assessment of the effectiveness of the committee was undertaken and concluded that the IAGC is delivering its core duties effectively and is committed to its further development (mainly in respect of its clinical duties) as facilitated through the development plan and through future effectiveness sessions.

  ### External Audit

  For 2015/16, the Trust's external auditors were Deloitte. During the year a total of £66,337 was paid to Deloitte for audit services.

  At its May 2015 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.

  Non-audit services were provided during 2015/15 by Deloitte at a total cost of £19, 521 for a Board of Directors preparation, workshop and report in relation to the informatics strategy.

  To maintain auditor objectivity, independence and probity, this service was carried out by Deloitte staff who are not involved in the Trust statutory audits, nor do the audit staff have any

involvement with the findings, which are reported directly to the Trust and not via the audit partner.

Internal Audit

In public sector organisations, internal audit work is regulated by the Public Sector Internal Audit Standards, which became effective on 1 April 2013 and govern the way in which all internal audit services operating within the public sector (including the NHS) should undertake their functions with regard to assurance audits and consultancy activity. The standards also support the professional practice of internal audit across the NHS.

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

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

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

Attendance of directors at all 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's website.

- **Charitable Funds Committee**

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

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

HEY Smile Foundation (Smile) have worked with HFT to evaluate the profile of charitable funds within the Trust. This has looked at the Trust's current charitable status to ensure its structure is still fit for purpose, levels of giving, organisational responses to donors, levels of expenditure, and levels of community engagement. This included researching charitable funds internally and in other areas of the NHS, and carrying out a staff survey to assess awareness levels.
This has highlighted that in some areas, potential donors have struggled to find out how to contribute, and some staff within the organisation did not know what funds they could access to improve the patient or client experience. Smile have developed a proposal to cultivate a proactive charitable arm of the Trust that can respond to meet the needs of its staff, patients, and visitors.

- **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;

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

  - approve and review Mental Health Legislation polices and protocols.

  The committee is chaired by Dave Crick, Non Executive Director and has a core membership of:

  - one other non executive director;
  - the medical director;
  - the director of nursing, quality and patient experience;
  - the mental health legislation manager ceased being chair of Mental Health Legislation Steering Group after 7th January 2016 meeting and Chair passed to Tom Phillips (Deputy Director of Nursing, Quality and Patient Experience) from 16th March 2016 onwards;
  - an independent consultant psychiatrist who has recognised particular experience in mental health and related legislation;
  - 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, a recommendation has yet been made to the Board of Directors as discussions continue.

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

  The committee chair is Andrew Milner, Non Executive Director, and has a core membership of two other non executive directors; the director of finance, infrastructure and informatics; 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	Rem	MHLC	CF	IAGC	StIC	CoG
Sharon Mays	Chairman	10/10	2/2	1/1			1/1	4/4
David Hill	Chief Executive	10/10	2/2			1/1	2/2	4/4
David Crick,	Non Executive Director	9/10	2/2	5/5		6/6		2/4
Andrew Milner	Non Executive Director (Senior Independent Director)	8/10	1/2		4/4		6/9	2/4
John Whitton	Non Executive Director	9/10	2/2			4/6	7/9	3/4
Peter Baren	Non Executive Director	9/10	2/2	4/5	4/4	6/6	9/9	3/4
Paula Bee	Non Executive Director (from 1 March 2016)	1/1						0/1
Vanessa Walker	Non Executive Director (up to 7 July 2015)	4/4	1/1	1/1		1/1		0/1
Simon Hunter	Director of Strategy and Performance (up to 7 May 2015)	1/2						1/1
Adrian Snarr	Director of Finance, Infrastructure and Informatics	9/10			4/4	6/6	9/9	4/4
Teresa Cope	Chief Operating Officer (from 1 April 2015)	9/9		2/2		2/2	3/3	3/4
Dasari Michael	Medical Director	9/10		5/5		5/6	1/1	4/4
Hilary Gledhill	Director of Nursing, Quality and Patient Experience (from 1 June 2015)	7/8		2/4		4/4	1/1	3/4
Elizabeth Thomas (non-voting)	Director of Human Resources and Diversity	10/10				0/4		4/4

Key: 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 2017)

Sharon is the first chairman of our Trust to have also served as an appointed governor and non executive director.

Sharon initially joined the Trust as a non executive director in July 2011 following the transfer of community services. She was reappointed by the Council of Governors in June 2014.

Sharon has previously held board positions with the former East Riding of Yorkshire Primary Care Trust. She is a qualified solicitor and was previously a partner at a firm of solicitors and specialised in commercial property.

John Whitton, Non Executive Director (term of office expires 31 August 2016)

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

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 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.

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.

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 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 well-being 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 the 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 currently also 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.

Vanessa Walker, Non executive director (up to 7 July 2015)

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

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

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

Peter Baren, Non Executive Director (term of office expires 31 January 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 Hill, Chief Executive (appointed 1 July 2014)

With a background in senior management in local government, this is David's first direct role within the NHS although 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 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

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

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

Simon Hunter, Director of Strategy and Performance (appointed 1 August 2011 up to 8 May 2015)

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

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

Dr Dasari Michael (appointed Medical Director 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 the 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 its 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 Masters degree in Human Resource Management and has many years' experience in NHS workforce planning and management.

She 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 both acute and mental health sectors and in both 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 the Trust, 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 both acute hospital services and the community before moving into senior quality improvement and nurse leadership roles, gaining experience in both 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.

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

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

Council of Governors

Governors engage with members of their constituencies and work with staff in service areas. During the year elections were held to fill vacant seats for existing governors coming to the

end of their term of office who had decided not to re-stand for election.

Elections took place for the East Riding, Hull and staff constituencies with a total of 11 seats available. All but one of the seats in the Hull constituency were filled and those elected took up their seats from 1 February 2016. Consideration was given to having another election to try and fill the vacancy in Hull, however it was felt that the Council could still operate with this vacancy until the next elections are held in 2016. An induction session was held and the newly elected governors are learning about their role and starting to engage with their constituencies.

The Council of Governors is comprised of people who have various skills and experience which they bring to the role together with enthusiasm and commitment to really make a difference. To fulfil their role governors choose to become members of the sub groups of the Council of Governors and also forge links with service areas. Governors also attend the Annual Members' Meeting (AMM) which forms part of the Trust's annual review. This year, the staff awards event was held separately and recognised the work and extra dedication that our staff have given so that patient care is of a high quality and standard.

The visiting programme for governors was modified and revised. A guide for visits has been produced to demonstrate the areas of discussion. The visits gave governors the opportunity to talk to both patients and staff to find out what they think about our services.

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

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

Julie Hastings, Lead Governor

The Council of Governors comprises of 28 Governors and 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 & East Yorkshire NHS Hospitals
Observers	NHS East Riding Clinical Commissioning Group

The Council of Governors met four times during 2015/16 and also held an Annual Members' Meeting (AMM). Council of Governors public meetings are open for members of the public to attend. 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 meetings. Each meeting begins with a patient story which is a presentation by a service area team and, where possible, service users who give their view of the service.

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.

The Council of Governors is made up of individuals who have been elected by the local people and staff who represent our constituencies. The Council 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:

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

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

Governors are invited to attend the Trust's public board meetings and 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 meet on a monthly basis (with the exception of January and August) with every meeting held in public. The agendas and supporting papers for the public meetings are published on our website. Details of attendance at

this meeting for 2015/16 is detailed on page 43. Confidential and commercially sensitive matters are discussed in a Part II (private) meeting and matters which were not confidential or commercially sensitive were discussed at meetings held in public. Governors are sent 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.

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 and three governor groups meet which are detailed below:

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

During 2015/16, the Appointments, Terms and Conditions Committee - chaired by a Governor - met four times. Committee membership is primarily governors and it is chaired by a Governor, supported by the Chairman, Senior Independent Director (SID) and Director of Human Resources and Diversity. The Committee made recommendations to the Council for the re-appointment of three non executive directors and approved the recruitment process for a non executive director position which included the use of an external consultant, Penna, to help identify potential candidates. The interview panel was chaired by a Governor and included members of the Appointments, Terms and Conditions Committee supported by the Chairman, SID, and Director of Human Resources and Diversity. Following the interviews, a recommendation for appointment was made to the Council of Governors. In considering these appointments the committee took into account the view of the Board of Directors and the skills, experience and qualifications required for the position.

Governors were involved in developing the Trust's Five Year Strategy and Operational Plan. The Council of Governors receives regular updates on implementation on specific aspects of the plan delivery. The have also been involved in developing the annual plan for 2015/16 through the Strategy and Business Development Governor Group, the outcome of which was reported to the Council of Governors.

Governors have taken part in the Recovery College Board and are invited to attend meetings of sub-committees of the Board to observe how they are run. Governor champions have been identified to be part of the Patient Experience Care Group which will take forward the patient and carer experience pledges outlined in the patient and carer experience strategy.

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

Bi-monthly governor development days were held with various topics being discussed including the of 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. Governors are involved in setting the agenda for the development days and identify areas they wish to receive more information on. Members of the Board of Directors are engaging with governors enabling them to gain an understanding of governor and member views through:

- attendance at Council of Governors meetings;
- joint board and governor sessions for budgets, cost improvement programme and quality accounts;
- membership of governor groups;
- attendance at development days;
- involvement in visits by governors to patient areas;
- attending Patient Led Assessment of the Controlled Environment (PLACE) inspections;
- involvement in member events.

The Board of Directors is responsible for the day to day running of the Trust although the Board of Directors takes account of the views of governors when developing its strategy and forward plans. Governors have also developed a governor forum, where only governors are present. The agenda for this meeting is set by the governors themselves and the actions from these meetings are shared with the chairman so they can be addressed.

Some governors have attended the Governwell training events and fed back on the outcomes of these courses. Governors complete activity logs to demonstrate the work they are undertaking. These are collated and fed into the meeting.

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

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

Council of Governors Members and their Attendance in 2015/16			
Name	**Constituency**	**No of Council Meetings attended / possible total**	**Term of Office ended/s**
Current Governors			
Rodney Evans (re-elected 1 February 2016)	Hull Public	3/4	Jan 2019
Robert Hunt (elected)	Hull Public	4/4	Jan 2017
Eric Bennett (elected)	Hull Public	3/4	Jan 2018
Gary Wareing (elected 1 February 2016)	Hull Public	0/1	Jan 2019
Martin Clayton (elected 1 February 2016)	Hull Public	1/1	Jan 2019
Ron Morgan (re-elected 1 February 2016)	East Riding Public	4/4	Jan 2018
Neel Kamal (elected 1 February 2016)	East Riding Public	1/1	Jan 2019
Sam Muzaffar	East Riding Public	1/1	Jan 2019

(elected 1 February 2016)			
Pat Collard (re-elected 1 February 2016)	East Riding Public	0/4**	Jan 2019
Julie Hastings - Lead Governor (re- elected 1 February 2016)	East Riding Public	4/4	Jan 2019
Ros Jump (elected)	East Riding Public	4/4	Jan 2018
Marie Nicoll (elected)	East Riding Public	3/4	Jan 2018
Nicholas Alexander (elected)	East Riding Public	2/4	Jan 2018
Mike Oxtoby (elected)	East Riding Public	4/4	Jan 2018
Peter Lacey (re-elected 1 February 2016)	Wider Yorkshire and Humber Public	3/4	Jan 2019
Vanessa Colman (elected)	Staff	2/4	Jan 2018
Sarah Tyreman (elected)	Staff	4/4	Jan 2018
Natalie Belt (elected)	Staff	3/4	Jan 2017
Anne Gorman (elected 1 February 2016)	Staff	1/1	Jan 2019
Mandy Dawley (elected 1 February 2016)	Staff	1/1	Jan 2019
David Smith (appointed)	Hull and East Yorkshire Mind	3/4	Aug 2017
John Thirkettle (appointed)	Humberside Police	0/1	Feb 2019
Elaine Aird (appointed)	East Riding of Yorkshire Council	2/4	Jan 2019
Helena Spencer (appointed)	Kingston upon Hull City Council	3/4	Jun 2016
Andy Barber (appointed)	HEY Smile Foundation	1/4	Feb 2018
Kirsty Fishburn (appointed)	University of Hull Faculty of Health and Social Care	3/4	Feb 2018
Observers – non voting			
Jonathan Beckerlegge	NHS East Riding Clinical Commissioning Group	1/4	Aug 2016
Governors who left during 2015/16			
John Nicholls (completed second term of office)	East Riding Public	0/3	Jan 2016
David Gibson (end of term)	East Riding Public	3/3	Jan 2016
Jezz Farmer (end of term)	Staff	2/3	Jan 2016
Kevin Blyth (completed second term of office)	Staff	2/3	Jan 2016
Gwen Lunn resigned October 2015	Hull Public	0/2	Jan 2017
Kay Durrant (appointed)	Humberside Police	0/3	Feb 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 2015 to 31 March 2016, a total of nine governors claimed reimbursement for expenses. This included those governors who are no longer in post or who have left during the year. The total cost reimbursed to governors for this period was £1,987.28.

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 email HNF-TR.governors@nhs.net

Governor Elections

Elections were held in November/December 2015 for 12 governor seats covering the four constituencies. The details are below:

Public – Hull – There were four seats available and three candidates were elected

Public – East Riding of Yorkshire – There were five candidates to elect and all seats were filled.

Public – Wider Yorkshire and Humber – There was one seat to fill and a candidate was elected.

Staff – There were two candidates to elect and both seats were filled.

Members and Governors

484 new members joined our Trust during 2015/16 taking our membership total (excluding staff members) to 13,299. This number aligned to our Membership Strategy to recruit at least the number of members that were lost due to bereavement, moved out of area or other reasons.

As of 31 March 2016, the Trust had 6,552 members in the East Riding, 5,908 in Hull, 677 in the wider Yorkshire and Humber area, 3,056 staff members and 108 members live outside our catchment area. Our Trust membership continues to grow and we continue to try to make it as representative as possible of the communities we serve. Our staff are broadly representative of the trust's public membership in numerical terms.

During 2015/16 recruitment opportunities were included as part of other events that took place throughout the year including World Mental Health Day, Hull Clinical Commissioning Group Annual Meeting and Health Fair, a Time to Talk event, Hull University Career 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 March 2016.

Membership Size and Movement		
Public Constituency	2015/16	2016/17(est)
At year start 1 April	13,299	13,245
New Members	484	750
Members Leaving	538	600
At year end 31 March	13,245	13,395

Staff Constituency*	2015/16	2016/17 (est)
At year start 1 April	3,056	2,993
New Members	227	500
Members Leaving	290	300
At year end 31 March	2,993	3,193

***as at 31.3.16**

Analysis of Current Membership		
Public Constituency	Number of Members	Eligible Membership
Age (years)		
0 – 16	1	1,078,746
17 – 21	481	360,677
22+	11,802	3,943,942
Ethnicity		
White	12,561	4,692,156
Mixed	51	84,561
Asian or Asian British	174	385,964
Black or Black British	171	80,346
Other	30	19,570
Gender Analysis		
Male	4,833	2,657,242
Female	8,393	2,726,123

On 1 March 2016 the Trust went live as the new provider of community services in Whitby and the surrounding area. This is a major development as we extend our geographical range and begin to work with a new commissioner – Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG). Membership events will be arranged to recruit members in this area. As of 31 March 2016, the staff who transferred had not been included in the figures above.

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

The Trust's members play an important part in our future development and can become involved in services by working with our governors if they so wish. Membership is about community engagement and developing our organisation in partnership with the community; 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 is having a membership that can influence the services we provide. Our membership magazine, Humber People, is produced three times a year and tells our members what is happening within the Trust.

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 associated with these conditions.

Contact Details

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

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

Tel: 01482 389132 or 01482 389194

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.

Regulatory ratings

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

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

Monitor performance ratings 2015/16

	Annual Plan 2016/17	Q1	Q2	Q3	Q4
Financial sustainability risk rating	3		2	2	4
Continuity of service rating		3			
Governance rating	Score not received from Monitor	Green	Green	Green	Score not received from Monitor

Monitor performance ratings 2014/15

	Annual Plan 2015/16	Q1	Q2	Q3	Q4
Under the Compliance Framework					
Continuity of service rating	4	4	3	3	4
Governance risk rating	Green	Green	Green	Green	Green

Statement of the chief executive's responsibilities as the accounting officer of Humber NHS Foundation Trust

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

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

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

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis

- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

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

To the best of my knowledge and belief, I have properly discharged the 168 responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Signed 

Chief Executive **Date: 26 May 2016**

Annual Governance Statement

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

The Trust Board through its Integrated Audit and Governance Committee (IAGC) agreed the Trust's 2015/16 Internal Audit Plan with its internal auditors. The results of these audits culminated in the Head of Internal Audit's opinion on the system of internal control.

Contracts were in place with a range of commissioners including Clinical Commissioning Groups (CCGs) and NHS England for 2015/16 setting out the contractual arrangements for services provided by the Trust, which have been agreed. Partnership agreements with Hull City Council and East Riding of Yorkshire Council for the provision of social care are also in place. I regularly meet with all chief executives in the Yorkshire and the Humber area and the Trust has a range of mechanisms in place to facilitate effective working with key partners. These include monthly meetings of the local patch chief executives and appropriate directors from the Local Authority; various monthly meetings of executive directors from the Trust and the CCG. There have been three East Riding Section 75 meetings in October and December 2015 and February 2016 and the Hull Partnership Board has met twice on 16 June and 21 September 2015. The membership includes: Directors of Social Services or their representatives; local councilors; and CCG representatives.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to

eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Humber NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Humber NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

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

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

The Risk Management Strategy expired during this reporting period.

The new care groups structures are the fundamental building blocks of organisational governance and as these structures were in the early stages of implementation at this point and the corporate structures were still in development, the decision was made to have an internal audit review of our existing risk structures, systems and processes to see if they are still fit for purpose to support the new operational structure of the Trust.

The audit, gave us a limited assurance rating on the current risk strategy, structures and systems and has led to a review of corporate risk structures and systems to create a new role for a risk management specialist within the Trust.

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

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

- corporate induction for all new starters
- health and safety
- fire training
- infection control
- information governance
- safeguarding

- Mental Health Act
- Mental Capacity Act
- incident reporting and investigation
- medicines management
- managing violence and aggression.
- Prevent training

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

The strategy clearly states that I have overall accountability and responsibility for risk management within the Trust. The Chief Executive has the Executive Lead/accountability for organisational risk management, and each Director is responsible for managing risks with are identified in the Board and sub committee structures.

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

The Risk and Control Framework

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

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

The requirement to sign an Annual Governance Statement as part of the statutory accounts and annual report requires the Trust Board to demonstrate that they are managing potential risks which would prevent the achievement of the Trust's principal corporate objectives. The Assurance Framework fulfils this purpose. The Assurance Framework does not exclude risks that are well-controlled but describes the existing controls and assesses independent assurance. The Assurance Framework also identifies gaps in control and gaps in assurance. The Assurance Framework is reported to and updated by the IAGC and the Trust Board on a quarterly basis, following a review of evidence which includes current risks identified in the risk register.

During 2015/16 the Assurance Framework identified a number of gaps in control or assurance. None of these gaps is deemed to be significant. The Trust has identified the actions required to

address all these gaps and the action plans, were monitored in year on monthly basis by the Executive Management Team, and by the Trust Board on a quarterly basis.

During 2015/16 all of our clinical and operational services were re-grouped into four new care groups. This new structure will provide the fundamental framework for the management and governance of our services in futures. The structures were implemented in-year and therefore have not had time to realise their true potential.

During 2015/16 under the leadership of the Director of Nursing, Quality & Patient Experience a new quality team and governance structure was established with the specific aim of embedding and driving quality improvements across the newly established care groups. The approach reflects the key quality priorities for the organisation across the domains of Patient Safety, Clinical Effectiveness and Patient & Carer Experience. There has been the development of three associated strategies to shape delivery for 2016-19. The strategies capture both the national and local context. Each of the three domains has priority focus areas:

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 unsatisfactory with respect to the IG toolkit assessment for 2015/16, due to not reaching the 95% threshold for staff having actual information governance training. A plan was put in place to achieve 95% by 30 April 2016, and as Accounting Officer I can confirm that as of 28 April 2016 the Trust is now compliant with this target.

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.

All data classified incidents were reviewed and none was deemed to be significant. The Trust has a qualified Chief Information Officer who is up to date with the training required by the Information Authority. The Trust has also migrated to NHS Mail for additional security for data transfers.

Public stakeholders are involved in the Trust through the implementation of 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 and there is effective reporting quarterly to the Trust's IAGC and Board meetings. The Trust Board holds a meeting in public on a monthly basis.

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

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

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

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

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

Humber NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC) as at the 31 March 2016.

Achievements

Below are some of our most important achievements during the past 12 months.

- We launched our Recovery College at the end of 2015 and were delighted to see all 12 courses (including mind mapping, wellbeing through creativity and managing anger) fill up within the space of a month.

- Our Hull Integrated Community Stroke Service took part in a pioneering collaboration with the Royal Philharmonic Orchestra (RPO) to create a Strokestra. The aim of the Strokestra is to use creative music-making to drive patient-led rehabilitation work with stroke survivors and their carers. The pilot programme (funded by the Hull City Council Public Health department) culminated in a high-profile performance ahead of the RPO season opening concert at Hull City Hall on Thursday 1 October 2015.

- We hosted the local Protected Time for Learning event for East Riding of Yorkshire CCG which involved getting GPs from Hull and East Riding together to discuss health matters in the elderly. It was the first time an event of this scale had taken place and we received some outstanding feedback.

- We celebrated 10 years of successful partnership working with registered charity the Alcohol and Drug Service (ADS). The partnership commissioned by East Riding of Yorkshire Council has over the years helped thousands of people rebuild their lives and overcome their difficulties and were awarded all lots of the contract.

- We achieved Stage 3 Accreditation of the UNICEF Baby Friendly Initiative (BFI) designed to support breastfeeding and parent infant relationships.

- In October 2015, together with our health and local government partners, we outlined a shared determination to transform emotional health and wellbeing services to make a difference to the lives of children and young people in Hull and the East Riding of Yorkshire. We committed to work together on a number of CAMHS priorities including setting up a Hull and East Riding

Crisis team which was operational in early 2016, to improve waiting times against which we have made great progress and to extend our perinatal mental health service to cover the whole of the East Riding of Yorkshire.

- We signed a seven year contract with NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group to become the new provider of community and out of hours services in Whitby and the surrounding area from 1 March 2016.

- Our award winning Health Trainer team was chosen to deliver Stop Smoking services in the East Riding.

- In Autumn 2015 we worked with public sector and NHS partners on a pioneering new scheme to provide a rapid 24/7 response for falls patients in Hull. Hull FIRST (Falls Intervention Response Safety Team) is part of the Hull 2020 transformation programme which has nine public services working together for a healthier, safer city.

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

During April 2016 the Trust had a planned cross organisation inspection by the Care Quality Commission. The findings from this inspection are expected early June 2016.

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

- We started looking at how to make our community hospitals less frightening for people with Dementia by signing up to the National Dementia-Friendly Hospital Charter. The aim is to focus on making life easier for dementia patients when in hospital, and their families, creating a friendlier and less confusing environment around them.

- We launched a new image and performance enhancing drugs clinic which is funded by East Riding Public Health. The Juice Bar is a free and confidential service designed to engage with and offer specialist advice and information to users of performance and image enhancing drugs.

  The service offers weekly evening drop-in clinics at pharmacies in Goole and Bridlington which offers: needle exchange; advice on steroids and other image and performance enhancing drugs; safer injecting advice and examination; dry spot blood testing; blood pressure checks; weight monitoring and advice on diet; and nutrition and health.

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

In 2015, we celebrated 10 years of successful partnership working with registered charity the Alcohol and Drug Service (ADS). The partnership commissioned by East Riding of Yorkshire Council has over the years helped thousands of people rebuild their lives and overcome their difficulties.

The service consistently reports high levels of performance and is one of the most successful in terms of patient outcomes in Yorkshire and the Humber and nationally. In fact, a recent tool

released by Public Health England shows East Riding of Yorkshire delivering better outcomes than other local authorities for less. Continuing this success story, we along with existing partner ADS and new partner and criminal justice specialist Nacro were chosen to continue to provide an enhanced service in the East Riding of Yorkshire from 1 April, 2016.

- We also worked with Humberside Fire and Rescue Service, City Health Care Partnership CIC (CHCP CIC) and Yorkshire Ambulance Service NHS Trust on a pioneering new scheme to provide a rapid 24/7 response for falls patients in Hull. Hull FIRST (Falls Intervention Response Safety Team) is part of the Hull 2020 transformation programme which has nine public services working together for a healthier, safer city.

  Hull FIRST's holistic approach to patient care involves Humberside Fire and Rescue officers following through from picking people up safely, to quickly assessing their needs and, in partnership with our Hull Falls Prevention team, resolving any instant problems that might have caused the fall. The team continues to support patients once they are safe and stable, providing risk assessments in the home which could result in occupational therapy and physiotherapy being provided.

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

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

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

The Trust Board is leading a number of processes applied to ensure that resources are used economically, efficiently and effectively. A major operational transformation project was launched in 2015/16 designed to ensure the best alignment and efficiency between the management of services and ensure that our senior clinical leaders are at the heart of our operational structure.

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

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

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

- Review of trust financial control mechanisms

Annual Quality Report

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

Developing the Accounts

In developing the Quality Accounts for 2015/16 the Trust worked with key stakeholders, for example Governors, HealthWatch local authority members, members of the Overview and Scrutiny Committees, patients and carers and their representatives and commissioners to ensure that the priorities selected for review and publication represented the quality of our service delivery. Where these partners have commented on the quality accounts these are printed verbatim within the document.

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

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

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

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

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

A public consultation on the priorities for 2016/17 took place during quarters 3 and 4, a number of events were held with stakeholders including commissioners, Governors, staff, HealthWatch and Hull and East Riding Overview and Scrutiny Committee members, patients and carers and their

representatives. During these events, presentations were given of the progress with the priorities and attendees were given the opportunity to share their views on Trust services with senior staff.

Data Quality

The Trust has taken a number of steps to ensure itself of the robustness of data quality. Over the past 12 months the Data Quality policy has continued to be implemented. The Trust has met the data quality requirements of all our contracts. However our work in this area is not yet complete and we will continue to address the issues during 2016/17, this includes the set and implementation of an internal data quality group to oversee improvements

Governance Arrangements

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

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

The IAGC also evidences clinical and information governance and risk management within the Trust and provides strategic leadership for the development of continuous quality improvement taking account of the user experience and feedback from stakeholders.

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

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

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

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

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within Humber NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of

internal control by the Trust Board and the IAGC and a plan to address weaknesses and ensure continuous improvement of the systems is in place.

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

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

The 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. However, some weaknesses in the design or inconsistent application of controls put the achievement of a particular objective at risk.

My review confirms that the internal auditors opinion above and for those audits of Care Group Governance Arrangements, Risk Management Arrangements and Strategic & Business Planning which provided limited assurance, indicating that further work is needed by the Trust to strengthen its corporate governance arrangements and structures – can confirm that this has been recognised and is planned for delivery by the 30 June 2016.

Signed  **Date: 26 May 2016**

Chief Executive

Equality and diversity

The Director of Nursing, Quality and Patient Experience is responsible for the patient care elements of equality and diversity. The Director of Human Resources and Diversity is responsible for the staff elements, with the Director of Human Resources and Diversity holding overall accountability for equality and diversity. Progress against our objectives for 2015/2016 and proposed core objectives for 2016/2017 are detailed below.

Patient care objectives 2015/2016

- Building on last year's inpatient review, the Trust will review the data for Community Services to establish if patient experience is affected, positively or negatively, by individuals who may have declared having protected characteristics. Actions will be put in place as appropriate.

- To improve communications with children, young people and their families about how to access our CAMHS services. This will include literature in plain English to support and enable self-care.

- To work with Public Health England and local commissioners to develop a campaign to be launched on 10 October 2015 (World Mental Health Day) on reducing stigma in the workplace for people suffering from a mental illness.

Key achievements or outcomes

- In response to staffs' frustration around multiple providers of translation services the Trust now accesses the service via a single provider to support ease of access for staff using the services. During 2015/16 the policy has been updated and a recent audit of staff has shown that staff experience of accessing translation services has improved under the new provider.

- A review of the Friends and Family Survey for inpatient services has identified that there is no evidence of patients being treated negatively. There is evidence of patients having a positive experience in particular with access to specific foods and spiritual support when on inpatient units.

- A review has found that we have had no complaints regarding ease of access for older people to our services. However, the Trust has recognised the need to ensure our patients with Dementia have access to information and services. The Trust launched its Dementia Friends campaign in October 2015 supported by training for staff which has been received very positively by patients, carers and staff.

Patient objectives for 2016/2017

- To develop an equality and diversity strategy for patients and carers by 31 July 2016.
- To roll-out the Butterfly Scheme across the Trust's Community and Older People's Services.
- To deliver the pledges outlined in the patient and carer experiences strategy ensuring that the needs of all of our population are recognised and realised in doing so.
- To put in place an equality and diversity group with patients, carers and local groups by 31 July 2016.

Staff Objectives 2015/2016

- To implement the requirements within the Race Equality Standard.
- To repeat the review of NHS job applications and HR case work activity.

- To review the findings from the positive actions implemented regarding supporting the needs of an ageing workforce.

Key Achievements/Outcomes

- **To implement the requirements within the Race Equality Standard**
  The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

  The NHS has published a Workforce Race Equality Standard (WRES) which required us to collect data against nine indicators. The Trust is now expected to scrutinise the data and act on it and then to work towards a level playing field where the treatment of our staff is not unfairly affected by their ethnicity. We will be expected to improve our workforce race equality year on year and demonstrate these through the annual publication of data for each of the indicators.

  The first Trust publication of information required to monitor progress under the standard took place in autumn 2015.

  The NHS Standard Contract for April 2015 also includes a clause requiring NHS providers (trusts and others except the very smallest providers) to demonstrate that they are closing the metrics between the indicators for BME and white treatment and experience.

  The next step is to act on the analysis and take steps to close the gap between the treatment of white and BME staff. This requires a determined effort to identify those areas where there is a gap that needs addressing.

  We will invite our BME staff and staff organisations during 2016/17 to develop an action plan to address any gaps identified.

- **To repeat the review of NHS job applications and HR case work activity. The period covered in this report is from 1 April 2015 to 31 March 2016**

  Our Trust profile shows a **Gender** split of approximately 80% female and 20% male. NHS Job applications are broadly proportionate in that 77% were from females and 23% were from males in the year to 31 March 2016. These figures show that as at 31 March 2016 we employed slightly more women and slightly fewer men than last year.

  Age profile of the Trust remains an ageing one with the highest headcount in the age ranges 40-59 (60%). NHS job applications show the highest number of applications come from age ranges 20-29 (40%) which is an encouraging sign for future workforce needs.

  The vast majority of applicants through NHS Jobs declared that they had no **Disability** (93%) however the Trust currently reports that 4% of staff employed declared a disability, which is proportionately similar to the 7% of applicants that do declare a disability, which could suggest the Trust is positive about employing staff with a disability.

  Ethnicity of the Trust is reported as 83% white British/white other, which is in line with the ethnicity data reported from applications on NHS Jobs which is detailed as 85% white British. Ethnicity data for the Yorkshire and Humber region is detailed at 91% white British/white other. This shows that as a Trust we employ a higher than average non-white British/white other workforce.

  Christianity is the highest **Religion** recorded in the Trust (39%) however 42% of staff did not disclose their religion or it remains unspecified. NHS job applications show 48% declared

themselves as Christians, 20% declared themselves atheists, 14% were undisclosed. So the Trust profile remains broadly proportionate with regard to applicants and Trust profile.

Sexuality disclosure in the Trust remains predominantly heterosexual (65%) or undisclosed or unspecified (20%). NHS jobs applications report 91% heterosexual. These figures imply that the Trust employs more than 9% of staff who are not heterosexual which is above the number of applications received.

Marital status in the Trust is reported as 54.75% married and 29.84% single whilst NHS job applications report single as the most recorded status at 57% followed by married at 30%.

HR casework during this period reports show that there have been 4 bullying and harassment cases which is a reduction of 11 from last year. Capabilities have increased by 3 to 13 and there has been a reduction of 10 (from 52 to 42) in disciplinary cases. Ten formal flexible working requests were received (a reduction of four from last year) and 26 grievances which is an increase from 19 last year. We received one whistleblowing case.

Of those individuals involved in HR casework just over a third (34%) were male and two thirds (66%) female staff, which indicates a higher proportion of male staff are involved in formal HR cases when compared to the Trust figure of 20% male staff employed by the Trust.

Of the 10 formal flexible working requests one was male, and nine were female, this shows a significant reduction (six) from last year of males making these requests. This demonstrates a slightly higher proportion of requests from women as opposed to men when compared to Trust workforce data. Nine requests were approved.

- **To review the findings from the positive actions implemented regarding supporting the needs of an ageing workforce**

  The Trust undertook a research based report which identified the following key areas for the Trust to assess and respond to:

  - Legislation, in particular equality in relation to ageism and prejudice
  - Recruitment of older workers
  - Occupational health and health and wellbeing
  - Education, training and development
  - Flexible working

  The positive actions that were identified from the research report were as follows:

  - Review of Trust policies regarding ageism particularly retirement, PADR and flexible working using the ACAS practical assessment for age bias in policies guide.

    There is a rolling programme of policy review in the Trust; the Retirement Policy was reviewed together with the Flexible Working Policy both of which were agreed in February 2016. The PADR Policy has been reviewed and updated and is waiting for agreement by the Trust's Consultation and Negotiation Committee.

  - To conduct a review of recruitment data of starters and leavers to establish any potential age discrimination or trends. Consider best practice guides ACAS age monitoring framework and CIPD talent management checklist.

    Starters and Leavers for the period 1 April 2015 to 31 March 2016

Starters	Leavers

Count of Age Band			Count of Age Band		
Age Band	Total		Age Band	Total	
-	1	0.15%	-	-	-
16 - 20	9	1.33%	16 - 20	-	-
21 - 25	94	13.88%	21 - 25	39	6.87%
26 - 30	66	9.75%	26 - 30	73	12.85%
31 - 35	68	10.04%	31 - 35	44	7.75%
36 - 40	66	9.75%	36 - 40	63	11.09%
41 - 45	77	11.37%	41 - 45	65	11.44%
46 - 50	81	11.96%	46 - 50	61	10.74%
51 - 55	91	13.44%	51 - 55	86	15.14%
56 - 60	76	11.23%	56 - 60	63	11.09%
61 - 65	41	6.06%	61 - 65	57	10.04%
66 - 70	7	1.03%	66 - 70	9	1.58%
71 & above	-	-	71 & above	8	1.41%
Grand Total	677	100.00%	Grand Total	568	100.00%

It can be seen that overall starters to the Trust compensates for our leavers.

The Chartered Institute for Personnel and Development (CIPD) (2010) suggest that organisations should identify ways to obtain and retain those individuals who are critical to success. The Trust can demonstrate that it is following this element of best practice by the evident success of the 'retire and return' scheme. This scheme is the Trust's way of retaining the skills and knowledge of key staff whilst also meeting the individual's needs in terms of wanting to reduce their hours and access their pension. The evidence of the success is that the Trust has had 18% of starters aged between 56 – 70 offset against 22% leavers in the same age range (retire and returns have to leave the Trust to access their pension and then they return as a new starter).

- Review PADR and performance management to include specific questions regarding future work plans and identify any associated training and/or flexible workforce needs of staff. Consider CIPD guidance on behaviours and support needed to enable staff to return to work.

  The Trust's PADR paperwork was reviewed and amended to take account of the above requirements. The documentation for PADR's in the Trust includes the following:

  - Are you managing to maintain a positive work/life balance and are there any new factors impacting on this that you wish to share? If so, do you have any requirements for reasonable adjustments that you wish to discuss?
  - What are your objectives for the forthcoming year?
  - What are your identified individual development needs and do these link with your current objectives?
  - Have all relevant statutory and mandatory training requirements been completed? This includes professional requirements for different professional groups, role-specific training and individual specific skills training that was required and identified.

- To review access to training and type of training undertaken by staff by age criteria to establish any potential age discrimination/gaps or trends.

  The Trust's training department takes all reasonable steps and measures to ensure as far as possible that there is no unlawful or unfair discrimination of either potential or existing

employees including bank staff, contract workers and volunteers, because of any protected characteristic including age.

When applying for any course, individuals are asked to contact the training department should they have any special requirements or needs (specialist learning materials, equipment or access). All employees will be treated in a fair and equitable manner and adjustments will be made in accordance with the special needs of any individual. On confirmation of a place on a programme the above is reinforced in a letter/email to the individual.

Training is undertaken via: face-to-face (classroom) at the Willerby Hill site; at team bases or at other external venues; or through E-Learning.

There are no restrictions placed upon interested parties regardless of age or any other protected characteristic and all individuals have equal access to the whole range of training and education provided directly by and or on behalf of the Trust. In the Annual Staff Survey 92% of staff believed the organisation provided equal opportunities for career progression / promotion against a national average of 89%.

- To review the retire and return procedure, establish guidelines for managers and staff and consider all retire and return requests are returned using the flexible working model in order to establish a consistent, fair approach to retire and return or step down to retirement requests.

  The retire and return procedure is part of the Retirement Policy which was reviewed, updated and agreed in February 2016; this includes a detailed procedure for managers to use when considering the retire and return process with individuals. The use of the flexible working model and contract was undertaken but there have been some barriers to implementing this. The Trust does however consider flexibility around working patterns and hours to all staff and appropriate contracts issued where necessary.

Staff Objectives for 2016/2017

- To act on the analysis of the 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.

Leadership objectives 2015/2016

- To formally adopt the EDS2 and to carry out an external assessment of our performance against the EDS2 and publish our results. This will include actions against Board and Committee papers in relation to equality-related impacts including risks and how the risks are managed.

- To review and refresh the equality intranet page with up to date data and outcomes in order to contribute to fulfilling the requirements of the Public Sector Equality Duties.

Key Achievements/Outcomes:

The Trust formally adopted the EDS2 during 2015/16. We have produced a nine step plan which has been published on the staff intranet. We need to identify an external assessor to work with in relation to our performance against our plan.

EDS2 is based on involvement with staff, patients and diverse communities; we recognise that often it is the lack of engagement with different groups that can lead to misunderstanding and complaints.

In its simplest form, the EDS2 gives the Trust the tools to work out our equality performance in relation to:

- How good we are now?
- How good we can be?
- How we can get there?

As we undertake this process we will be listening to patients, to carers, to people who work in the NHS and to the community and voluntary sector.

We have recently set up a Workforce Group for the Trust which will oversee the work of the Equality and Diversity Steering Group which we have recently re-launched. The Workforce Group will monitor the Trust's performance against our equality and diversity objectives.

The Trust Intranet and Internet pages were updated during 2015/16 and will continue to be updated as and when required.

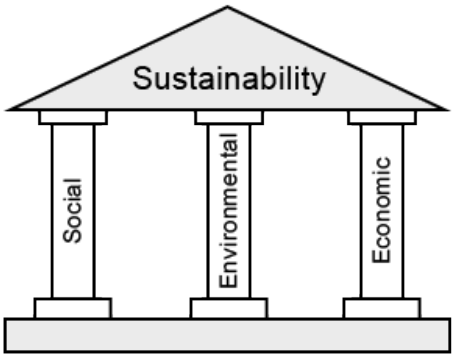
Leadership Objectives for 2016/2017

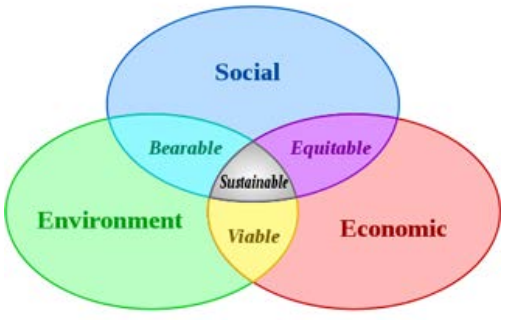
- To ensure that the EDS2 action plan is reviewed and further developed.
- To provide equality and diversity training for the Trust Board.

Sustainability Report

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

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





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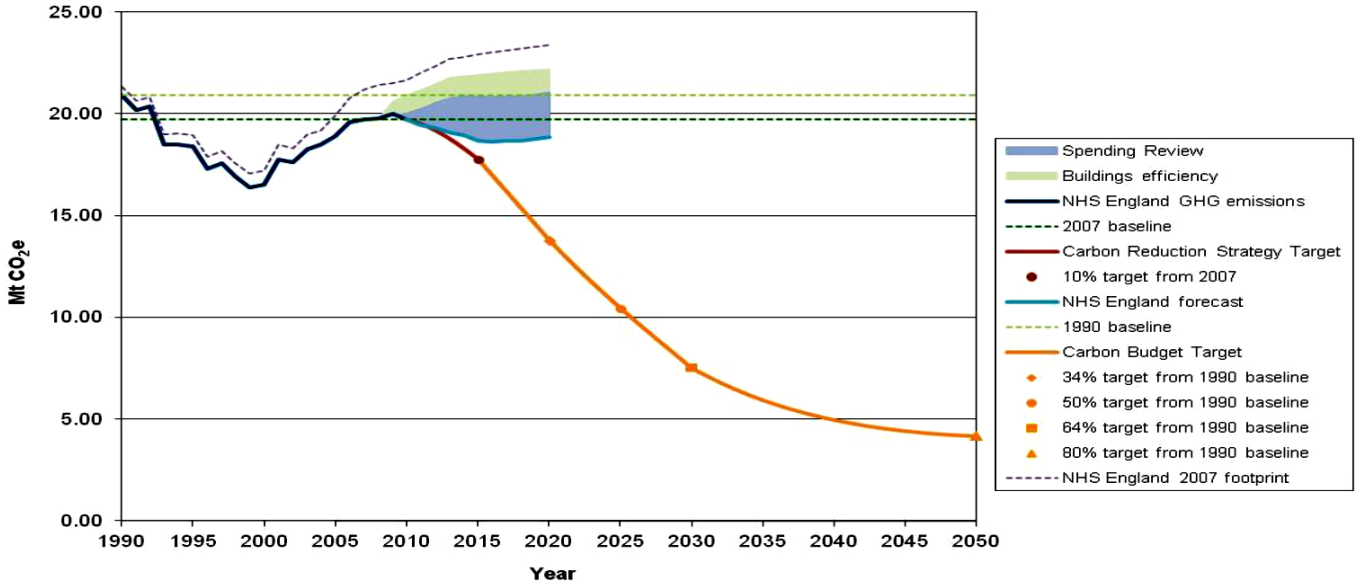
The driving force behind the reduction of all trusts energy consumption are the guidelines set by government (Sustainability Development Unit (SDU) Sustainability Strategy 2015) it defines all trusts must reduce their carbon foot print by 10% by 2015/16 and 34% by 2020, based on 2007

level. The NHS has been set a target of 80% reduction of its emissions 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 behaviour change across our organisation.

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



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

It's a very exciting time for the Trust as we look at more innovative ways to make us a front runner in the fight against climate change.

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

Our aim is to reduce our carbon foot print by introducing new technologies and changing behaviour across the Trust. Over 2015/16 the Trust has gained a large amount of investment from revenue recovery services working with an external partner giving the Trust the opportunity to start its green fund to invest the money in green technologies. Over the year the investment has been put into LED lighting schemes for Miranda House which will return £67,474.98 on investment over a five year period and a saving of 302 tonnes of CO2 over the life of the fittings.

We have also installed electric vehicle (EV) posts for hybrid and full electric vehicles at our Trust Headquarters site. There are 12 parking bays with six posts - each post can charge two vehicles. This will give Trust staff and visitors the ability to charge their vehicles while at the Willerby Hill site and hopefully entice more EV cars to be used across the Trust. Our first EV estates maintenance van has been ordered and will be with us very soon.

Utilities and energy

The 2015/16 performance figures highlighting the Trust's energy usage and cost have dropped with the cost of gas been at an all-time low. The low cost of gas has resulted in an 8.4% decrease on energy spend from last year, although our electricity consumption had increased. See chart below.

Our water consumption is due to be assessed and we have a project to reduce water usage.

The British Independent Utilities (BIU) carried out a forensic audit of our utilities which has proven to be a great success for the Trust, giving us the ability to invest in the renewable green technology mentioned previously. The project has brought the Trust £90,000 during 2015/16 and a further £50,000 is expected over the next financial year, which will be reinvested into sustainable projects across the Trust. The business travel emissions calculated from the miles claimed show a reduction in the usage claimed and the CO2 emissions produced on the previous year.

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

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 Trust's affairs as at 31st March 2016 and of its income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

The financial statements comprise the Income Statement, the Statement of Comprehensive Income, the Balance Sheet, the Cash Flow Statement, the Statement of Changes in Taxpayers' Equity and the related notes 1 to 37. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

Certificate

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

Going concern

We have reviewed the Accounting Officer's on page 58 that the Trust is a going concern. We confirm that:

- we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern.

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

Independence

We are required to comply with the Financial Reporting Council's Ethical Standards for Auditors and we confirm that we are independent of the Trust 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:

Risk	How the scope of our audit responded to the risk
NHS revenue and provisions As described in note 1.2, Accounting Policies and note 1.21, Critical Accounting Estimates and Judgements, there are significant judgements in recognition of revenue from care of NHS patients in recognising contract variations and in provisioning for disputes with commissioners. Details of the Trust's income, including £128.4m, (£128.2m in 2014/15) of Commissioner Requested Services are shown in note 4.1 to the financial statements. NHS debtors are shown in note 18.1 to the financial statements The Trust earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position. The majority of the Trust's income (£56.7m) comes from East Riding Clinical Commissioning Group (CCG), increasing the significance of associated judgements. The settlement of income with CCGs continues to present challenges, leading to disputes and delays in the agreement of year end positions.	We evaluated the design and implementation of key controls in relation to the invoicing process with commissioners including calculation and invoicing of over-performance. We have agreed the income recognised in the year to the signed contracts and signed contract variations. We have discussed with management any contract variations that are in dispute and actual or potential challenge from commissioners and the rationale for the accounting treatment adopted. We have challenged the appropriateness of the judgements made in recognising revenue and providing for any disputes following discussion with staff involved and review of correspondence with commissioners and other relevant documentation.
Property valuations The Trust holds property assets within Property, Plant and Equipment at a modern equivalent asset valuation of £60.9m, (£59.8m in 2014/15). The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis 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	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties, including through comparison against revaluation movements experienced by other Trusts at 31 March 2016. We have reviewed the disclosures in notes

Risk	How the scope of our audit responded to the risk
judgements in property valuations due to the specialist knowledge required to conduct the valuation and assumptions used.	1.5 and 15 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.

The description of risks above should be read in conjunction with the significant issues considered by the Integrated Audit and Governance Committee discussed on page 40.

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.

We determined materiality for the Trust to be £1.95m (2014/15: £1.46m), which is 1.5% of operating income and 3% of Taxpayers' equity (2014/15: 1% of revenue). Revenue 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 reassessed the percentage used from 1% of revenue in 2014/15 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.

We agreed with the Integrated Audit and Governance Committee that we would report to the Committee all audit differences in excess of £98k, (£73k in 2014/15), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Integrated Audit and Governance Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's head offices in Willerby directly by the audit engagement team, led by the audit partner.

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

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

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the 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 have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements;
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we 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 Integrated Audit and Governance Committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the 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 Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based

on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Paul Thomson (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Leeds, UK
26 May 2016

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Improving Health and Wellbeing

Humber NHS
NHS Foundation Trust

Humber NHS Foundation Trust Quality Account 2015/16

Contents

Part One

1.1 Quality Statement

Welcome to our Quality Report for 2015/16. This document not only sets out the quality of the services we provided over the past 12 months but hopefully will give you a greater understanding of our Trust and what we are doing to drive our standards even higher during 2016/17 and the years to come.

The vision that underpins everything we do is one of supporting local people to live healthier lives, manage periods of ill health, live as independently as possible and take control of their own wellbeing.

We do this by providing the very best care we can, by not resting on our laurels and always learning lessons, responding to what you tell us and taking action to keep improving quality, safety and striving for a better experience for the people who use our services.

The past 12 months have seen us continue to improve the quality and effectiveness of our services at a time when resources are increasingly scarce, demand is greater than ever and innovation and transformation are absolutely vital.

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

- We launched our Recovery College at the end of 2015 and were delighted to see all 12 courses (including mind mapping, wellbeing through creativity and managing anger) fill up within the space of a month.

- In February 2016 we won the Addictions tender in the East Riding in partnership with the Alcohol and Drugs Service (ADS) and Nacro.

- Our Hull Integrated Community Stroke Service took part in a pioneering collaboration with the Royal Philharmonic Orchestra to create a Strokestra. The aim of the Strokestra is to use creative music-making to drive patient-led rehabilitation work in stroke survivors and their carers. The pilot programme (funded by the Hull City Council Public Health department) culminated in a high-profile performance ahead of the Royal Philharmonic Orchestra's (RPO) season opening concert at Hull City Hall on Thursday 1 October 2015.

- We hosted local the local Protected Time for Learning event for East Riding of Yorkshire CCG which involved getting GPs from Hull and East Riding together to discuss health matters in the elderly. It was the first time an event of this scale had taken place and we received some outstanding feedback.

- We celebrated 10 years of successful partnership working with registered charity the Alcohol and Drug Service (ADS). The partnership commissioned by East Riding of Yorkshire Council has over the years helped thousands of people rebuild their lives and overcome their difficulties.

- We achieved Stage 3 Accreditation of the UNICEF Baby Friendly Initiative (BFI) designed to support breastfeeding and parent infant relationships.

- In October 2015, together with our health and local government partners, we outlined a shared determination to transform emotional health and wellbeing services to make a difference to the lives of children and young people in Hull and the East Riding of Yorkshire. We committed to work together on a number of CAMHS priorities including setting up a Hull and East Riding Crisis team which was operational in early 2016, to improve waiting times against which we have made great progress and to extend our perinatal mental health service to cover the whole of the East Riding of Yorkshire.

- We signed a seven year contract with NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group to become the new provider of community and out of hours services in Whitby and the surrounding area from 1 March 2016.

- Our award winning Health Trainer team was chosen to deliver Stop Smoking services, including nicotine replacement, alongside the proven support, advice and motivation that has already helped hundreds of people in the East Riding to change their lives for the better by making healthier lifestyle choices.

- In Autumn 2015 we worked with Humberside Fire and Rescue Service, City Health Care Partnership CIC (CHCP CIC) and Yorkshire Ambulance Service NHS Trust on a pioneering new scheme to provide a rapid 24/7 response for falls patients in Hull. Hull FIRST (Falls Intervention Response Safety Team) is part of the Hull 2020 transformation programme which has nine public services working together for a healthier, safer city.

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

The Trust Board and Executive Management Team have held a number of workshops as part of the ongoing development of the Trust's strategic planning framework. Through this the Trust is seeking to:

- protect the quality and safety of its existing Adult Mental Health Service within Hull and East Riding of Yorkshire through an extensive transformation programme;
- protect the quality and safety of its existing Children & Learning Disability Service within East Riding of Yorkshire and Hull and grow aspects of the service into neighbouring counties;
- expand Community & Older People Services provision into a wider geographical area whilst redesigning services.
- redesign the Forensic Service in terms of the reduction of medium & low secure learning disability beds which will be relocated into community settings and to expand the collaborative care model for community alcohol and drugs services into a wider geographical area.

During 2015/16 under the leadership of the Director of Nursing, Quality & Patient Experience a new quality team and governance structure was established with the specific aim of embedding and driving quality improvements across the newly established care groups. The approach reflects the key quality priorities for the organisation across the domains of Patient Safety, Clinical Effectiveness and Patient & Carer Experience. There has been the development of three associated strategies to shape delivery for 2016-19. The strategies capture both the national and local context. Each of the three domains has priority focus areas:

Strengthened Approach to Patient Safety

Built around the 'Sign up to Safety' campaign priority areas the Trust Strategy aims to reduce harm experienced by people receiving care across seven priority areas:

- Develop a patient safety culture across the Trust
- Increase understanding of violence and aggression within mental health services and reduce restrictive interventions in the Trust
- Reduce Severe Self harm events & support a Zero Suicide culture within the Trust
- Interrogate issues relating to ensuring safer staffing across the Trust to ensure our workforce is equipped with the knowledge and skills and organised in the right way to deliver optimum care.
- Reduce the number and severity of pressure ulcers acquired within our care
- Improve medicines management and knowledge within the Trust
- Reduce communication errors and associated patient harms through appropriate electronic technology for patient records

Clinical Effectiveness

The Trust strategy sets out the commitment to deliver on the following four central themes:

- Practice is based on the best available evidence

- Use the clinical audit programme to improve our services
- Use outcome measures to inform us, our patients, the public and commissioners on our performance
- Innovate to improve outcomes in a safe and sustainable way

Patient & Carer Experience

The strategy ensures that our patients and carers receive the best possible experience from the Trust is structured in terms of delivery against seven pledges identified following consultation with staff, patients and carers.

Pledge 1: We will listen to our patients & carers and respond to their feedback
Pledge 2: We will provide a safe environment for our patients
Pledge 3: We will meet the physical and comfort needs of our patients
Pledge 4: We will support the carers of our patients
Pledge 5: We will recognise our patients individuality and involve them in decisions about their care
Pledge 6: We will communicate effectively with our patients throughout their journey
Pledge 7: We will aim to ensure our patients are cared for by skilled and caring staff

Throughout the following pages, there are some elements that we are asked to include by both the Department of Health and Monitor (the independent regulator for NHS Foundation Trusts). Whilst I appreciate this means the Quality Report is not the easiest read, we have tried to help by including a glossary at the end to help explain some terminology you might not be familiar with.

Everything contained in this report has been subject to robust internal review and external verification by both stakeholders and our external auditors. This means that, to the best of my knowledge, these accounts honestly and accurately reflect the quality of care we deliver to our patients and the communities we serve.

Quality is a word you will come across a great deal as you work your way through the following pages. I make no apology for saying it once again as, on behalf of our entire Board, I take this opportunity to reaffirm what is our ongoing commitment to constantly improving the services we provide and ensuring that safe, quality and compassionate care remains at the very heart of everything that we do.

David Hill
Chief Executive, Humber NHS Foundation Trust

1.2 About Us

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. It also provides specialist mental health services to people from across the UK.

- We employ over 3,000 staff
- We have over 16,000 members that we encourage to get involved, have their say and make a difference to how local healthcare services are provided.
- We are fortunate to have 120 volunteers on hand to work within our services and who are available to help not only patients, but staff and visitors too.
- We are a Teaching Trust with close relationships with academic partners Hull York Medical School and the University of Hull
- Based on their experience of our care, the vast majority of patients and their carers (94% from October 14 – January 15) would recommend us to their family and friends if they needed our support (Friends and Family Test data)
- We provide secure services for people from across Yorkshire and the Humber, using innovative treatments and award-winning activities to enhance the physical and mental wellbeing of our forensic patients.
- Our specialist clinicians are nationally-recognised experts involved in high-level research that directly benefits our patients and service users.
- We are constantly improving the way our integrated teams work together to make sure people are treated in the setting that's best for them, including intensive home treatment and early discharge with excellent support.
- Our working age adult inpatient units are AIMS accredited.
- We are better than most trusts at ensuring patients in our community mental health services feel involved in reviewing their own care (Community Mental Health Survey 2015)
- As a Foundation Trust, we constantly re-invest back into healthcare and improving the environments in which our patients are treated.

1.3 Service We Deliver

We are proud to provide a broad 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 a population of over 740,000 across a large geographical area that includes Hull, the East Riding of Yorkshire and North Yorkshire. It also provides specialist mental health services to people from across the UK.

Our comprehensive portfolio of services is listed below:

- A&E mental health liaison for working age adults and older people
- drug and alcohol services
- bladder and bowel specialist care
- child and adolescent mental health services (CAMHS)
- children's services
- chronic fatigue
- counselling
- community hospitals in Beverley, Withernsea, Bridlington and Whitby providing inpatient medical beds and in Hornsea and Driffield providing outpatient services
- community nursing
- diabetes services
- forensic services for mental health, learning disability patients and personality disorder patients,
- health services in prisons including mental health in-reach
- health trainers
- health visiting
- Huntington's disease team
- inpatient and community mental health for working age adults and older people
- intermediate care
- learning disability community and inpatient services
- long-term conditions
- Macmillan nurses
- multidisciplinary falls prevention
- nutrition and dietetics
- out of hours and unscheduled care
- palliative care
- perinatal mental health
- pain
- physiotherapy
- podiatry
- psychiatric liaison
- psychological interventions
- psychotherapy
- school nursing
- self-harm
- speech and language therapy
- stroke services
- tissue viability
- traumatic stress
- unscheduled care

- veterans' mental health

This list is not exhaustive. For more information and for referral pathways, please visit us at www.humber.nhs.uk/services

1.4 Our Vision

To be a leading Trust known for the quality of our integrated healthcare services and staff commitment and recognised as a valued partner in problem solving.

1.5 Our Values

- Put the needs of others first
- Act with compassion and care
- Continuously seek improvement
- Aspire to excellence and be the best
- Value each other and teamwork

Part Two

2.1 Working with our Commissioners

During 2015/16 Humber NHS Foundation Trust provided 109 and sub-contracted 47 relevant health services.

Humber NHS Foundation Trust held a number of contracts for the services delivered by the Trust and for services delivered for the Trust by other providers. The most significant contracts agreed were as follows:

Commissioners:

- NHS East Riding of Yorkshire Clinical Commissioning Group
- NHS Hull Clinical Commissioning Group
- NHS Vale of York Clinical Commissioning Group
- NHS England
- Kingston upon Hull Local Authority
- East Riding of Yorkshire Local Authority
- Hambleton, Richmond and Whitby Clinical Commissioning Group

Humber NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 97% of the total income generated from the provision of relevant health services by the Humber NHS Foundation Trust for 2015/16

2.2 Update on Priorities

For the 2014-15 Quality Report, a set of new priorities were chosen for the Trust to take forward in 2015-16 following a three year rolling programme for previous years. The priorities were chosen through a full consultation process with Trust Stakeholders.

The work carried out around the priorities, at the end of the period is set out in the tables below.

Improve access to and support from Child and Adolescent Mental Health Services

	Q1	Q2	Q3	Q4
To complete external review of Hull and East Riding CAMHS to inform future service model.	Complete			
To implement new cross organisational waiting list policy for CAMHS to ensure patient safety and deliver a high quality of care	Complete			
Implement a 24 hour, 7 day a week Crisis Team.	In progress	Complete		
Overall Status	**Complete**			

Performance against this clinical priority is completed and reported to the Trust Board as complete.

Improve communications with patients, relatives, carers and our staff

	Q1	Q2	Q3	Q4
To review complaints and friends and family data to identify priorities for improvement in communications	Complete			
Hold focus groups with staff	Complete			
Gather and analyse data from focus groups and present plans	Deferred	Complete		
To review friends and family data/staff survey and develop actions plans	On Track	Complete		
Fully implement programme of communication channels and models of media for service users	On Track	On Track	On Track	Complete
Overall Status	**Complete**			

Performance against this clinical priority is 'Complete' and has been rolled forward as a new priority for 2016/17.

Ensure systems are in place to support organisational learning across the Trust and release staff time for patient care and professional development through increased use of technology

	Q1	Q2	Q3	Q4
Complete the e-transcribing proof of concept to identify the effectivity and productivity saving	Complete			
Implementation of total mobile for mental health staff	On track	On track	Deferred	
Implementation of SystmOne mobile working in the NCS teams	In progress	In progress	Complete	
Overall Status	**Ongoing**			

Performance against this clinical priority is ongoing. A project plan has been setup to ensure the mobile working solution is up and running within mental health teams by July 2016, some the open key milestone are listed below in the action. The following milestones have been completed to date.

Due to integration issues with Total Mobile the Trust has not been able to implement a mobile working solution to mental health staff.

A mobile working solution is expected to be in place for mental health teams by July 2016.

Increase awareness of the needs of dementia patients and carers across Trust services

	Q1	Q2	Q3	Q4
Engage the 'Grandma Remember Me' theatre company for two sessions initially to raise awareness	On Track	Complete		
Launch the 'dementia friend' scheme across the Trust, encouraging staff to sign up	On Track	Complete		
Undertake a specific friends and family questionnaire to identify changes in patient/carer experience	On Track	On Track	On Track	Complete
Overall Status	**Complete**			

Performance against this clinical priority is completed and reported to the Trust Board as complete.

Review Neighbourhood Care Teams (NCTs) to ensure they are able to be responsive to future service needs

Undertake a multi-agency review of NCTs to inform future service model	On Track	On Track	Completed	
Improve access to NCTs by integrating the current multiple points of access	On Track	On Track	Completed	
Change the current shift patterns for community nurses to improve capacity across the 24/7 period	On Track	On Track	Completed	
Overall Status	**Complete**			

Performance against this clinical priority is completed and reported to the Trust Board as complete.

2.3 Priorities for 2016-17

How did we select new priorities?

In the run up to the publication of this report, a number of consultations took place at various locations for our key stakeholders, Governors, staff and patient group representatives. In attendance at the consultations were representatives from;

NHS East Riding of Yorkshire Clinical Commissioning Group
NHS Hull Clinical Commissioning Group
East Riding of Yorkshire Council Health and Wellbeing Overview and Scrutiny Committee
East Riding of Yorkshire Healthwatch
Kingston upon Hull Healthwatch
Alzheimer's Society

The following were also invited;

Rethink
Hull and East Yorkshire Mind
Carers Advisory Group
Hull City Council Health and Wellbeing Overview and Scrutiny Committee

During the event, presentations of the proposed priorities were delivered. Following group discussion, those present were asked to vote for their preferred top five priorities. During the discussions, we were given feedback that some of the priorities should be amended to better reflect the needs of our patients and staff. These changes were made and the final priorities were then agreed by our Board members.

2016-17 Priorities

Develop a dementia training pathway for staff

As part of our sign-up to the Dementia Action Alliance's (DAA) Dementia Friendly Hospital Charter we are developing action plans to ensure that our local Community Hospitals strive to develop innovative and creative approaches and seek out existing good practice to ensure that the community hospital experience of people with dementia, their families and carers is a positive one, locally by developing a dementia training pathway for staff working within East Riding Community Hospital's ward. This forms part of a dementia training CQUIN to be achieved in collaboration with Maister Lodge, our local acute mental health inpatient unit for dementia.

Measures	Implementation Date
Commence delivery of staff training sessions	30 September 2016
Audit of effectiveness	31 December 2016
Year-end report and next steps	31 March 2017

Expand our 'quality visits' programme to include external stakeholders and experienced patients and carers

Work with patients/carers and other key stakeholders to develop open and transparent approaches to working with our clinical teams to maximise the quality and safety of our services through our programme of quality visits. These visits will focus on celebrating good practice.

Measures	Implementation Date
Recruit patients and carers to undertake quality visits	30 September 2016
Provide training to external stakeholders in the approach utilised	31 July 2016
Provide training and support to patients and carers in the approach	30 November 2016
Confirm external stakeholders as co – reviewers in the quality visits	31 July 2016

Develop Trust Intranet, Internet and Social Media

Develop the Trust use of social media, intranet and internet to engage with our patients, carers and the public

Measures	Implementation Date
Our website will be inviting, accessible and easy to use	31 March 2017
Use of electronic media policy to be completed to enable us to vary the methods we use to communicate with patients from face to face to social media	31 August 2016
Clearly communicate the available feedback channels to patients	31 October 2016

Embed an open culture across the Trust

Embed an open culture across the Trust to ensure staff, feel safe to report incidents and raise concerns as part of our commitment to patients and staff.

Measures	Implementation Date
Implement the new Monitor guidance on freedom to speak up	30 September 2016
To review the current incident reporting system to ensure it supports transparent and robust incident	31 October 2016

reporting	
To identify and train the patient safety champions within every clinical team	31 July 2016

Standardise the Trust Approach to reviews of Unexpected Deaths

During 2015/16 the Trust has faced adverse publicity as a result of serious untoward incidents, in particular as a result of unexpected deaths.

We are committed to developing a standardised approach for reviewing unexpected deaths in terms of methodology, scope, data analysis, and contribution to learning encompassing a consistent process of reviewing care through structured analysis of patient records; to improve the quality of care by learning.

Measures	Implementation Date
Develop and approve the mortality review pathway for the management of all unexpected deaths	30 June 2016
All unexpected deaths to be reported and reviewed within the clinical risk management group with a clear outcome of action for all unexpected deaths	31 July 2016
All deaths which meet the criteria of an SI will be reported to the Clinical Commissioning Group within 2 working days and be managed under the Trusts Serious Incident policy	Completed at time of submission
Any unexpected death that does meet the SI threshold will be reviewed using significant event analysis	Completed at time of submission
Any unexpected death that does not meet the criteria for an SI or SEA will be reviewed as part of the mortality review using the structured case note methodology	31 July 2016
To train further experienced clinical staff in the structured case note methodology	30 September 2016
To review all mortality reviews within the mortality steering group	As of 1 September 2016
Quarterly feedback on all SI's, SEA's and mortality reviews within the Quality and Patient Safety Committee in the quarterly clinical risk report	31 July 2016

2.4 How We Review Our Services

Participation in Clinical Audit

During 2015-16, 5 national clinical audits and 1 national confidential enquiry covered relevant health services that Humber Foundation Trust provides.

During that period Humber NHS Foundation Trust participated in 55.6% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Humber NHS Foundation Trust was eligible to participate in during 2015-16 are as follows:

National Pulmonary Rehabilitation Audit
National Diabetes Foot Care Audit
National Audit of Intermediate Care
The Sentinel Stroke National Audit Programme (SSNAP)
Prescribing Observatory for Mental Health (UK) (POMH-UK) – 9c Antipsychotic Prescribing for People with a Learning Disability
Prescribing Observatory for Mental Health (UK) (POMH-UK) – 13b Prescribing for ADHD in Children, Adolescents and Adults
Prescribing Observatory for Mental Health (UK) (POMH-UK) – 15a Prescribing Valproate for Bipolar Disorder
Prescribing Observatory for Mental Health (UK) (POMH-UK) –14b Prescribing for Substance Misuse – alcohol detoxification
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The national clinical audits and national confidential enquiries that Humber NHS Foundation Trust participated in during 2015-16 are as follows:

National Pulmonary Rehabilitation Audit
National Diabetes Foot Care Audit
The Sentinel Stroke National Audit Programme (SSNAP)
Prescribing Observatory for Mental Health (UK) (POMH-UK) – 9c Antipsychotic Prescribing for People with a learning Disability
Prescribing Observatory for Mental Health (UK) (POMH-UK) – 13b Prescribing for ADHD in Children, Adolescents and Adults
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The national clinical audits and national confidential enquiries that Humber NHS Foundation Trust participated in, and for which data collection was completed during 2015-16 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

Clinical Audits – Eligible to participate in	Participated in	Sponsoring Body	Cases Submitted	Data Complete
National Audit of Intermediate Care	No	NHS Benchmarking Network	0	No
National Falls & Fragility Fractures Audit	No	Royal College of Physicians	0	No
The Sentinel Stroke National Audit Programme (SSNAP)	Yes	Royal College of Physicians	Ongoing	Ongoing
National Pulmonary Rehabilitation Audit	Yes	Royal College of Physicians	25	Yes
National Diabetes Foot Care Audit	Yes	HQIP	90	Yes
Prescribing Observatory for Mental Health (UK) (POMH-UK) – 15a Prescribing Valproate for Bipolar Disorder	No	National Audit sponsored by POMH-UK	0	No
Prescribing Observatory for Mental Health (UK) (POMH-UK) – 13b Prescribing for ADHD in Children, Adolescents and Adults	Yes	National Audit sponsored by POMH-UK	42	Yes
Prescribing Observatory for Mental Health (UK) (POMH-UK) – 14b Prescribing for Substance Misuse	No	National Audit sponsored by POMH-UK	0	No
Prescribing Observatory for Mental Health (UK) (POMH-UK) – 9c Antipsychotic Prescribing for People with a learning Disability	Yes	National Audit sponsored by POMH-UK	11	Yes
National confidential enquiry into Suicide and Homicide by People with Mental Illness	Yes	Centre for Suicide Prevention	14	Yes

The reports of 1 national clinical audits were reviewed by the provider 2015-16 and Humber NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit Ref	Audit Title	Actions
MHLD110 POMH-UK Topic 9c	Antipsychotic prescribing for people with a learning disability	• To improve on recording information for antipsychotic prescribing in the last 12 months • To improve on recording of indication for antipsychotic prescribing • To record patients who decline monitoring • To audit standards for antipsychotic prescribing within Learning Disability services

The reports of 9 local clinical audits were reviewed by the provider in 2015-16 and Humber NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit Ref	Audit Title	Actions
MHMS177	Achieving psychotherapy competency according to the standards set out by Royal College of Psychiatrists (Re-audit)	IAPT psychotherapists to supervise the core trainees for their short case to achieve psychotherapy competency
MHAD263	To Establish Compliance with ECG Monitoring for Patients Prescribed Antipsychotic Therapy	• Highlight the importance of performing an ECG on every patient admitted to a mental health unit within the first 48 hours. • Clinical pharmacists to check notes and care plans for every new admission, with the aim to identify if an ECG has been performed, or it has been arranged
MHFS108	Re-audit of compliance with T2 and T3s related to prescription charts	• To ensure that all forms T2/T3 clearly specify the dose of psychotropic medication (for individual drug and for combination) • If some aspects of the prescribing are unlicensed, it is mentioned on the T2/T3 form • Humber Centre to consider to develop a system to make sure that T2/T3 forms to be placed in the patient folder on the same day they are updated in case of T2/ once they received the form from the Legislation office in case of T3
MHAD285	Re - audit of the Electroconvulsive Therapy (ECT) Policy and Clinical Guidelines	• ECT pack redesigned to include all the changes recommended in Audit of Electroconvulsive Therapy (ECT) Policy and Clinical Guidelines • Hamilton Depression Rating scale or Addenbrookes Cognitive Examination III result on the form in ECT pack
MHAD276	Audit of driving advice given to patients referred to the Emergency General Liaison Team	• All patients, as part of a psychiatric assessment, should be asked if they drive if they seem physically fit enough to do so. If not, this should be clearly documented as to why this was not asked. • A short tutorial or educational email to be given to assessing staff to remind them of DVLA guidelines that would warrant notification. • • Patients should be given a pamphlet concerning appropriate driving advice or reasons as to why driving advice was not appropriate at that time with a view to give appropriate advice at a later date. Any outcome should be documented within the patient notes and GP letter.
MHSM110	Re-audit of MHSM107 the risk of QTC interval prolongation with methadone	• The development of a protocol for the use of ECG in Addictions (including patients on methadone. This protocol should include: • Request from GP a summary of Past Medical History and a list of prescribed medication • Obtaining routine blood tests (including Full Blood Count, Renal Function Tests and Liver Function Tests) and how this could be best facilitated

MHLD112	Audit on monitoring baseline physical health parameters in patients admitted to Townend Court and on antipsychotics	• To formulate a checklist of baseline investigations along with physical health parameters for all patients admitted to Townend Court who are on antipsychotics.
MHAD271	Re-Audit of Community Treatment Order Documentation	• • Inpatient consultants to complete Transfer of Responsible Clinician (available in Intranet form Z11) from Inpatient to Community forms and vice versa
MHLD113	Audit of Section 17 Leave of Absence in Townend Court	• For Section 17 Leave of Absence: o To formally revoke previous section 17 leave forms o Overnight leave must specify proposed location o Must have discussion documented with patient or at least be signed by/on behalf of patient o Indicate for how leave will be monitored o Specific risk plans in notes or reference to suitable management plan o Specify number of escorts o Specify male or female escort

Commissioning for Quality and Innovation (CQUINs)

CQUIN is an annual scheme where commissioners and providers agree on which areas need more focus for improvement and payments are made for evidencing those improvements. The scheme is refreshed every 12 months and each scheme may be different from preceding years.

This year's scheme is worth around £2.41 million.

Mental health and community services areas are collecting information from patients who use our community hospitals, adult mental health inpatient units and community district nursing services as part of this year's CQUIN payment framework.

A proportion of Humber NHS Foundation Trust's income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between Humber NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at:

http://www.humber.nhs.uk/about-our-trust/CQUIN-scheme-2015-16.htm

http://www.humber.nhs.uk/about-our-trust/cquin-scheme-201617.htm

The table below shows the money available to the Trust from the CQUIN schemes.

Commissioner	15-16 CQUIN Available	Total 15-16 CQUIN Achieved	2015-16 Shortfall	Total % Achieved
	£000's	£000's	£000's	%
NHS Hull CCG	794	763	31	96.10%
NHS East Riding CCG	1272	1222	50	96.10%
NHS York CCG	38	38		100%
NHS England	313	307	6	91.80%
Total	**2417**	**2330**	**87**	**96.40%**

The CQUIN scheme impacts on clinical quality in a variety of ways including: working innovatively, creating or improving patient pathways and improving quality or patient satisfaction. A number of examples from our 2015/16 scheme are outlined below:

Safe Wards: this CQUIN asked the adult inpatient teams to investigate and implement a number of 'safe wards' solutions which are intended to address patient behaviour to prevent episodes of seclusion or violence on the wards. 2 of the many solutions adopted by the teams include 'comfort boxes' and 'knowing me, knowing you'. Comfort boxes are boxes created by the patients with items such as reading books, colouring books or iPods (for example) which the patient is encouraged to use when they feel anxious or frustrated, the contents of the box are intended to be their chosen items to help them feel more calm or comfortable, thus reducing potential incidents linked with negative or aggressive patient behaviour. Another method adopted by the wards is 'knowing me, knowing you' which are brief outlines of staff

interests such as football teams they support, interests and hobbies such as gardening or listing the type of music/bands they like. This encourages patients to identify staff they feel they have an affiliation to, encouraging them to communicate more openly with staff about their anxieties or issues whilst being on the ward. Both of these initiatives have proved successful and staff, patients (and their families) have written brief stories about the difference these approaches have made to their behaviour and recovery.

Health Improvement Profile: this CQUIN has been running for 3 years at the Trust and is a health assessment focussed on physical health elements. This is carried out alongside the usual mental health assessments but allows staff to support the patient (through GP referrals) to address their physical health needs, including weight management, smoking, safe alcohol limits, diet and exercise. The quality of information collected has been instrumental in the recent Royal College of Psychiatry audit score where the Trust was awarded 100% achievement for the CQUIN this year. Physical health information is held on the patient file and is used to provide a holistic overview of the patient's needs.

Commissioning for Quality and Innovation (CQUIN) 2016/17

During 2016/17, Humber NHS Foundation Trust will be working towards CQUINs which have been agreed with its commissioners. Over the last four years the Trust has agreed a number of indicators with local commissioners. The indicators have been developed with a key focus on the local priorities that the Trust and the commissioners feel need to be addressed.

Mental Health and Community Services CQUINs for 2016/17

No	Indicator Name	Indicator Description
1	Health and Wellbeing – Staff Initiative	Initiatives for Staff Health & Wellbeing including providing stress management and sleep hygiene training, encouraging outdoor activities and team events
2	Health and Wellbeing – Healthy Food	Reduction in salt, sugar and fat and sugar sweetened beverages in all food contracts in our 15 inpatient units
3	Health and Wellbeing - Flu Vaccine	Flu Vaccine target of 75% for staff in our Community Hospitals and Neighbourhood Care Teams
4	PSMI – Royal College of Psychiatry National Audit – Physical Health	Physical health-checks for all mental health team patients with diagnosis of psychosis
5	PSMI – Sharing Information with GP's – Local Audit	Sharing information with GPs
6	Training – Dementia and End of Life Care	A comprehensive training package in Dementia (for all Community Hospital staff) and in End of Life Care (For Older People Mental Health ward staff)
7	CAMHS Crisis Pathway	Evaluation of the new CAMHS crisis pathway, referral numbers and patient feedback and stories
8	Personality Disorder Training	Providing personality disorder training to staff in mental health teams, development of new pathway
9	Early Intervention in Psychosis Services	Implementation plans to meet national EIP accreditation needs, support with physical health-checks to meet NICE guidelines

Forensic NHS England CQUINs for 2016/17

No	Indicator Name	Indicator Description
1	Recovery College	Implement a Recovery College for patients in secure settings, encouraging co-production and co-delivery of training courses
2	Reducing Restrictive Practice	Audit of current practice and plans to reduce restrictive practice
3	Care and Treatment Reviews	Quality of care and treatment reviews

Whitby Community Services CQUINs for 2016/17

No	Indicator Name	Indicator Description
1	Friends and Family Test	Utilising the feedback from patients to action plan for improvement, developing feedback methods to share results with patients, including 'you said, we did' and the use of infographic dashboards
2	Falls Education and New Pathway	Implementing new falls pathway, implementing falls training and delivering education sessions to patients
3	IV Training and Implementation	Delivering Intravenous Fluid training to all hospital staff and implementing new IV referral pathway allowing patients to receive IV therapy in a local community hospital instead of in an acute hospital setting

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub contracted by Humber NHS Foundation Trust in 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 1256.

713 patients were recruited to the National Institute of Health (NIHR) Research Portfolio studies and 543 were recruited to local studies. In total there were 34 Portfolio studies and 27 (non-Portfolio) local studies running in the Trust in 2015-16. The Trust exceeded its target of 660 for recruitment to Portfolio studies in 2015-16.

In 2015-16 there was no Trust core funding for Research and Development (R&D) staff. However, moving forward into 2016-17 core funding for key R&D posts has now been identified. As the Trust is a Partner Organisation in the Yorkshire and Humber NIHR Clinical Research Network (Y&H CRN) £304,891 of ring-fenced funding, an increase of almost £13k from the previous year in recognition of performance, was provided to support research delivery in 2015-16. A further £18k was provided to support two Trust clinicians in their roles as Specialty Leads for the Y&H CRN, one for dementia and the other for mental health. The Trust also received £20k Research Capability Funding from DoH.

A new research strategy for 2015-17 was introduced in the Trust April 2015, with the objectives below and an associated work plan, against which significant progress has been made in 2015-16.

1. Provide greater opportunities for patients and their families to become involved in research and research processes
2. Maximise involvement in research in order to contribute to the economic stability of the Trust
3. Meet national NIHR governance metrics & key performance indicators
4. Operate in accordance with national research governance procedures
5. Support and develop high quality research that is initiated by Trust staff
6. Develop research capacity and experience in the Trust
7. Maintain existing partnerships with Universities, other research organisations and facilitate new partnerships
8. Strengthen the research culture in the Trust, improving organisational engagement with research at all levels

There are a number of national high level objectives (HLOs) that the Y&H CRN is measured against, one of which is for ‘studies to obtain NHS permissions within 40 days’. To enable the CRN to achieve this there is a target of 30 days for Trust R&D departments to approve Portfolio studies locally, and for all studies in 2015-16 this target was achieved by the Trust. Another HLO is to achieve ‘first participant recruited within 30 days’ and for those Portfolio studies that were approved to run in the Trust in 2015-16, 100% met this target. Linked to these HLOs is a national DoH benchmark for performance in initiating and delivering (PID) research, for which the Trust must publish its results quarterly on its website. The Trust met this benchmark in each quarter throughout 2015-16.

It is widely acknowledged that it is important for research to have patient and public involvement and throughout 2015-16 there were many examples of how the Trust achieved this: 1) the R&D Department worked with local and national ‘Join Dementia Research’ (JDR) Champions; people who are living with dementia and their families; 2) the Trust actively promoted the JDR service as a way for more patients and carers to get involved in research, including organising a public launch event at the Hull Memory Clinic in May 2015 and attendance at various Trust and local community events; and 3) a local Patient Research Ambassador has been established, which is part of the NIHR initiative aiming to help other patients to have better choices about participating in research and to help the Trust promote research locally, and 4) links have been established with various local support groups for promoting and recruiting to studies.

In 2015-16 the R&D department have developed new Principal Investigators, opened studies in services that have not previously been involved and strengthened relationships with higher educational institutions and other key stakeholders; ensuring continuity of research opportunities for those accessing Trust services. The Trust has collaborated with a number of universities resulting in new research studies opening in the Trust, including University College London, Kings College London, the Universities of Nottingham, Manchester, Hull, Bradford and Cardiff, as well as NHS Trusts in Nottinghamshire and London.

There has been a concerted effort to raise the profile of research within the organisation and activities are reported to the Board on at least a six monthly basis. During 2015-16 terms of reference were approved for a new R&D Committee, with the first meeting under these new terms having taken place in March 2016. The process of adapting internal R&D procedures has also begun in readiness for full implementation of the new Health Research Authority assessment process for research applications in 2016-17.

Care Quality Commission

Humber NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. The Care Quality Commission has not taken enforcement actions against Humber NHS Foundation Trust during 2015-16.

Humber NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust was fully inspected by the CQC during the final quarter of 2015/16, the report is anticipated to be published in July 2016. Following which the Trust will issue an addendum to its accounts containing a summary of findings, our rating and any required action plans by the end of quarter 2 2016/17.

You can find the reports for all visits on the CQC website at **www.cqc.org.**

Data Quality and Coding

Humber NHS Foundation Trust submitted records during 01 April to 31 December to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.8% for admitted patient care
- 100% for outpatient care and
- 100% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care.

Payment by Results

Humber NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015-16 by the Audit Commission.

Information Governance Assessment Report

Humber NHS Foundation Trust's Information Governance Assessment Report overall score for 2015-16 is 78% and was graded Unsatisfactory

The IG Toolkit was audited and assessed achieving significant assurance, however, IG training compliance was not at 95% by the end of March 2016 therefore the Trust did not claim Level 2 compliance on standard 112.

The following action plan was formulated which took into account any perceived barriers to undertaking training;

Action		Completion Timescale
Identify key areas of non- compliance from training report.		01/04/16
IG Training session delivered in the workplace	A defined number of IG Training session delivered in the workplace BUT Managers will be provided with a list of non -compliant staff. Managers to be made responsible for ensuring that non-compliant staff are booked on and attend the sessions delivered in the workplace.	30/06/16
Enable accessible training	Utilising Trust Intranet. Training made available on IG Intranet page In form of training material covering key IG topics following which staff undertake IG competency testing at the end. (similar to online training) The competency test to be received and scored by the IG Team. - If staff pass the test of understanding their training record is updated as a pass. - Staff who do not pass - the manager is notified and they ensure the staff member is booked on face to face training session.	30/04/2016
Provide paper based training	same as accessible training above but in paper format. The competency test of understanding to be sent to IG for marking.	30/04.2016

This action plan above; combined with the additional actions below:

- Email from the SIRO to the Directors
- Individual emails to all non-compliant staff from the SIRO
- The Care Group Directors responding to the SIRO's email and actively pursuing staff to do their training.

The result of which is by the 30 April 2016 IG training compliance was 95%.

Information Governance refers to the way in which organisations process or handle information in a secure and confidential manner. It covers personal information relating to our service users and employees and corporate information, for example finance and accounting records.

Information Governance provides a framework in which the Trust is able to deal consistently with, and adhere to, the regulations, codes of practice and law on how information is handled, for example the Data Protection Act 1998, the Freedom of Information Act 2000 and the Confidentiality NHS Code of Practice.

The way in which the Trust measures its performance is via the Information Governance Toolkit. The Information Governance Toolkit is a performance tool produced by the Department of Health, which draws together the legal rules and guidance referred to above, as a set of requirements.

In the current version (Version 13) there are 45 requirements relevant to this Trust. Each requirement has an attainment level from level 0 (no compliance) to level 3 (full compliance). Trusts must score a minimum of level 2 or above in all requirements to achieve an overall rating of Satisfactory. If any one of the 45 requirements is assessed at level 0 or 1, the Trust will be rated Unsatisfactory.

The Trust's submission for version 13 of the Information Governance is as follows:

Level 0	No requirements rated at this level
Level 1	1 requirements rated at this level (loss of records from member of staffs car)
Level 2	27 requirements rated at this level
Level 3	16 requirements rated at this level
Not relevant	1 requirement assessed as not relevant

Key areas of development in the year 2015/2016 have been:

'Spot Check' Audits

To provide assurance that information governance practices are fit for purpose and embedded in the Trust culture a programme of random 'spot check' audits are 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. The results of these audits confirm that Information Governance practices are well established and fit for purpose.

Audit of Corporate Records

The Trust must ensure complete and accurate corporate records to protect the legal rights of the organisation, its employees, its patients and third parties. Good records management practice necessitates that organisations should undertake an audit of records management processes and systems to determine what records are held, where they are located and in what form they are held. This provides assurance so that actions may confidently be taken on reliable information as validated by the Audits.

This year audits were completed across four Corporate areas.

- Complaints& Patient Advice & Liaison Service
- Estates Department
- Human Resources
- Procurement

New Systems/PIA

When new services begin, new information processing systems are introduced or there are significant changes to existing information processing involving personal confidential information the Trust ensures that it remains complaint with legislation and NHS requirements. This process is a mandated requirement on the Information Governance Toolkit.

The Privacy Impact Assessment (PIA) process has been reviewed and further developed to provide a robust assessment to ensure that privacy concerns have been considered and actioned to safeguard the security and confidentiality of personal confidential information.

Policies

During 2015/16 a number of key information governance policies were reviewed. Lawful and correct treatment of personal data is important. Robust information governance policies ensure information is lawfully and effective managed.

Fair Processing

The Trust aims to be transparent and open with individuals about how their information is used. The information available to patients and the public has been reviewed this year and improvements have been made to the fair processing leaflet given to patients and the information available to the public on the Trust website.

Data Quality

A clinical coding audit was performed on discharge patient records in 2015/16. The results from the audit were excellent. The percentage of records that had a correctly coded primary and secondary episode overall:

- 94% primary
- 96.6% secondary

This means the Trust can claim a level 3 on standard 514 of the Information Governance Toolkit.

Freedom of Information

The Trust supports the principle that openness and not secrecy should be the norm in public life and wants to create a climate of openness. The Freedom of Information Act 2000 provides individuals with a general right to access all types of recorded information by public authorities. The right is subject to certain exemptions. The aim of the Act is to promote openness and accountability within the public sector.

The Trust responded to 266 requests for information under the Freedom of Information Act, this is a rise of 26%. 22 requests were not answered within the statutory 20 day timescale due to delays in the information supplied and the change in the authorisation process.

Registration Authority (RA)

Humber NHS Foundation Trust is established as a Registration Authority. The Registration Authority for the Trust's employed staff is managed within the Human Resources (HR) and Diversity Directorate, working closely with Informatics and Information Governance, together with other relevant organisations externally. A key element of the RA process is to perform identity checks. For new starters these checks are no longer carried out as standalone identity checks, they have been incorporated into the recruitment process, during which identity checks are also required. For other staff requiring a smartcard the relevant ID checks are undertaken by either the HR RA staff, the RA Officer or as necessary an RA Manager. Once a member of staff's identity is confirmed they are issued with a Smartcard and a pass code.

Staff have to use their Smartcard and pass code each time they log on to access and use information in systems such as SystmOne, Lorenzo or the NLMS e-learning platform.

The Trust has in place an RA Policy and Procedures which reflect national RA policy, procedures and guidance.

2.5 Core Quality Indicators

7 Seven-day follow-up

Description

The National Suicide Prevention Strategy for England recognises that anyone being discharged from inpatient care under the Care Programme Approach (CPA) should be contacted by a mental health professional within seven days of their discharge. The Trust has set a local performance standard that all patients should be seen face to face. However, phone contact is acceptable where face to face is not possible.

Aim/Goal

The aim of this priority is to ensure everyone discharged under the CPA process from a mental health inpatient unit is followed up within the criteria set by Monitor. As a National Key Performance Indicator, our goal is to achieve the target and that at least 95% of all patients are contacted within seven days of discharge. The national target is accounted as the Trust having followed at least 95% of patients who are on CPA each quarter. Exceptions to this are:

People who die within seven days of discharge;
Transfers to other psychiatric units;
Where legal precedence has forced the removal of a patient from the country; and
Patients discharged or transferred to other NHS hospitals for psychiatric treatment.
All CAMHS inpatient units are excluded; however, Children and Young People placed on Adult Inpatients Unit and on CPA must be followed up.

For any other instances which fall outside of these categories, then advice and support is sought from the Department of Health and Monitor. These include patients transferred to private mental health providers and to other NHS Trusts for community-based treatment.

Patients with a learning disability (LD) who have an episode of inpatient stay on one of our mental health units are also contacted if they are on CPA and recorded on our reports.

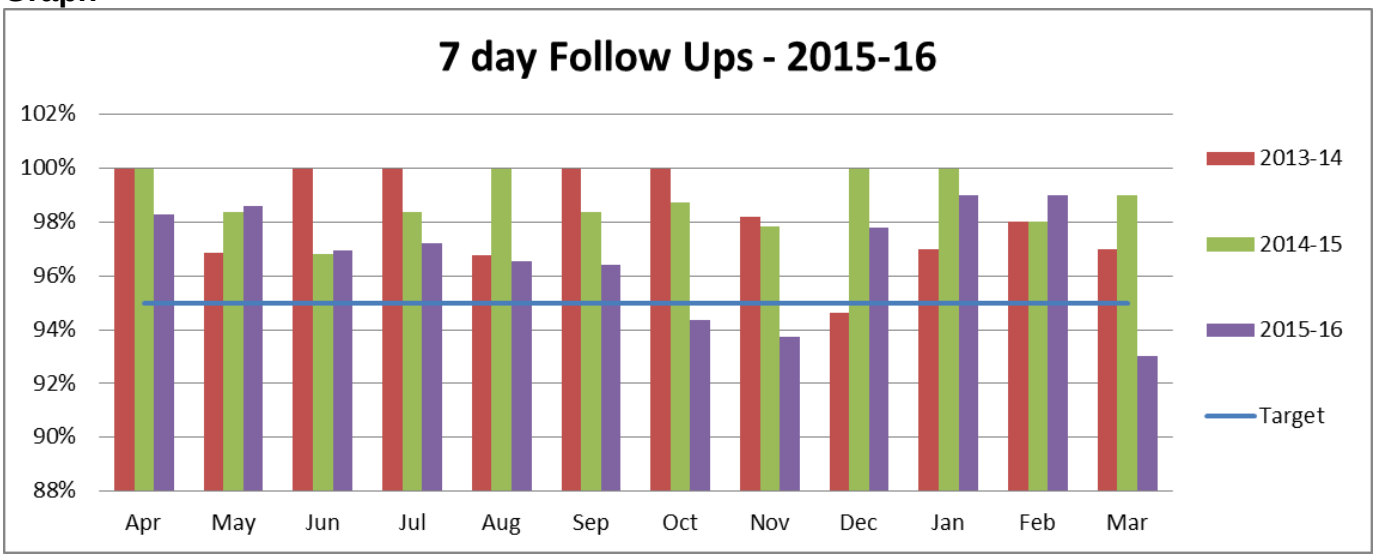
Summary of Progress

Throughout the year to the end of Quarter 4; 30 incidents occurred when patients were unable to be contacted within the seven days and includes 15 patients not wishing/willing to engage with Trust Services. This is a significant increase compare to last year (2014/15). These were investigated individually and appropriate actions and resolutions sought.

The Trust, taking the above into account, has remained an average 96.6% across all quarters within 2015/16. This equates to 856 patients seen out of the 886 discharges. The number of patients that were not seen were reported as adverse incidents and fully investigated. The Trust can report a constant 100% achievement of patients from out of our local area.

Throughout the year, the Trust has continued to achieve the minimum 95% on a quarter by quarter basis and subsequently achieved the Monitor target.

Graph



The HFT considers that this data is as described for the following reasons:

- This indicator is a national target (95%) and is closely monitored and audited. The data is recorded and reported from the Trust's patient administration system (Lorenzo) and is governed by standard national definitions.
- It is reported to the Trust Board as part of the Level 1 performance report and monthly to services managers and their teams as part of Level 2 and 3 performance reports.
- It is also reported externally to our commissioners on a monthly basis and to both the Department of Health and to Monitor on a quarterly basis.

The Trust has taken the following actions to improve this % and the quality of its service by:

- The Trust reports on patients who are discharged out of area for their continuing community care.
- The teams are notified of each discharge via email as an additional reminder of their obligations to carry out a 7 day follow up contact
- Making aware of the current Monitor and Department of Health requirements within the Compliance Framework
- The Trust actively increased the monitoring of the 7 day follow up procedure. We can see the benefit of this work from December.
- The Trust Care Group Directors meet weekly to keep constant review of the 7 day follow up trend.

The table below benchmarks the HFT's achievements against the national average submitted to Department of Health. Figures may differ slightly on occasion due to timing of submission and refresh of data.

Indicator	NHS Outcomes Framework Domain	Health & Social Care Information Centre Performance Data (2015-2016)				
Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	1. Preventing people from dying prematurely 2. Enhancing quality of life for people with long-term conditions		Q1	Q2	Q3	Q4
		Humber	98.4	96.7	95.4	96.6
		National average	97	96.8	96.9	
		National best score	100	100	100	
		National worst score	88.9	83.4	50	

Gate Keeping

Description
A mental health inpatient admission is said to have been gate-kept if the patient has been assessed by a crisis and home treatment team (CRHT) or intensive home treatment team within 48 hours prior to their admission and if they were involved in the decision-making process which resulted in the admission.

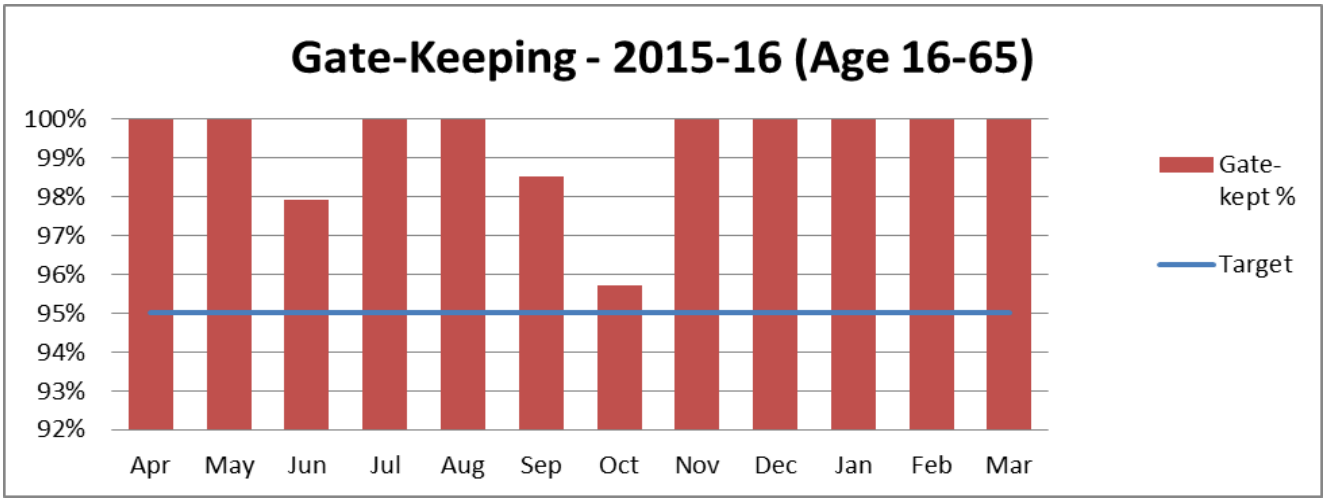
Aim/Goal
Every referral for admission is assessed to ensure the most appropriate method of care is provided across both Hull and East Riding. Only when a patient's care and treatment cannot be best met in their own home, an admission is made.

Summary of Progress
For the Monitor submission, only adults aged 16-65 are gate-kept prior admission as per guidelines. During 2015/16 there were a total of 748 admissions of patients in this age group for the financial period. The Trust reported that 99.3% of these admissions were gate-kept. (See graph 1).

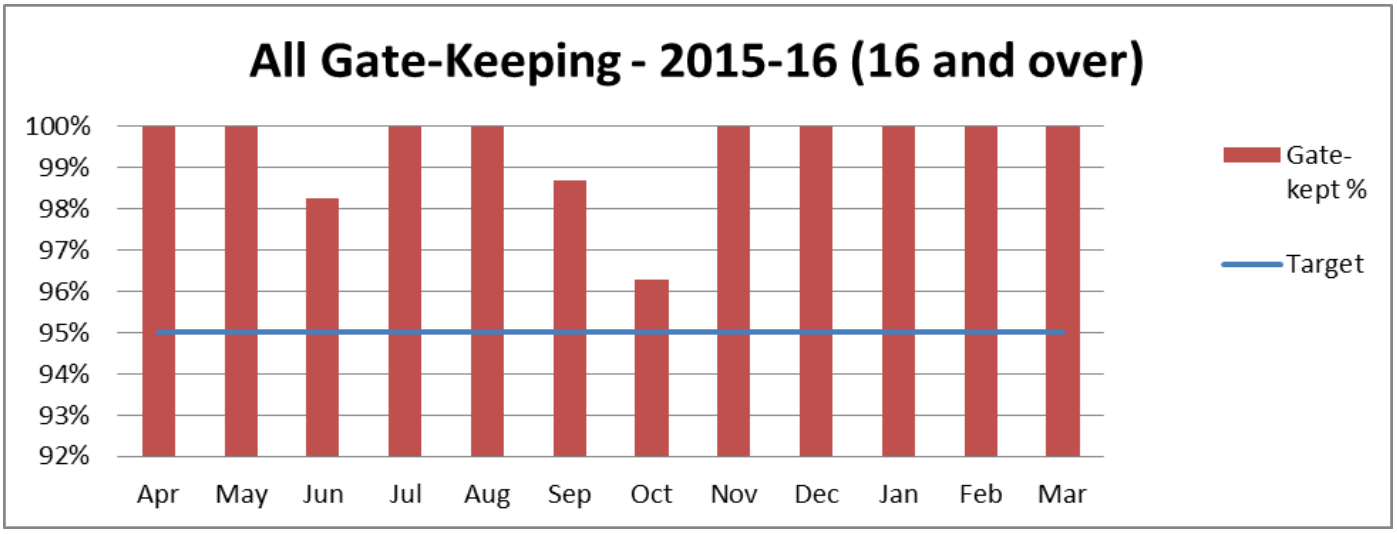
The Trust also reports to the Department of Health (DoH). The guidelines for DoH require that ALL patients aged 16 and over are gate-kept and these are benchmarked against other Trusts. There were a total of 864 patients aged 16 and over admitted to Trust units and 99.4% were gate-kept for the 2015/16 financial period. (See graph 2).

The data below does not include admissions to the Trust's Psychiatric Intensive Care Unit, Learning Disability or Forensic units and does not include transfers in from other hospital wards.

Graph 1



Graph 2



Benchmarking Table

The table below benchmarks the HFT's achievements against the national average. This is based on all patients aged over 16 for Hull and East Riding patients. The national target for this indicator is set at 95%.

Indicator	NHS Outcomes Framework Domain	Health & Social Care Information Centre Performance Data (2015-2016)				
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	2. Enhancing quality of life for people with long-term conditions		Q1	Q2	Q3	Q4
		Humber	100	99.5	98.7	100
		National average	96.3	97	97.4	
		National best score	100	100	100	
		National worst score	18.3	48.5	61.9	

The HFT considers that this data is as described for the following reasons

All gate-keeping is recorded on the Trust's patient administration system (Lorenzo) and is adopted across both Hull and East Riding. Patients aged 16-65 are reported to Monitor and the Trust Board as per Monitor guidelines (see Graph 1). However, by way of good practice this process continues to be in place for all patients aged 16 and over (see Graph 2) and is reported to the Department of Health.

Gate-keeping is monitored weekly to ensure consistency and accuracy of data and is subject t regular refresh.

The Trust has not had to take any actions to improve the % but will maintain its good practice and quality of service and continue to strive for excellence.

- Any patients not gate-kept throughout any year are reported through the Trust's Adverse Incident procedure and fully investigated.

Clostridium Difficile

Description
This indicator measures the number of Clostridium Difficile (C.Diff.) cases where a Foundation Trust has a nationally set objective.

Aim/Goal
The target on this National Key Performance Indicator is currently not to exceed 4 cases (Hull and East Riding) and 4 cases for Whitby Hospital. It is the aim of the Trust to achieve this target each year and is monitored monthly.

Summary of Progress
In the table for the financial year 2015/16 there has been note of three cases where C.Diff. has been present within Trust Inpatient Units. There were two cases in East Riding and one case in Hull. This is an increase compared to 2014/15 when there were no reported cases. The Trust was successful in securing the contract to provide services for Whitby Hospital in March 2016. These are also shown below with no cases reported.

2016/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year End
Hull	0	0	0	0	0	0	0	1	0	0	0	0	1
East Riding	0	0	0	0	0	1	1	0	0	0	0	0	2
Whitby Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0
Trust wide	0	0	0	0	0	1	1	1	0	0	0	0	3

The HFT considers that this data is as described for the following reasons:

There is a Clostridium Difficile Infection Policy (April 2016) on the Humber Intranet that all relevant staff on the wards / unit should be aware of. Staff on the wards/units are expected to take a faecal sample from any patient that has diarrhoea that is of an unknown cause.

The majority of samples are sent to the laboratory at Hull & East Yorkshire Hospitals (HEYH), except for Macmillan Wolds Unit at Bridlington, where the samples are dealt with by Scarborough. The turnaround time for the results is usually one day. Only C.Diff. cases that occur after three days following admission are included in the quality data reporting. Any cases that occur in the first few days are not deemed to be the result of the Trust and the patient is assumed to have been infected with C.Diff. before admission.

If the laboratories do find C.Diff. present, there is an alert process in place of who needs to be informed.

- The lab at HEYH will inform the Infection Control Team there who, in turn, will contact the Trust's Infection Control Team.
- The HEYH team provide the Trust team with all cases across Hull and East Yorkshire, as and when these occur, and not just those that relate to the Trust wards / units.
- The HEYH Infection Control Team will input the C.Diff. case on the MESS website (Public Health England - Mandatory Health Care Associated Infection Surveillance data capture system).
- The Commissioner will also notify Trust Infection Control Team of any C.Diff. cases that relate to HFT (e.g. Macmillan Wolds Unit samples that are not dealt with by the HEYH lab).
- The Commissioner also has access to MESS (data system) and inputs any cases that have arisen from the lab tests undertaken by Scarborough.

The trust has taken the following actions to improve this % and so the quality of its service:

- Identifying root cause analysis and whether the cases of C.Diff could have been avoided

- Ensuring antibiotics were prescribed and administered appropriately
- Liaising with NHS England
- Identifying and eliminating (where applicable) any potential of cross contamination and other possible risk factors

Emergency Re-admissions

Emergency Re-admissions (mental health)

Description
Helping people to recover from episodes of ill health.

Aim/Goal
To monitor all patients who have been re-admitted within 30 days of discharge. Although the national target is to be confirmed, the Trust has set an internal target of 10% or less.

The percentage target is worked out by dividing the number of re-admissions by the number of discharges per month.

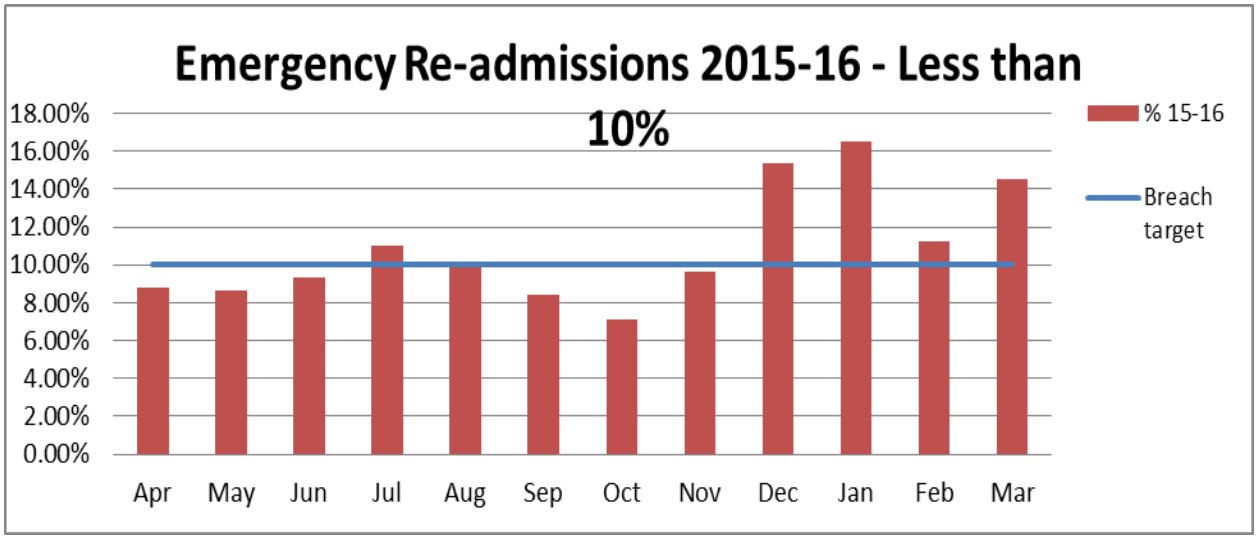
The data below is based on patients re-admitted to adult, older adult mental health, Forensics and Learning Disabilities units.

Summary of Progress

For 2015-16 there were a total of 1101 discharges and 121 emergency re-admissions for patients aged 16 and over (10.99%). There were zero re-admissions for patients aged 0-15.

Not all patients who are re-admitted are classified as an emergency. Some patients are recalled as part of their treatment. Patients may also be discharged earlier as part of the home treatment and care plan with a view to them being re-admitted if the patient and care co-ordinator feel it is more beneficial to their overall recovery.

Graph

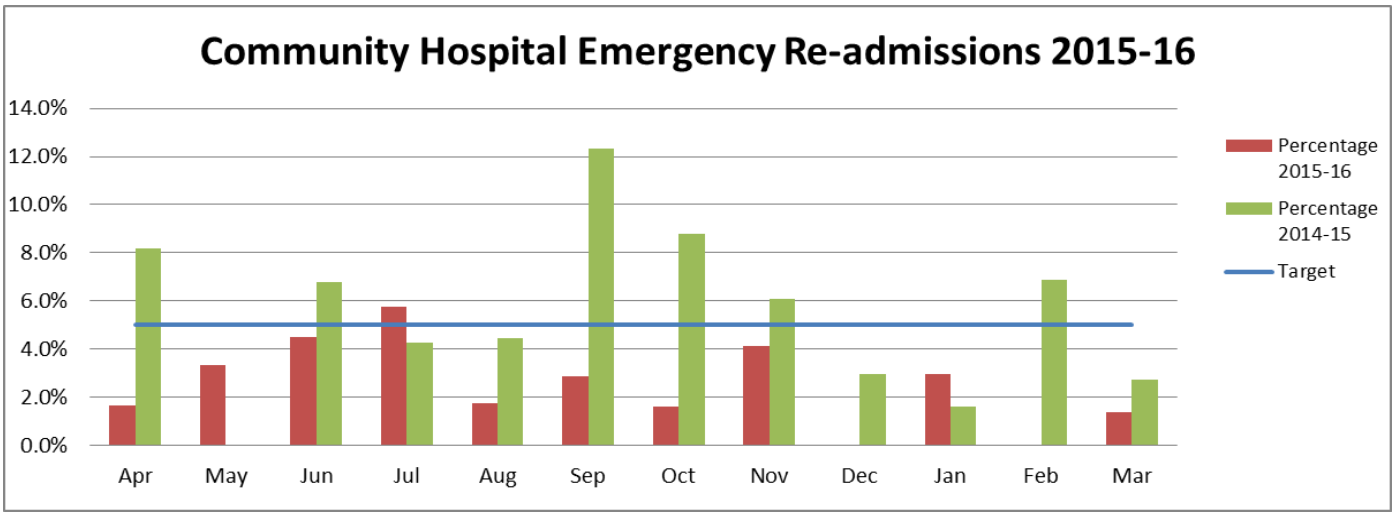


The HFT considers that this data is as described for the following reasons

- Patients who have been transferred from another bed either within the Trust are not included
- It does not include patients who have been recalled under a Community Treatment Order (CTO)
- Patients who return to hospital as part of their care plan are included, including patients who return from a spell of physical acute care
- Please note, during 2015-16 new technical guidance has been issued which has resulted in a change of reporting and methodology of calculating readmission rates. Therefore, a direct comparison to previous years cannot be taken.

Emergency Re-admissions (community hospitals)

The following chart and graph relates to the three Community Hospitals within the Trust.



This indicator is affected by palliative care patients who are discharged home where possible in the knowledge that they will be re-admitted at some point. Although the re-admission is expected it is not 'planned' and is included in the denominator. This is the first year that the Trust has reported on this indicator for Community Hospitals.

The HFT considers that this data is as described for the following reasons

A community bed provides short term (usually no longer than 3 weeks) 24 hour clinical care and rehabilitation for individuals whose clinical care needs cannot be supported at home but do not require acute level care.

Evidence suggests that patient outcomes are enhanced by robust delivery of community care, including a step up and step down approach to the management of individual episodes of need and long term conditions. This, together with flexible and accessible community beds, within community hospitals have been shown nationwide to deliver beneficial outcomes for patients.

The Trust has taken the following actions to improve this % and the quality of its service by:

Monitored on a monthly basis, along with admission timescales for step up and step down admissions, to ensure community beds are available when required by the patient(s).

Figures include palliative patients who may access community beds as required within short timescales i.e. within 28 days.

The NHS Community Mental Health Service Users Survey

Each year, a national study takes place across the NHS to gather patient's experience of using community based mental health services. The percentage response rate for Humber NHS Foundation Trust was slightly higher than the national average.

The survey comprises of nine sections, these include;

1. Health and Social care workers
2. Medications
3. Talking Therapies
4. Care Co-ordinators
5. Care Plan
6. Care Review
7. Crisis Care
8. Day to day Living
9. Overall

The survey allows for comparison of year on year results within the Trust and also allows for comparison between different NHS providers of mental health services.

The table below shows a year on year comparison of our Trust's results over the last three years.

Section descriptor	Score 2013	Score 2014	Score 2015
S1. Health and Social Care Workers	Same	Better	Same
S2. Medications	Same	Same	Same
S3. Talking Therapies	Same	Same	Same
S4. Care Co-ordinator	Same	Same	Same
S5. Care Plan	Same	Better	Same
S6. Care Review	Better	Same	Same
S7. Crisis Care	Same	Same	Same
S8. Day to Day Living	Unscored	Better	Same
S9. Overall	Same	Same	Same

At the start of 2015, the survey was sent to 850 people chosen at random who received community mental health services. 247 responses were received (29.05%). The results are shown below;

Patient Safety Incidents

2015 has seen a significant overhaul of the reporting, response and investigation of patient safety incidents. A significant piece of work was undertaken by the Head of Nursing to review the existing procedure and to update the current policy for the management of Serious Incidents and Significant Events in line with current best practice and guidance.

All incidents are recorded through the DATIX system, these incidents are then reviewed by managers and actions appropriate assigned. Any incidents rated as a moderate harm or above are now reviewed at the Organisational Risk Management Group (ORMG), which consists of Directors, Professional Leaders and Operational Managers. Scrutiny at this level ensures that the appropriate level of investigation is assigned to incidents.

The review of categories for Serious Incidents has meant that the number reported has dropped during 2015/16; however we have seen an increase in the number of Significant Event Analysis completed to ensure robust investigation and lessons learnt.

Staff complete briefing reports for incidents of severe harm to patients, these are also reviewed weekly in the ORMG. Briefing reports may result in a decision to log as a Serious Incident, Significant Event or that with the information contained in the briefing report that no further action is required.

Serious Incidents are logged with the appropriate commissioner and investigators assigned from within the Care-groups. A “Buddy” is allocated from the nursing and quality directorate to provide support and an independent view to the investigation to ensure due process is carried out.

The Serious Incident Review panel with Commissioners is attended by an operational representative and a nursing and quality representative. This ensures that investigations and action plans are kept on track and monitored closely. An Organisational Learning Report has recently been introduced to capture all the action plans from Serious Incidents in one place and is reviewed regularly through ORMG.

In March 2016 the Trusts Patient Safety Strategy was signed off by the board and Humber NHS Foundation Trust also Signed up to Safety. Work has recently commenced against the priority action areas and will be reported on through 2016/2017.

Work has been undertaken throughout the year to improve upon the reporting of incidents, this is strongly reflected in the total number of incidents reported at year end. A quarterly clinical risk report picks up on the themes and categories of incidents for each of the care groups and has influenced the development of the Trusts patient safety strategy.

Given the changes in procedures and reporting, it is therefore difficult to draw conclusions from comparative year end data for last year.

	Total Incidents 2014/15	Total Incidents 2015/16	Severe/Death 2014/15	Severe / Death 2015-16	SI External 2014/15	Serious Incidents 2015/16
April – June	902	936	17 (1.88%)	20 (2.21%)	18	6
July – September	1005	1029	16 (1.59%)	9 (0.87%)	21	15
October – December	960	1010	16 (1.67%)	18 (1.78%)	10	6
January- March	952	1039	17 (1.79%)	16 (1.53%)	8	7

The National Patient Safety Agency (NPSA) reports nationally on all incidents relating to patient safety. Within these figures, the national median rate for incident reporting from their last six-monthly report, which was published in April 2016 was 39.12 per 1,000 bed days. Humber NHS Foundation Trust's reporting rate was 55 incidents per 1,000 bed days. This puts the Trust in the mid-range for incident reporting. The highest number of incidents per 1,000 bed days was 83.72.

The Trust considers that this data is as described for the following reasons:

- To allow us to compare our patient incident figures with those reported nationally to the National Reporting & Learning System by other similar NHS Trusts.
- To pick up any trends that would alert us to areas of concern.

Humber NHS FT intends to take the following actions to improve this data, and so the quality of its services by:

- Continue to educate staff on the positive impact of reporting incidents and near misses
- Commence work within the patient safety strategy to reduce the type of harm or incidence of harm in its key priority areas
- Commission thematic work of the previous year's SIs and SEAs
- Align with the mortality review and Trust consideration of the recent Mazars report into deaths in Learning Disability and Mental Health services

Patient Safety

As part of the ‘Sign up to Safety’ campaign, the Trust has created actions in response to the five ‘Sign up to Safety’ pledges (below in bold text).

- **Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans:**

We will
Continue to focus on patient safety through our Organisational Risk Management Group and Quality and Patient Safety Committee within the organisation.

Develop Patient Safety Champions and Ambassadors across the priority action areas with our staff group, patients and carers

Develop patient safety work groups that focus on reducing patient harms within the organisation across 6 priority areas which will be reported upon quarterly through our clinical risk report.

Ensure the patient safety work groups embed the principles of SU2S and developing a patient safety culture across the organisation

Support the Quality Visit methodology to review patient safety within clinical teams.

Ensure that staff have the professional training and development they need to deliver safe care

- **Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are.**

We will
Review trends and analyse incident/feedback data in patient safety groups based on our priority action areas

Join regional and national collaboratives and campaigns focussed on reducing harms to patients – a current example is the Y&H Safer Staffing collaborative for MH Trusts

Disseminate and promote best practice guidance and outcomes from the priority action areas in our strategy

Consider a review of safety training for employees through analysis of human factors training and impact on incidents.

- **Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.**

We will
Ensure our responsibilities in relation to Duty of Candour are understood across the organisation

Collect and review data in relation to Duty of Candour across all incidents and complaints

Publish quarterly data in the clinical risk report from the priority action areas to demonstrate our progress against our success criteria

Develop a training package for clinical staff that explores and facilitates confidence to be open, honest and candid with patients and carer if something goes wrong

- **Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.**

We will

Join regional and national collaboratives and campaigns focussed on reducing harms to patients

Contribute to Regional Public Health Initiatives across the health and social care economy

Ensure each Care Group always has attendance at the relevant working groups in order to ensure distribution and sharing of learning objectives

Share learning and best practice with GPs, Local Authorities, Clinical Commissioning Groups, Acute Health, Police and other parties in a confidential manner to embed and improve patient safety outcomes

- **Help our people understand why things go wrong and how to put them right. Give them the time and support to improve and celebrate progress**

We will

Work towards a patient safety conference within the organisation to share SU2S work based from across the organisation

Develop Recognition awards for patient safety champions to reward involvement and energy in patient safety

Develop Recognition awards for teams to encourage discussion around local team initiatives and openness within care groups about areas to improve upon

Recommend the use of reflective practice within all clinical teams in the organisation

Part Three

3.1 Key National Priorities

How We Measure Performance – Meeting Monitor Targets

Our Trust uses a 'traffic Light' or 'RAG Rating' system to report on performance and quality against our selected priorities and Key Performance Indicators (KPIs), eg Red = Weak, Amber = Fair and Green = Good. This is translated to reflect the organisation's performance on the selected priorities and initiatives.

Our internal reporting is split into three levels:

Level 1:
Monthly and quarterly performance reports to the Trust Board via the newly developed Integrated Performance Tracker (IPT)

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

We also report externally to our Commissioners via:

Contract Activity Report (CAR)

Completed monthly by the Information Management team jointly with the Performance team

This system ensures that we can:

- Monitor critical clinical processes and activities using measures of clinical and corporate performance that trigger alerts when potential problems arise.

- Analyse the root cause of problems by exploring relevant and timely information from different sources and at various levels of detail.

- Manage people and processes to improve decisions, be more effective, enhance performance, and steer the organisation in the right direction.

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.

Performance Indicator returns (PIs)

All Monitor and CQC indicators are reported in the IPT 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.

National Key Priorities

There are three domains in which the Key National Priorities fall under that the Trust has reported on in Section 3, this is explained in the table below (Please note that some of these indicators have already been included in Part Two of the report, where this is the case, reference is made to Part Two):

Domain	**Indicator**
Patient Safety	Immunisation Rate for Human Papillomavirus (HPV)
	7 day follow up **(part 2)**
	Clostridium (C) Difficile **(part 2)**
Clinical Effectiveness	Delayed Discharges
	Early Intervention
	Gatekeeping **(part 2)**
	Percentage of Children Measured for Height/Weight in Reception
Patient Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability
	Percentage of Infants Breastfed at 6-8 weeks
	Percentage of Patients Seen within 18 weeks for (Admitted &) None Admitted Pathways
	Percentage of Patients Discharged or Transferred within 4 Hours – Minor Injuries Units

Domain 1 – Patient Safety

Immunisation Rate for Human Papilloma Virus (HPV)

Description

Immunisation against Human Papillomavirus (HPV) highlights an area of national and international concern to end the transmission of preventable life-threatening infectious diseases. Vaccines prevent infectious disease and can dramatically reduce disease and complications in early childhood, as well as mortality rates.

Uptake of the vaccine is reported via the Health Protection Agency (HPA) website. The HPA issues a report each autumn on the national uptake, by CCG, in the previous academic year. The 85% target relates to the uptake of the complete course of vaccination, measured as the total number of 12 to 13 year-old girls in East Riding of Yorkshire schools who have received all required doses.

HPV immunisation is commissioned by NHS England.

The programme of vaccinations is delivered in schools by the Trust's School Nurses, supported by our Health Visitors because of the scale of the programme. Up to the 2013/14 academic year (September 2013 to July 2014) the vaccination for HPV was delivered in three doses. From September 2014 onwards a new vaccination has been used (nationally). Delivery of the two doses has to be spread out over at least a six month period to work properly, and to fit this around the academic school year and deliver it efficiently it is delivered across two academic years, in the summer term.

For the first cohort of girls receiving the new vaccine, the first dose was delivered in schools in the summer term of 2015 and the second dose will be delivered in the summer term of 2016, at the same time as the first dose for the next cohort.

Aim/Goal

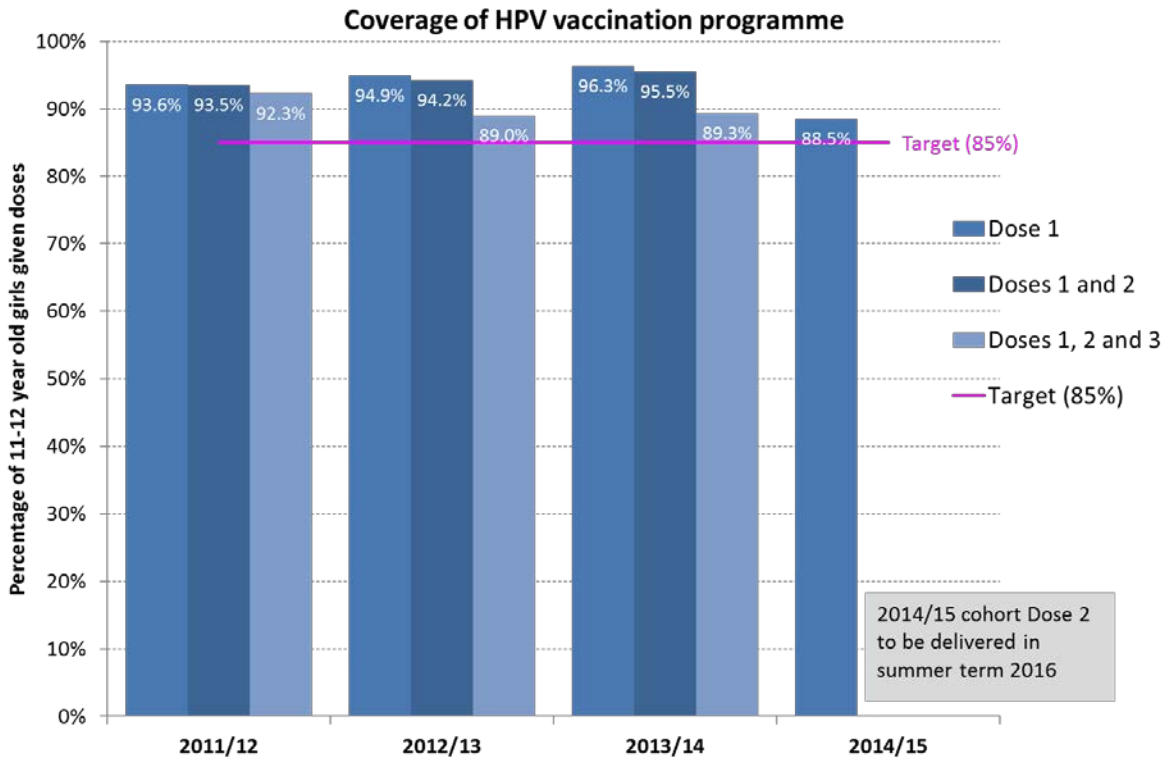
In order to achieve a level of immunity in the population 85% of girls aged 12-13 should have completed a full course (both doses) of immunisation against HPV within the timescales prescribed for delivery.

Summary of progress

Due to the difference between the financial year we are describing in this report (April 2015 to March 2016) and the academic year that dictates the delivery timings of the vaccination doses (September 2015 to July 2016), we are not able to report the completed vaccination cycle for 2015/16, as vaccination for Dose 2 will take place after the date this report is published. Dose one will be delivered to the 2015/16 cohort at the same time, with Dose 2 in summer 2017.

Between April 2015 and July 2015 the Trust delivered Dose 1 of the HPV immunisation to 88.5% of girls aged 12-13 in East Riding Schools. This allows a drop-out rate of 3.5% (of total cohort) between Dose 1 and Dose 2 to achieve the target of 85% receiving both doses (by the end of July 2016).

Graph



The Trust considers that this data is as described for the following reasons:

The Trust set its own internal target of 88% for Dose 1 to ensure that there was sufficient coverage of girls receiving the first dose to achieve least 85% coverage for receiving both doses.

The immunisation programme is recorded against the record of each child individually on SystmOne (our electronic patient record system) and the output is compared with a master list of all eligible children. We are therefore able to accurately identify the overall percentage coverage. The Trust monitors the delivery of each dose to ensure there is enough scope in the delivery of dose one to be able to achieve 85% for both doses, allowing for 3% drop out between doses.

The Trust has taken the following actions to improve this % and so the quality of its service:

The trust has a 3.5% margin for drop-out to still achieve the target of 85% coverage. The programme for delivery of Dose 2 (and Dose 1 to the next cohort) has been planned and communications have gone out to schools to ensure smooth delivery of the programme.

Domain Two – Clinical Effectiveness

Mental Health Delayed Transfers of Care (Delayed Discharges)

Description
This indicator measures the impact of community-based care in facilitating timely discharge from a hospital and the mechanisms in place to support this. The aim is to ensure people receive the right care, in the right place, at the right time.

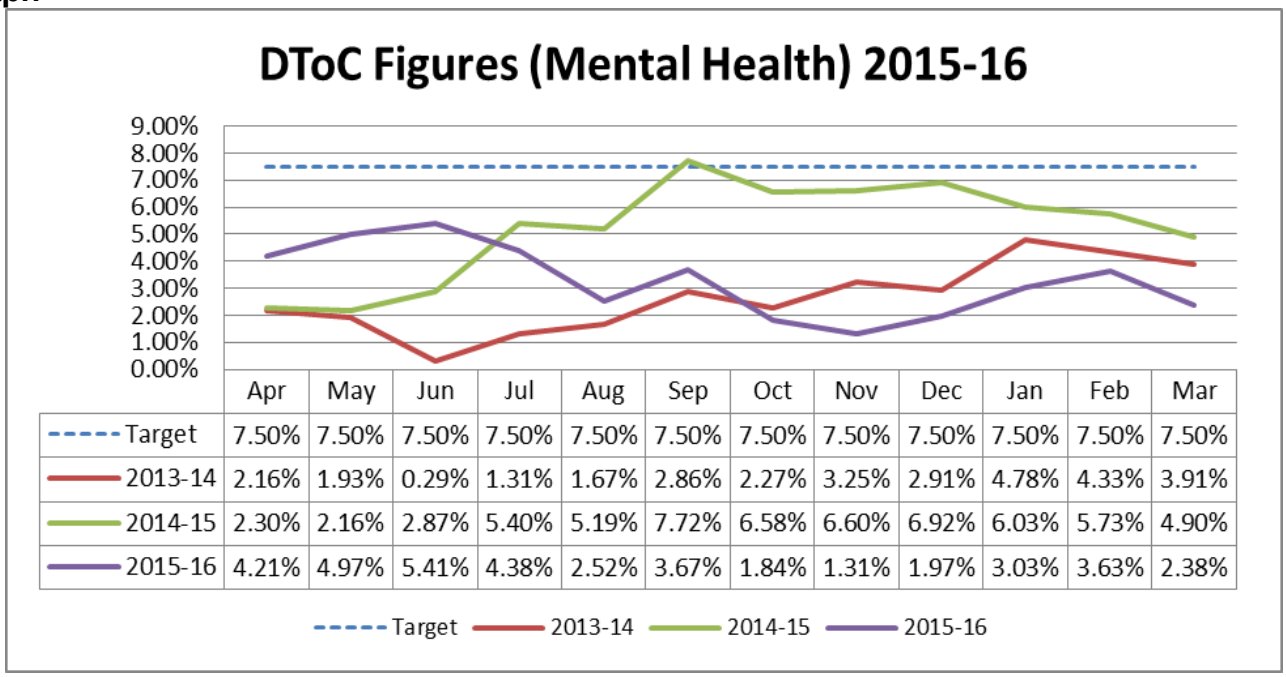
Aim/Goal
The target on this National Key Performance Indicator is to show less than 7.5% of delayed transfers. This figure compares the number of days delayed with the number of occupied bed days (OBDs) for mental health. It is the aim of the Trust to achieve this target.

Summary of Progress
As at the financial year end, the Trust reported a percentage of 3.29% delayed transfers, which is 4.21% within the measure and also an improvement compared with the 2014/15 year end result of 5.22%.

The number of occupied bed days is reported through the Trust's patient administration system (Lorenzo). The number of patients affected and the number of days that they were delayed by are reported via weekly unit submissions to the performance team who then submit this internally to Care Group Directors. The data is governed by standard national definitions. The OBDs are subject to constant refresh.

Delayed Transfers of Care are also reported to the Department of Health. The Department of Health return (SitReps), looks at the count of all patients (community hospitals and mental health) who were delayed as at midnight on the last Thursday of each month and the total number of days delayed during the month. It does not compare against Occupied Bed Days. In accordance with Monitor guidelines, the Trust only records mental health inpatient delayed discharges for patients aged 18 and over.

New weekly return forms have been introduced to allow for consistent entry submissions limiting the choices to the nationally set criteria. This allows for more accurate data quality. Patients fit for discharge and classed as delayed are identified following multi-disciplinary and recovery plan meetings between clinical professionals.

Graph


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%
2013-14	2.16%	1.93%	0.29%	1.31%	1.67%	2.86%	2.27%	3.25%	2.91%	4.78%	4.33%	3.91%
2014-15	2.30%	2.16%	2.87%	5.40%	5.19%	7.72%	6.58%	6.60%	6.92%	6.03%	5.73%	4.90%
2015-16	4.21%	4.97%	5.41%	4.38%	2.52%	3.67%	1.84%	1.31%	1.97%	3.03%	3.63%	2.38%

The graph above compares three years data by month. Below are the quarterly figures as at quarter 4 end.

Numbers

	Q1	Q2	Q3	Q4
OBD	***17934***	***17776***	***17551***	***17391***
Delayed Days	874	625	300	522
	4.87%	3.52%	1.71%	3.00%

The HFT considers that this data is as described for the following reasons:

- Both the Care Quality Commission and Monitor measure delayed discharges for patients whose transfer of care was delayed due to factors which were the responsibility of Social Care or NHS or both.

The Trust has taken the following actions to improve this % and so the quality of its service by

- Holding weekly operational meetings to identify problem areas and seek to plan early, appropriate discharge more effectively.
- Delayed Transfer of Care within Community Hospitals are routinely raised at a fortnightly patient flow and escalation meeting which is attended by East Riding of Yorkshire Council. Equally all other delays are raised via the daily system wide meetings.
- Liaising with families, carers and housing providers. Regular liaison also takes place with residential homes to give support/advice and ensure patients settle in well.

Mental Health Data Completeness: Identifiers

The NHS has a duty to collect the following information as a minimum data requirement to enable them to perform their duties effectively. Patient identifiable data completeness metrics (from Mental Health Minimum Data Set) to consist of:

- NHS Number
- Date of birth
- Postcode (normal residence)
- Current gender
- Registered General Medical Practice organisation code, and
- Commissioner organisation code

As at end March 2016, the Trust achieved a primary result of 99.7% against a national target of 99%.

Mental Health Data Completeness: Outcomes

Accommodation and Employment information is collected for those patients who are on the Care Programme Approach (CPA). This information helps monitor the patient's progress in gaining and maintaining settled accommodation and/or employment, both of which contribute to quality of life and patient recovery.

As at end March 2016, the Trust achieved a primary result of 89.8% against a national target of 50%.

Community Information Data Set (CIDS)

Description
Data completeness for Community Hospital on Referral Pathways

Aim/Goal
A target of 50% for each of three indicators as set out in the table below.

Summary of Progress
There has been no further update on this indicator since 2014/15. The HSCIC has yet to issue any further guidance but we are expecting an interim Information Standards Notice modifying the Community Information Data Set to align it with the Children and Young People's Health Services Data Set. Until this final specification is available and all required system changes can be assessed we have not asked our services to adopt the CIDS-specific RTT functionality so as previously noted we continue to infer our RTT completeness levels based on the data collected by current processes.

The table below shows the status as at the end of the 2014/15 financial year and will therefore remain as such for the end of 2015/16.

Data Completeness Levels to be provided using Community Services Data Set definitions against the following:

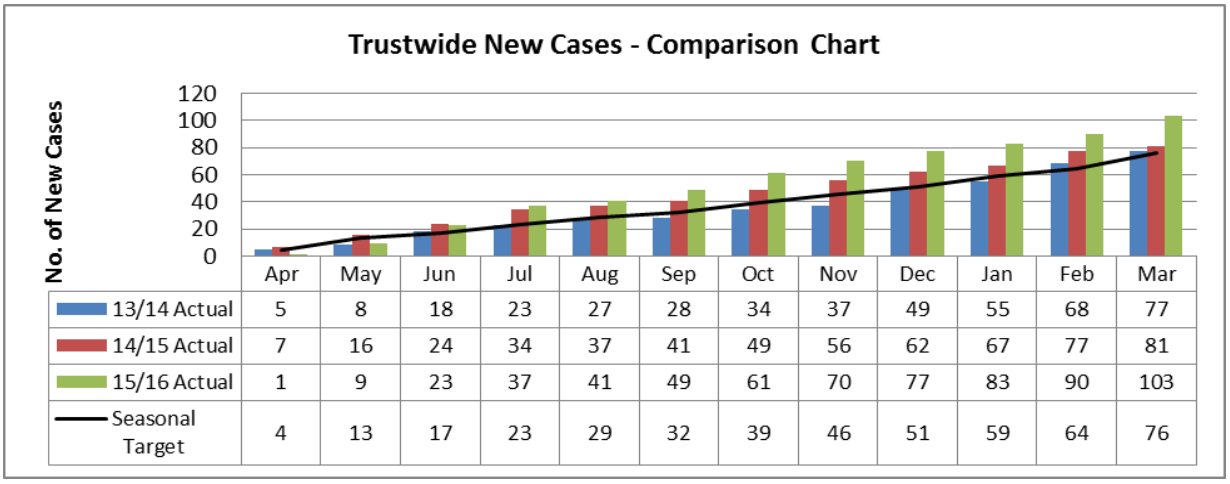
Records submitted	Target	Q4, 2015/16
Referral to Treatment Information		100%
Community treatment activity - referrals; and		66%
Community treatment activity - care contact activity		75%
Patient Identifier Information (TBC)	N/A	
Patients Deaths at Home Information (TBC)	N/A	
		80%

Early Intervention in Psychosis

Description
Referrals come through from a variety of sources including education, child care, child and adolescent mental health services (CAMHS), family, GP and self. A number of referrals come through the Single Point of Access service; both assessments and treatment are carried out within this service. The assessment process for this patient group may take up to six months before a decision is made for continuing treatment or referral on.

Aim/Goal
Meet the commitment to serve new psychosis cases for ages 14-35. At year end it is the Trust's aim to meet the agreed local commissioner target of 76 new cases for 2015/16.

Summary of Progress
There has been a higher than average increase in the number of referrals coming through from across both Hull and East Riding. The team continue to work hard with local GPs and the local authority/education to identify strategies to promote the service. The overall caseload is now being managed more effectively and discussed at monthly team meetings. As at the end of the financial period there were 61 new Hull cases and 42 new East Riding cases (103 in total). The Trust therefore exceeded its target by 27 new cases across Hull and East Riding (135.5%).

Graph


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
13/14 Actual	5	8	18	23	27	28	34	37	49	55	68	77
14/15 Actual	7	16	24	34	37	41	49	56	62	67	77	81
15/16 Actual	1	9	23	37	41	49	61	70	77	83	90	103
Seasonal Target	4	13	17	23	29	32	39	46	51	59	64	76

The HFT considers that this data is as described for the following reasons:

A significant increase in the number of new referrals coming through for Hull, the Trust has seen an increase of new referrals on a monthly basis from July 2015 – higher numbers against previous years. The Trust also foresaw the achievement of the full year target by the end of quarter 3, having been above the target set every month from June 2015.

The Trust has taken the following actions to improve this % and so the quality of its service by:

- Monitoring on a weekly basis at team meetings
- Monitoring every month at the 'Trust Board' Meetings
- Pro-actively liaising with education services
- Marketing the service with local GPs
- Providing workshops and road shows to further education facilities throughout the area in particular Bishop Burton College in the East Riding and Hull University. Specifically providing greater publicity regarding the need to refer young people who are not so clearly exhibiting symptoms at present, who are no longer being referred.

From 2015/16, new cases will no longer be a Monitor target and will be replaced by the new two week Referral to Treatment waiting times target.

Percentage of Children Measured for Height/Weight in Reception

Description

Good nutrition is essential for the healthy development of children, with long term effects on health for the whole of a person's life. Collecting data about childhood obesity and under-nourishment provides parents with important health information about their children. Health service commissioners at both local and national level need the information to make decisions about the services required now and in the future.

The Trust is commissioned to deliver the National Child Measurement Programme (NCMP) in East Riding Schools by East Riding of Yorkshire Council.

Aim/Goal

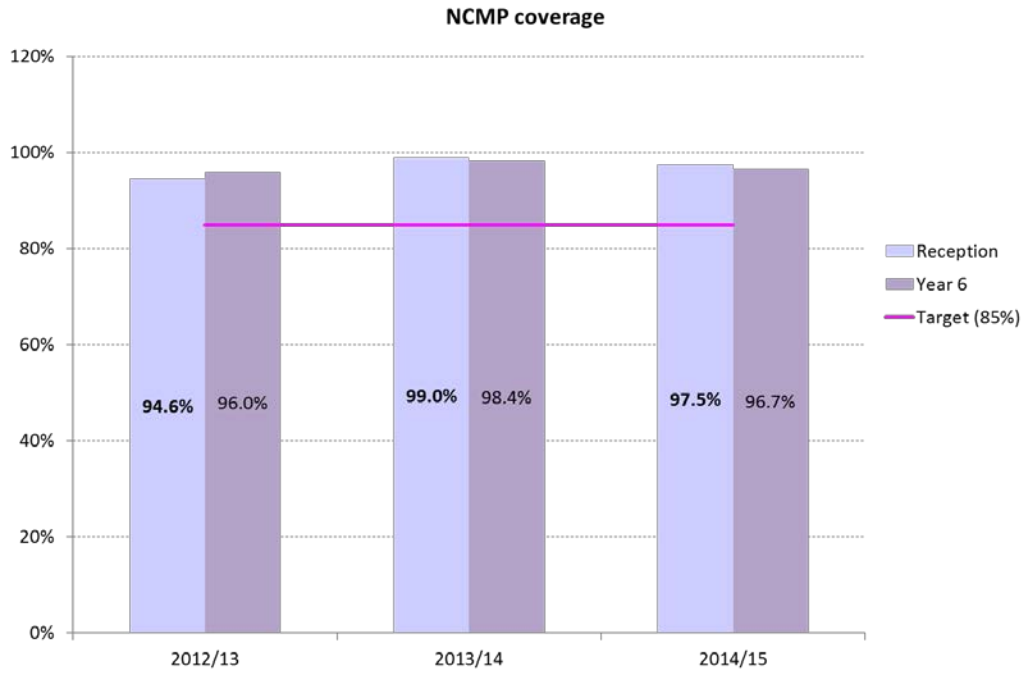
This is a nationally mandated indicator with a target of 85% coverage. Every school child is measured for height and weight in Reception (age 5-6 years old), and again in Year 6 (age 10-11 years old). In the East Riding this is done in schools each year by School Nurses, between February and May. Because financial and academic years are different the data collection overlaps the financial year end so we are unable to report on the complete programme for the current year. This report looks at the financial year and therefore shows the full year achievement for 2013/14.

The data is used to calculate the Body Mass Index (BMI) for each child. Parents receive a letter explaining their child's BMI to raise awareness of the health risks for over or under weight children. The data is also used for Public Health planning.

Summary of progress

In 2015 School Nurses recorded the height and weight for 97.5% of children in Reception and 96.7% of children in year 6. The 2015/16 academic year will be measured between February 2016 and April 2016 and reported next year.

Graph



The Trust considers that this data is as described for the following reasons:

The target is to measure and weigh at least 85% of children in Reception (age 5-6 years old), and again in Year 6 (age 10-11 years old. The NCMP programme is recorded against the record of each child individually on SystmOne (our electronic clinical record system) and compared with a master list of all eligible children. We are therefore able to accurately identify the overall percentage coverage.
6682 children were weighed and measured (3460 Reception age and 3352 Year 6). Many infants, juniors or primary schools achieved 100% participation.

The Trust has taken the following actions to improve this % and so the quality of its service:

The 2014/15 planned programme commences in February following the half term (which was later than last year due to Easter being later), and will finish in May 2015. Any children missed in the first rollout will be identified from the master list. They will be weighed and measured during catch-up sessions, as school nurses visit the schools regularly. We expect coverage to reach similar levels to last year, well above target.

Domain Three – Patient Experience

Certification against compliance with requirements regarding access to healthcare for people with a learning disability

Description of Priority

Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in *Healthcare for All* (DH, 2008)

Aim/Goal

NHS Foundation Trust Boards are required to certify that their Trusts meet requirements at the annual plan stage and in each quarter

Summary of Progress

This key indicator has also being monitored closely at the monthly Trust board meetings via Integrated Performance Tracker (IPT).

Period 2015-16	Q3	Q4	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Activity			100.0%			100.0%			100.0%			100.0%
Target/Plan	met	met	met			met			met			met
Variance to plan												

Question	CQC Questions
1	Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?
2	Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria?: a) Treatment, b) complaints procedures and c) appointments
3	Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning Disabilities?
4	Does the NHS foundation trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?
5	Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?
6	Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?

The Trust can confirm that each of the 6 criteria have been achieved for each quarter during 2015/16.

Attrition (drop-off) rate of breastfeeding prevalence between ten days and six weeks

Description of Priority

There is clear evidence that breastfeeding has positive health benefits for both mother and baby in the short and longer-term (beyond the period of breastfeeding). Breastmilk is the best form of nutrition for infants and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life. However, a majority of mothers give up breastfeeding in early weeks and infants therefore lose out on the many health benefits. Babies who are not breastfed are many times more likely to acquire illnesses such as gastroenteritis and respiratory infections in the first year. In addition, there is some evidence that babies who are not breastfed are more likely to become obese in later childhood. Mothers who do not breastfeed have an increased risk of breast and ovarian cancers and may find it more difficult to return to their pre-pregnancy weight.

Prevalence of breastfeeding at 6-8 weeks is therefore a key indicator of child health and wellbeing, with parents getting help and support with breastfeeding in hospitals and in the community from health visiting and midwifery teams, General Practices, Child Health services and Children's centres.

Although the breastfeeding prevalence remains an important indicator for public health, comparing the breastfeeding status of each child at six weeks with what it was at ten days is a better measure of how effective the Health Visitors are at supporting mothers who are breastfeeding to continue doing so, and our commissioners are now measuring our performance on this basis. The drop-off between the two is referred to as the attrition rate.

Aim/Goal

To support all mothers who have chosen to initiate breastfeeding to continue to do so, and increase the proportion of mothers who choose to continue to breastfeed until at least six to eight weeks after birth.

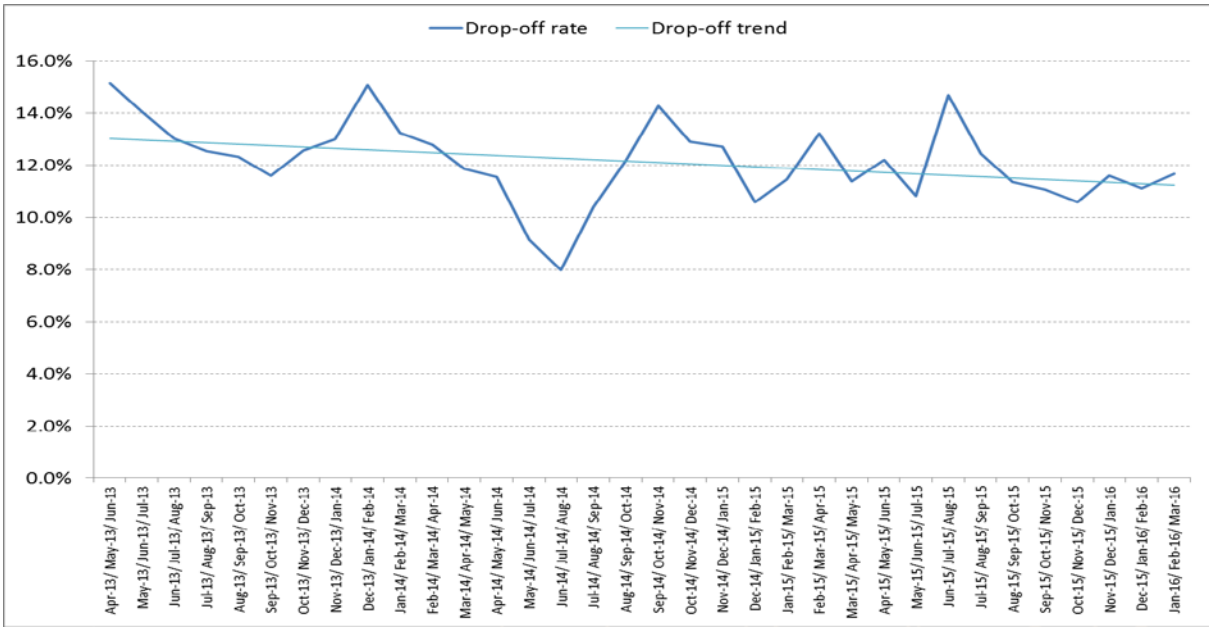
Summary of progress

After they leave hospital support for mothers and babies is provided by the Health Visitor service, which in the East Riding is provided by Humber NHS Foundation Trust.

From 1 October 2015, East Riding Council took over responsibility from NHS England for commissioning (planning and paying for) public health services for children aged 0-5 years old. This includes Health Visiting and Family Nurse Partnership (targeted services for teenage mothers).

The population definition has changed from babies registered with East Riding GPs to babies resident in the East Riding.

At the same time the key indicator for measuring our performance on supporting breastfeeding changed from using the six week prevalence rate to measuring the attrition rate.
The attrition rate fluctuates considerably each month, but comparing longer periods gives a more useful indication of progress. A lower attrition rate indicates good performance, as it indicates that a greater proportion of the mothers who were breastfeeding at ten days have been supported to continue breastfeeding until at least six weeks. Graph 1 illustrates that the long term trend shows a clear reduction (improvement) in the attrition rate.



The average attrition rate for 2015/16 was 11.7%.

The Trust considers that this data is as described for the following reasons:

- Breastfeeding is initially is initially supported by the midwife. Midwives continue to be responsible for supporting babies and their mothers for the first 10-14 days after birth, after which they become the responsibility of the Health Visitors until the child enters school. In the East Riding Humber Foundation Trust provides the Health Visitor element of the support for mothers and babies, starting with the Birth Visit, which takes place 10-14 days after birth.

- Breastfeeding prevalence at six weeks is highly dependent on whether or not mothers initiate breastfeeding the babies; any rise or fall in initiation rates directly impacts on the percentage of mothers who will be breastfeeding at six to eight weeks.

- We do not monitor initiation rates as we do not provide that part of the service. However, we do monitor the proportion of babies being breastfeeding at ten to 14 days (our first point of contact). Comparing that with the rate at six to eight weeks helps us to understand the impact our Health Visitors are able to make once the mother and baby have left hospital. The data is collected on our Health Visitor unit on SystmOne.

- The proportion of babies who are breastfed at ten days dropped by 0.6%, from 54.9% in 2014/15 to 54.3% in 2015/16. The proportion of babies who are breastfed at six weeks remained the same at 43% in 2014/15 and 2015/16. The attrition rate dropped (improved) from 11.85% in 2014/15 to 11.25% in 2015/16.

The Trust has taken the following actions to improve this % and so the quality of its service:

- The Trust's Children Services Management team are committed to and very supportive of the UNICEF BFI and are proud to have achieved Level 3 of the UNICEF BFI accreditation scheme in 2015. Government policy, underpinned by NICE guidance, promotes the adoption and implementation of the UNICEF Baby Friendly Initiative (BFI) as the best evidence-based vehicle to raise levels of breastfeeding prevalence. Evidence suggests that mothers delivering in Baby Friendly accredited hospitals are more likely to initiate breastfeeding and Community accreditation improves the length of time a mother breastfeeds.

- The Trust is continuing to work closely with Children's Centres to increase the amount of antenatal (pre-birth) contact pregnant women receive to help them make informed and healthy choices about breastfeeding.

Percentage of Patients Seen within 18 Weeks for (Admitted &) Non-Admitted Pathways (Community Services)

Description of Priority

The Trust provides consultant-led outpatient clinics at the Alfred Bean Hospital for a limited range of acute specialties including Orthopaedics and Cardiology in order to make the clinics more accessible to patients who would otherwise need to travel to the acute trusts in the region. The national target is for at least 95% of patients receiving outpatient care for these specialties to start their treatment within 18 weeks of referral. Clinics at the Alfred Bean Hospital only provide consultant-led outpatient care and do not undertake any inpatient care. For patients on an incomplete pathway the national target is set at 92%.

Underlying the 18 weeks target is the principle that patients should receive excellent care without unnecessary delay. The target focuses on patient pathways that do or might involve medical or surgical consultant-led care, setting a maximum time of 18 weeks from the point of initial referral up to the start of any treatment necessary for all patients who want it, and for whom it is clinically appropriate.

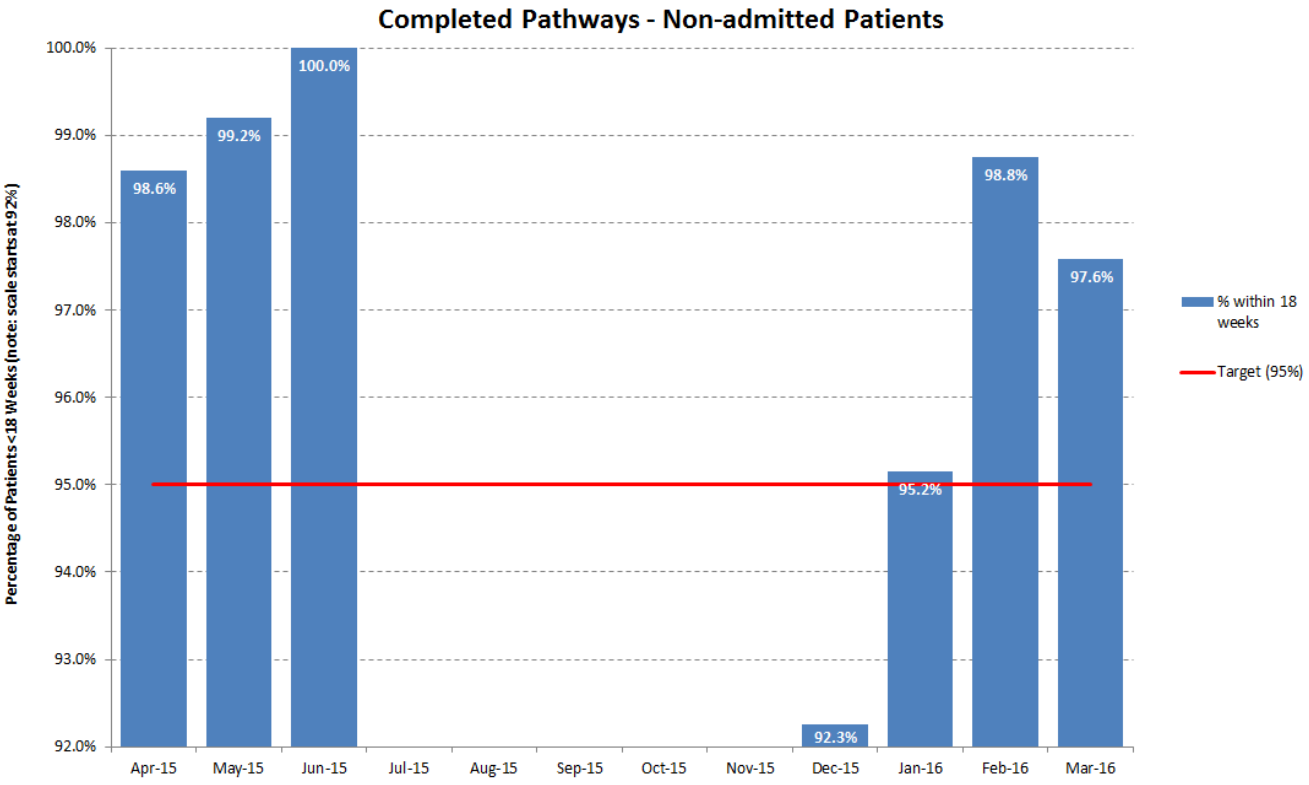
Aim/Goal

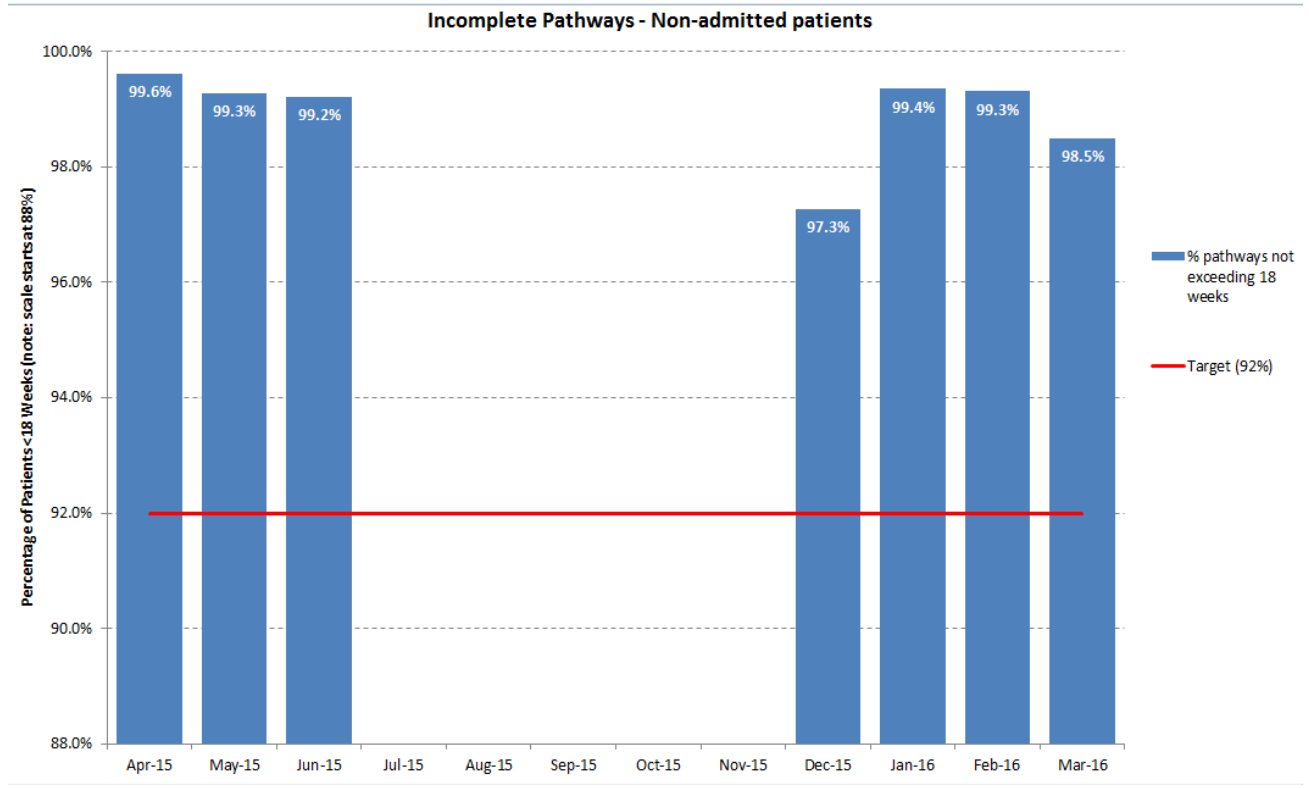
Because the target relates to the start of treatment, this will involve the majority of patients having had at least two appointments. The first appointment is to assess the patients' needs and potentially order diagnostic tests, and the second (or potentially third) is to start treatment. The team therefore works towards ensuring that the first appointment occurs early enough to allow for the return of any test results before the next appointment, which can take up to six weeks.

Summary of progress

During the reporting year, our acute provider of the 18 Weeks PAS System "Clinicom" moved to a new PAS system "Lorenzo" on the 8th June 2015, which unfortunately caused 5 months where data was not available due to inability to extract the correct data. The Trust treated patients in the consultant led outpatient clinics provided at Alfred Bean Hospital during April 2015 to March 2016, and has consistently ensured that over 95% of patients attending the clinics start their treatment within 18 weeks.

Graph





The HFT considers that this data is as described for the following reasons:

- Exception reports ensure that the service is notified of every patient who has not received definitive treatment and does not have a booked appointment within the necessary timescale to achieve the 18 week target. These patients are then targeted to ensure that appointments are booked.

- Data is sourced via the Clinicom April-June 2015 and Lorenzo since December 2015 patient administration systems.

The trust has taken the following actions to improve this % and so the quality of its service:

- Performance against the target is reported on a weekly basis. The team plans, monitors and prioritises each appointment to ensure that all outpatients at Alfred Bean start their treatment within the 18 week target. The clock start, end and (where appropriate) pauses, are governed by the National Standard definitions.

Percentage of Patients Seen and discharged / transferred within 4 hours for Minor Injuries Units

Description of Priority

The Trust provides three Minor Injuries Units (MIUs) across the East Riding of Yorkshire, which can treat a range of conditions, such as minor wounds and lacerations, suspected closed limb fractures, sprains and minor burns. These are nurse-led units. The nurses are highly skilled clinicians, with extended skill sets, who have all undertaken specific accredited training to enable them to work as nurse practitioners in the field of minor injury / illness.

The national target for other Accident and Emergency departments including Urgent Care Centre / Minor Injury Units is for at least 95% of patients attending to have a total time in the service less than 4 hours from arrival to discharge or transfer.

Underlying of the 4 hour target within Accident and Emergency and other Urgent Care Centre / Minor Injury Units is the principle that patients should receive excellent care without unnecessary delay. The target focuses on patients requiring treatment which can be accessed without an appointment for treatment at a minor injury or illness. The service has to have an average weekly attendance of more than 50 people, which is calculated over a quarter.

Aim / Goal

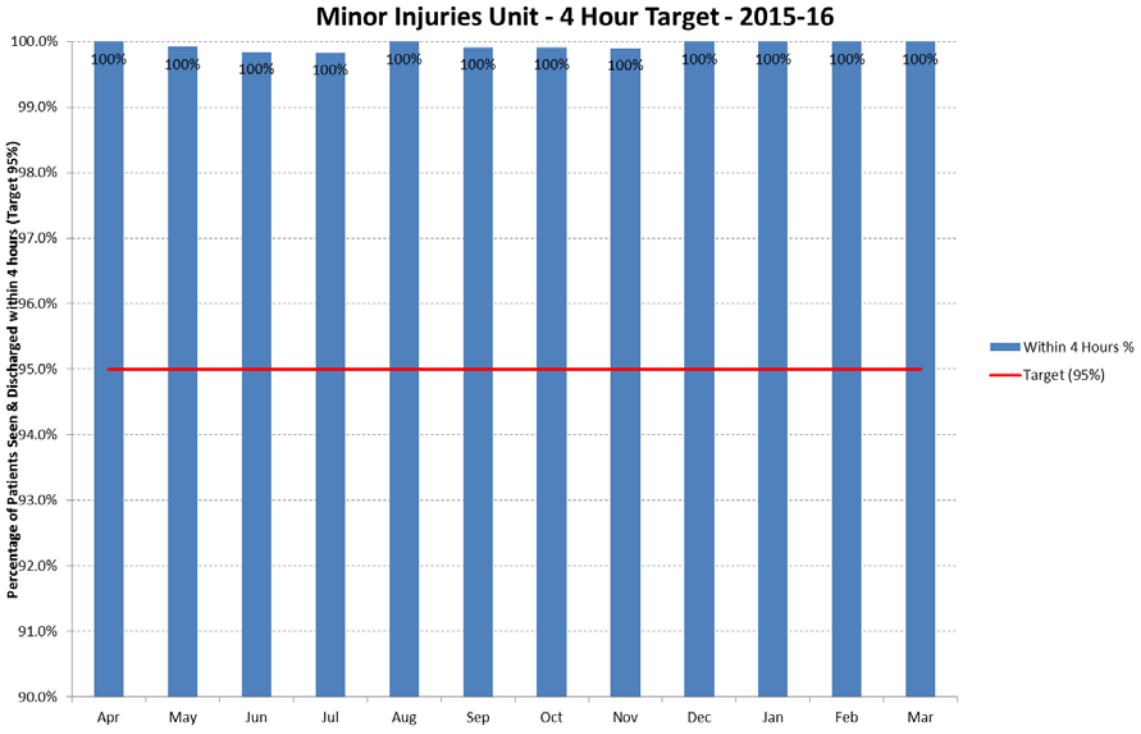
The target relates to when the patient arrives in MIU and stops when the patient leaves the service. For example, this could be is either on discharge or referred to an acute hospital for further management or admission.

The arrival time is logged on the patient administration system using the 24 hour clock and is then ended as the time of discharge or transfer is entered on the system. Taking into account ambulance transfers this would be no later than 15 minutes after the ambulance has arrived.

Summary of progress

The Trust seen 12,981 East Riding patients and 2770 Out of Area patients totalling 15,751 in the MIUs at Driffield, Hornsea and Withernsea during April 2015 to March 2016, and has consistently attained 100% of patients seen and discharged / transferred within 4 hours of arrival.

Graph



The HFT considers that this data is as described for the following reasons:

Time of Departure and Total time in the Department ends when the patient is discharged home or transferred.

Discharged home; Time of discharge home is defined as when the patient's clinical episode is finished, unless they are waiting for hospital arranged transport or social care/social service support. In these cases, the time of departure is the time the patient actually leaves the department. Patients awaiting family or 'private' transport or who wish to make their own arrangements should be considered discharged once the clinical episode is complete whether or not they have actually left the department.

Transferred; Transfer is defined as transfer to the care of another NHS organisation or other public/private sector agency (for example social services). Time of transfer is defined as when the patient leaves the department.

Data is sourced via the SystmOne patient administration system.

The trust has not had to take any actions to improve the % but will maintain its good practice and quality of service and continue to strive for excellence.

Safer Staffing

All hospitals in England are required to publish information about whether the amount of nursing care provided on wards/units meets the planned levels for those wards/unit. The information is presented as percentage ‘fill rates’ based on total hours actually worked as a proportion of the total planned hours.

This is part of the NHS response to the Francis report which said patients and their families needed a lot more information about how hospitals were being managed and run.

Safer Staffing links to the following Strategic Aims of the Trust:

- Deliver high quality, safe and effective services;
- Prioritise prevention, early intervention, recovery and rehabilitation; and

- Maintain a sustainable business to ensure that we can continue to care in the future.

What we are presenting in this report is a brief summary of the six-monthly board report that was presented to the public meeting of our Trust Board in March 2016, based on the six months to the end of December 2016 – the full report is available on our website. The purpose of the six-monthly safer staffing review is to provide intelligence to the Board and public with regards to:

- The staffing levels across the inpatient services of the Trust;
- How safe staffing levels are being maintained; and
- Where staffing levels fall short of establishment requirements, the impact this had on patients and staff in terms of delivering safe services that meet required quality outcomes.

The report is split into four sections based on our four Care Groups:

- Adult Mental Health Services
- Children's Services and Learning Disability Services
- Community Services and Older People's Care
- Specialist Services

There are no nationally set thresholds for rating the percentage nursing fill rates but we have benchmarked against similar trusts in setting our own thresholds. Although we have used a Red/Amber/Green (RAG) rating system in our reports, these are used to draw attention to the areas of concern rather than indicated poor performance, as the position on each unit needs to be understood in a wider context in terms of factors such as bed occupancy and the complexity and acuity of the patients on the ward/unit, which may require more (or occasionally less) staff than the standard planned level. We have set the following thresholds:

Lower thresholds, indicating staffing levels were below the planned levels and require investigation	• Below 75% of planned: Red • 75% to >90% = Amber
Within expected parameters, no further action	• 90% to >110% = Green
Higher thresholds, indicating that the staffing levels were above the planned levels, requires investigation	• 110% to >120% = Amber • Above 120% = Red

The upper thresholds are in place because it important to identify where a unit consistently requires staffing levels above the planned and budgeted levels, as this can indicate that the bed occupancy and complexity/acuity of patients regularly exceeds the expected levels and the staffing of the unit requires review.

Summary

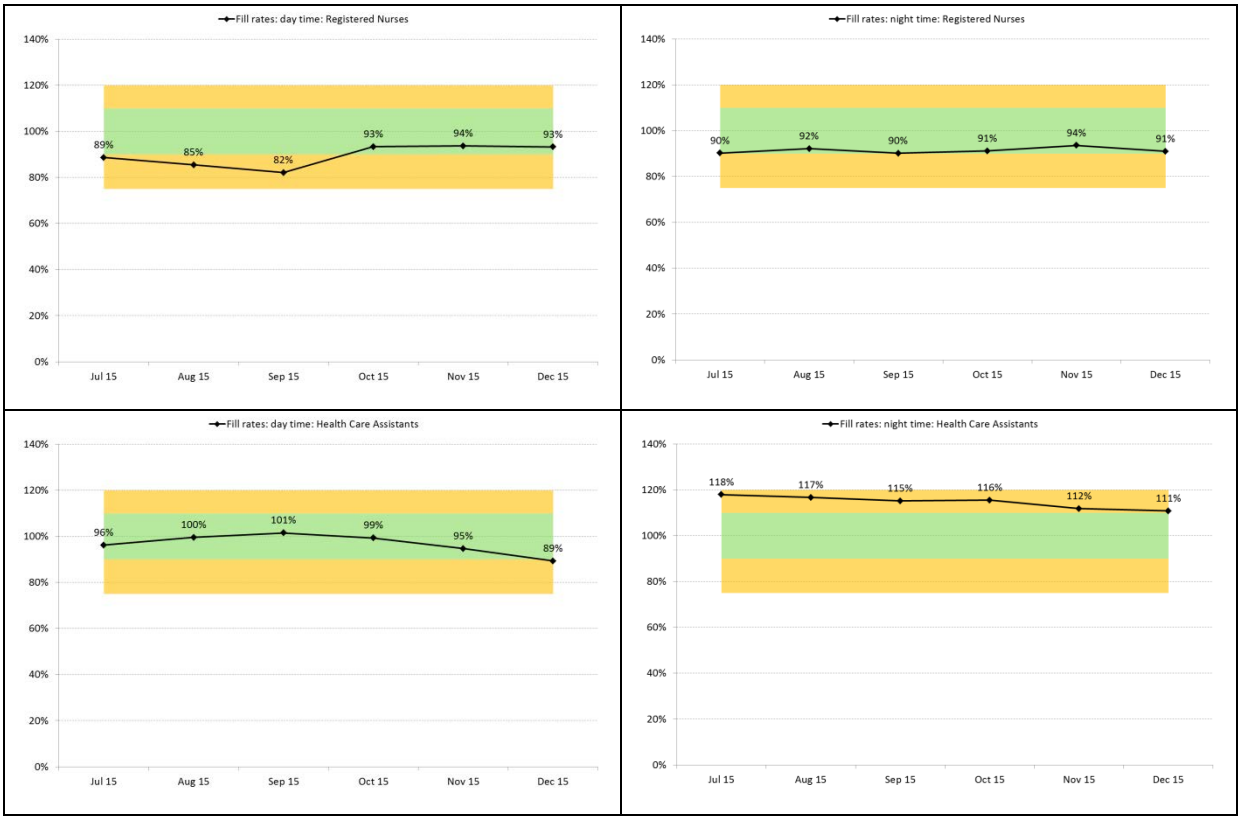
The main risk issue identified in the March 2016 Safer Staffing report is the ability to attract and retain registered nurses within the organisation against the national background of limited registered nurse availability. This risk is predominantly mitigated within the Trust by the use of bank staff and senior clinical staff covering shifts. The report highlights the planned work within the Trust to review current funded

establishments, shift patterns and clinical roles, led by the Care Groups supported by the Nursing and Quality Directorate.

Further work is planned during 2016 to revisit the staffing establishments for the wards, utilising some of the nationally available tools, safety and audit data and the clinical skills and knowledge from the Care Groups to review every staffing establishment within inpatient services. The Care Group Directors and Clinical Care Group Directors are leading on this work across their inpatient services.

The Trust is also planning to review the role of Assistant Practitioners within inpatient services. This will enable a focussed competency based approach to aligning clear roles and responsibilities to the Assistant Practitioners that may have previously been assigned to RNs.

Adult Mental Health Services

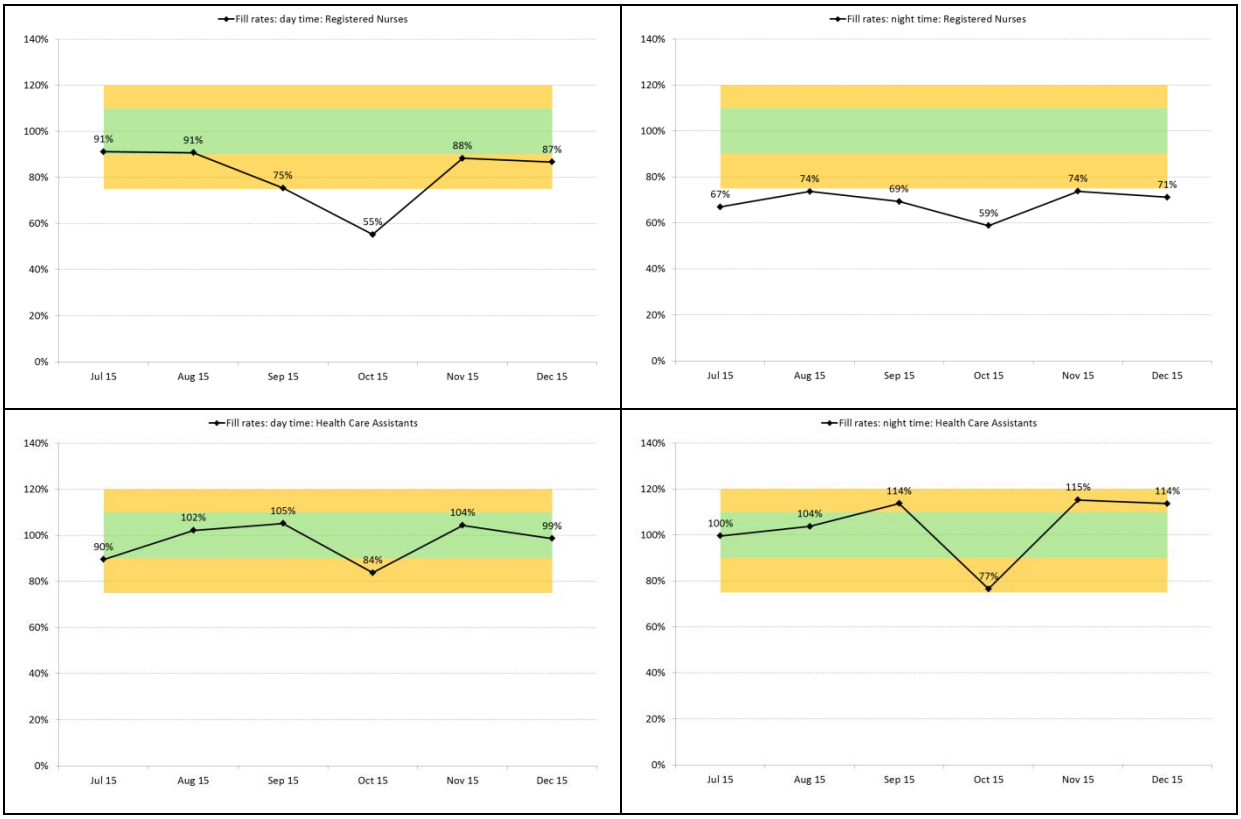


The adult mental health care group six month summary focused on the arrangements made for managing vacancies for Registered Nurses (RNs). Where two RNs could not be secured on duty, additional support workers were booked to cover shifts.

Over the six months reviewed, adult mental health care group was very proactive in looking for ways in which to attract nurses into the area including recruitment incentives/ premiums on appointment and a further incentive after one year service and commitment to further 6 months retention in post. This incentive was aimed at nurses for Band 5 and 6 posts.

In addition the care group was supported to undertake national advertising through the Royal College of Nursing (RCN) bulletin and radio and newspaper campaigns across Yorkshire and the Humber.

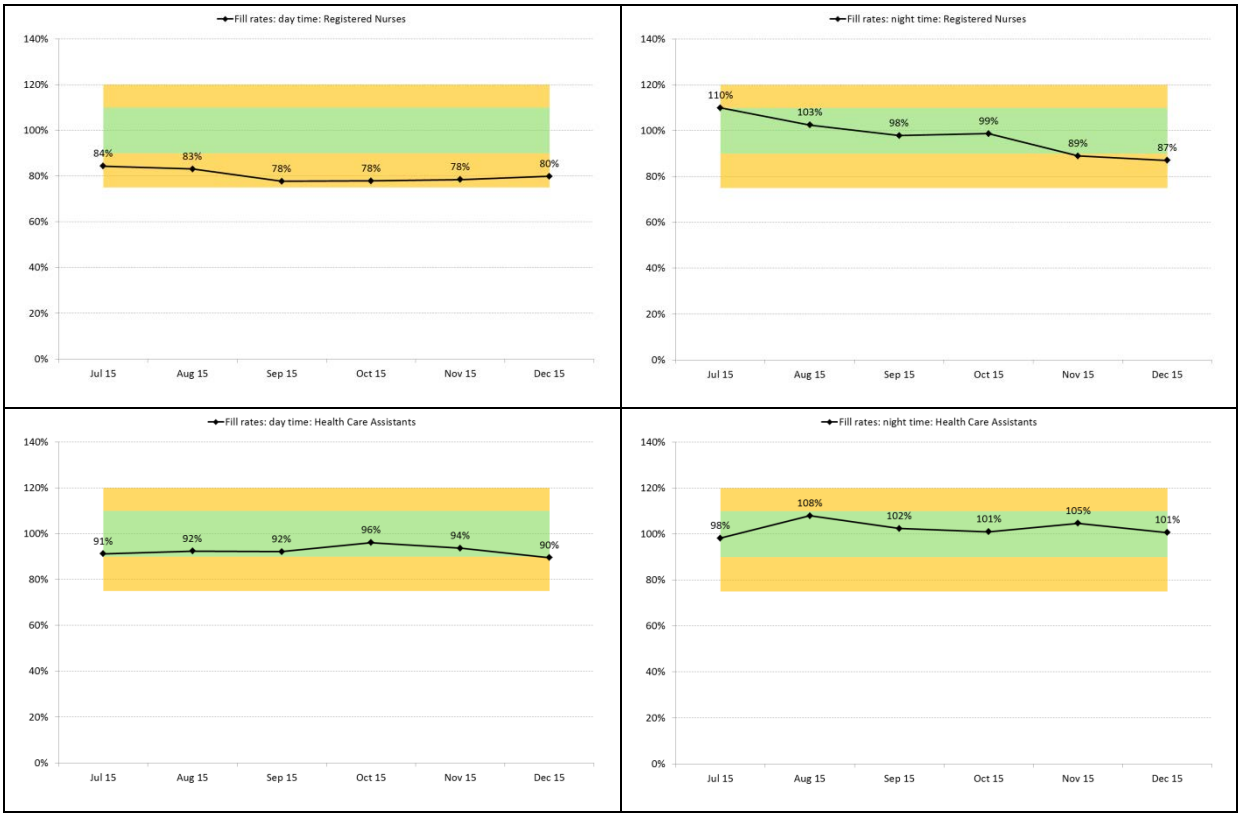
Children's Services and Learning Disability Services (learning disability wards only)



During the six-month period reported the staffing data for Townend Court was brought together from Lilac and Willow wards to better represent the two wards are managed and staffed together with a single roster. Overall Townend Court did not meet safer staffing levels in the past 3 months, with a significant deficit in the RN staffing numbers, particularly at night which has flagged red for the past 6 months.

A review of the staffing establishment was undertaken and adjustments made to the number of registered nurses required across the service to meet safer staffing on a night. The establishment has been reduced from three RNs to two to reflect the function of the third unit that is a step down rehabilitation service with only settled patients being admitted. The adjustment in establishment has resulted in the optimum staffing levels being realised consistently. At the time of the report there were five Band 5 nurses out for recruitment to the Townend Court Services; although some recruitment has taken place, as at the end of April 2016 the service was still carrying five Band 5 nurse vacancies.

Community Services and Older People's Care



The Community Services and Older People's Care Group clinical and service leads manage the acuity and dependency of the resident patients using a series of measures including:

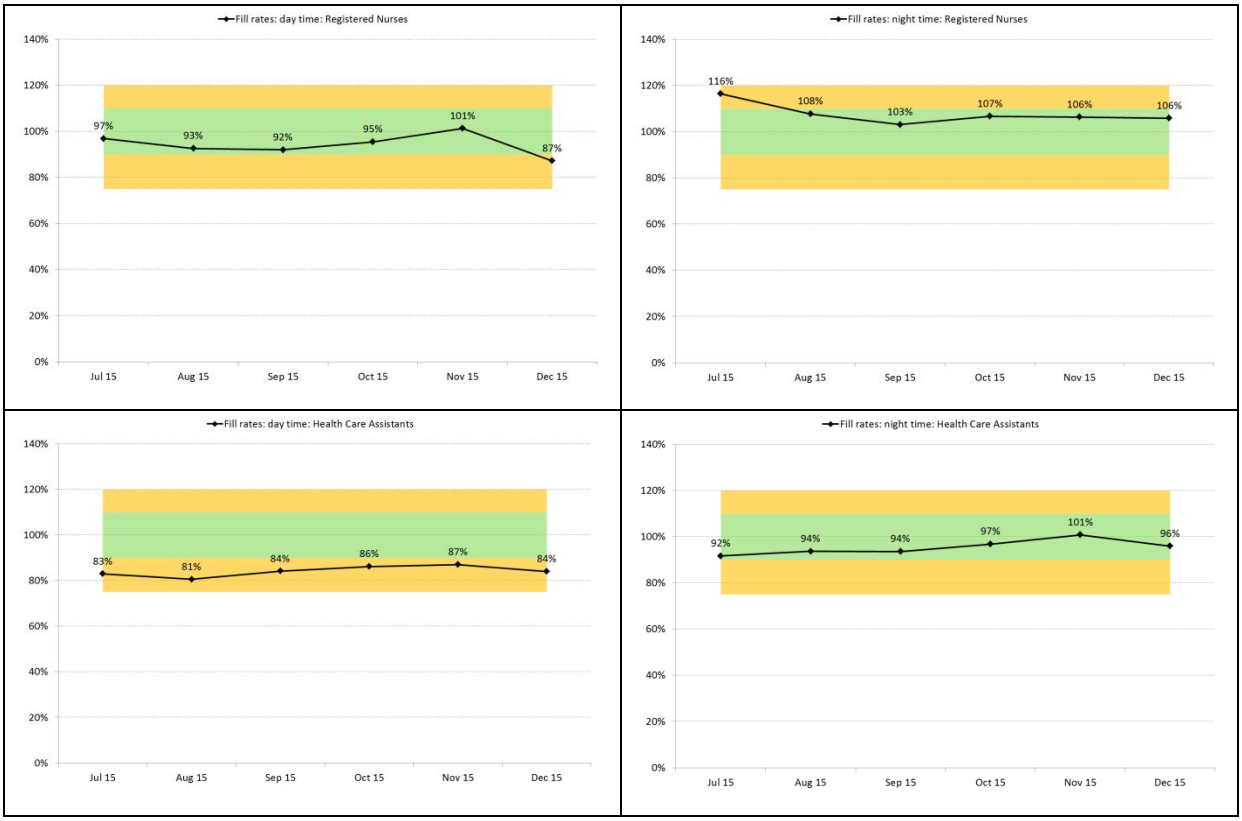
- Management of unplanned absence with deployment of managers and Allied Health Professionals (AHPs) into the delivery of direct patient care where appropriate;
- Employment of long-term bank contracts to cover vacancies;
- Reduction in the release of staff for non-essential duties as necessary; and
- Assessment on a daily basis of the acuity and dependency of patients in our care.

In addition the occupancy rate in each unit varies significantly as does the presenting needs of the resident patient group, meaning at times the Care Group is able to provide additional staff or reduce the number of staff to address the variables concerned with safety.

Although the community wards ran below the safer staffing numbers on the roster template in this reporting period, occupancy has not been above 85% at some points and have not required full staffing complement. In our other inpatient settings occupancy varies from 65% - 90% though again acuity and dependency is more variable than staffing numbers and occupancy rates.

East Riding Community Hospital (ERCH) averaged a fill rate of approximately 85% over the reporting period. Fill rates were not met during both day and night for RNs and for support staff during the day. Flexible workforce solutions were used with use of bank staff averaging at 26% over the period. As at the end of April 2016 staffing continues to be a challenge at ERCH.

Specialist Services



Within the Specialist Services Care Group the safer staffing report highlighted that Darley House appeared to be overfilling against planned staffing levels for RNs. This relates to the change of function of the unit and the consequent need to review staffing levels.

Work is ongoing within the Care Group to amend the template roster to ensure it reflects the working requirements.

During an audit of safer staffing figures reported on the following discrepancies were found:

- Adult day Registered October 93% (96% in report) Unregistered 99% (97% in report)
- Children Unregistered October 84% (85% in report)
- Community Night –
    - Registered July 110% (111%)
    - August Unregistered 108% (109% in report)
    - September Unregistered 102% (104% in report)
    - November Registered 89% (88%) Unregistered 105% (106% in report)
    - December Registered 87% (86% in report)

Whilst these don't affect the overall auditor's opinion we have a duty to disclose the above data discrepancies which have previously been published in the public domain.

Overall the shortage of applicants with the right skills, abilities and experience in many professions has created a more competitive market, coupled with an aging workforce and increasing turnover due to retirement. The ability to deliver high quality, compassionate care depends upon recruiting and retaining the right people with the right skills. Therefore, an effective recruitment and retention strategy that complements the Trusts workforce strategy and Trust objectives and vision is essential. The Trust will aim to achieve the following:

1. We will recruit high calibre healthcare professionals to ensure the provision of safe integrated care and high level clinical services and work towards a Value Based approach.

2. We will manage talent effectively so that it always has the right staff and skill mix to be able to respond speedily and effectively to necessary changes.

3. Ensure staff work effectively in their roles and find their working life to be an enjoyable and rewarding experience by the use of Supervision and PADR policies. Flexible patterns of work are also encouraged and managed in the context of Trust objectives

4. Reduce the Trusts dependency on bank staff and eliminate reliance on agency, reducing overall workforce costs as well as ensure the provision of consistent high quality care.

5. Continue to raise the profile of the Trust as the place to work and be treated

6. Maximise cost effectiveness of Recruitment Advertising and use of multimedia platforms

7. Improve the efficiency and dispel perception of the recruitment process being lengthy and with unnecessary delays.

8. Reduce the time taken to recruit and fill a vacancy by stopping unnecessary checks for internal staff moves.

The Trust will advertise all posts on the NHS Jobs. However NHS Jobs alone will not attract the significant calibre of applicants we aspire to, therefore the following media have been and will continue to be considered:

- Job fairs
- Open days
- On-line advertising campaigns
- Digital media
- Professional Networking
- Work Shadowing
- Social Media
- Face Book
- Twitter
- Linkdin
- Text alerts
- Web banners
- Work experience
- Apprenticeship Schemes
- Internships and placements
- Local/national newspapers (cost attached)
- Recruitment agencies

For those areas which have a high vacancy rate due to national shortages we could consider running focussed campaigns agreed by recruiting managers who would own the activity.

These could include:

- Vacancy and Directorate specific recruitment literature
- Ensuring a Trust presence at profession specific events

- Continued Social Media presence
- Open Days for specific professions or Divisions

3.2 Improving Services

Complaints and Patient Advice and Liaison Service (PALS)

The Complaints and PALS Department records and responds to complaints, concerns, comments and compliments received from all areas of the Trust. It is our procedure to allow the caller/complainant to decide whether they wish to have their concerns considered formally through the NHS Complaints Procedure or informally via PALS. Offering both services through one department allows the Trust to monitor all concerns raised, whether formally or informally, to see if there are any trends and to provide a consistent approach to complainants/callers.

Formal complaints

For the period 1 April 2015 to 31 March 2016, the Trust received 164 formal complaints which compares to 223 for 2014/15. The Trust responded to 167 formal complaints for 2015/16 which compares to 213 for 2014/15.

Each complaint is treated individually, as although the issues raised may be similar to others, the circumstances are often different for the individual concerned. The Trust aims to respond to formal complaints within 25 working days, although if at the outset it is considered that a longer investigation period may be required, the complainant is informed.

It is important to note that not all formal complaints are the result of a Trust failing or poor service. For example, a complainant may not be happy with the service provided because they consider their needs are different to what the Trust has assessed them as needing. At the outset of each complaint staff try to determine the complainant's desired outcome from making the complaint, however it is not always possible to give people what they seek.

The primary subject areas of the 167 formal complaints responded to are as follows:

Communications	48
Patient Care	28
Values and behaviours of staff	22
Appointments	21
Trust admin/polices/procedures	10
Admissions and discharge	7
Other	6
Prescribing	5
Access to treatment or drugs	5
Facilities	5
Clinical treatment	4
Staff numbers	2
Waiting times	2
All aspects of restraint	1
Integrated care	1

Of the 167 responded to, none of the complaints have taken their case to the Parliamentary and Health Service Ombudsman.

The following are some examples of actions/learning from complaints responded to between 1 April 2015 and 31 March 2016; all patient specific actions have been excluded.

- Adult Mental Health Community – All conversations, letter, documentation relating to referrals, assessments and appointments must be recorded on SystmOne and Lorenzo at the time this takes place to ensure this is not missed off the system for future use.

- Paediatric Speech and Language Therapy - To ensure that written report with advice and recommendations for future speech and language therapy interventions is completed for all children receiving an initial assessment with the Hull pre-school service.

- Adult Mental Health, Inpatient - Trained nurse dispensing medication to observe the health care assistant identify/administer giving patients their medication and inform all junior doctors to speak to patients about their medications before writing them on the medication card. To ask questions such as: has the GP made any changes to the dose(s) recently and have they been taking the medication at the dose(e) shown in the GP summary before admission.

- District Nursing - To increase the time slots for both blood clinics to minimum of 10 minute time slots and to have a maximum number of patients for the clinics due to time constraints of 2.5 hours. Also to discuss with the GP practice that if they wish to continue booking patients for the clinic then they will need to adhere to above recommendations, if not, then the patients to be referred to the clinic via normal pathway which is the patient contacting little SPOC for an appointment.

- Podiatry - Training to all staff in staff meeting that patients must be kept onto Podiatry service with increased risk of Diabetes - foot problems such as verruca/callus on a pressure area will need treatment regularly

- Secure Services - CPA reports should be given to the patient at least two weeks before their meeting, as per CPA standards, so that they can read and digest information. The professional who has compiled the CPA report should also sit down with the patient and go through it with them in case the patient needs anything clarifying.

- Older People's Mental Health - Joint review meetings between the Intensive Home Treatment Team and the unit each morning to discuss shared patients to include any issues relating to safeguarding and care plans to be documented in patients' case notes with a clear plan of who is to action any issues

Patient Advice and Liaison Service (PALS)

For the period 1 April 2015 to 31 March 2016, the Trust responded to 745 PALS contacts which compares to 639 for the previous year.

Of the 745 contacts, 202 were referrals to other Trusts. Of the 543 contacts for this Trust, 161 of these were compliments; the remainder were concerns or queries.

Priorities for 2015/16
To continue to manage and respond to complaints, concerns, comments and compliments for all our services. To aim to ensure staff are aware of the importance of a professional and informative response to patients and carers when they raise a concern or complaint.

Below are examples of a few of the compliments which have been received:-

Adult Mental Health, Inpatient - "I would just like to say that you are all wonderful people and thank you for trying to help me. I know you did your best. I really appreciate everything you have done for me and I will never forget you. You saved my life literally. I wouldn't be here if it wasn't for you so thank you from the bottom of my heart. You are all great at your job. I now know that you all do care about me and I will miss you and I will try not to come back this time. I love you all and thank you."

Community Hospital – "To all the staff, thank you so much, for all the help that you have given me over the last 6 weeks. I have really enjoyed myself and really appreciate all the support you have given me."

Older People's Mental Health, Inpatient - "I can't believe how well I am after 6 months it is amazing that I feel confident to tackle anything. I would like to thank everyone for the care and friendliness I have been given. I hope to keep in touch - possibly by volunteering. I will miss you!"

District Nursing - "About 3 months ago I badly hurt my leg. I want you to know that your District Nurses have cared for my leg and it is now ok. A nurse looked after me most of the time, she was very professional and I had great faith in her - she is a credit to the NHS."

Physiotherapy - "Just to say thank you very much for all the time, care and skills you have given to me. Together we have had a lot of success, more than expected"

Learning Disability Service - "(Patient's name) was transferred to your care from another unit were he had been sent after his behaviour had become unmanageable. With the treatment he has received and gradual reduction of his medication we have seen a tremendous improvement in his condition, both physical in his posture and energy levels, and mental he no longer presents as being very agitated and anxious. We are both tremendously grateful for all the staffs support to enable (patient's name) to become more like himself and are surprised at the speed this recovery has occurred."

Staff Survey

The NHS Staff Survey continues to be recognised as an important way of ensuring that the views of staff working in the Trust inform local improvements and outcomes for both staff and patients. The results from all participating Trusts are made available on the NHS Picker Institute, Europe website and benchmarked against similar profile Trusts. The survey is undertaken on the Trust's behalf by Quality Health an independent contractor using the nationally specified criteria.

The findings of the Annual Staff Survey are presented and considered by the Trust Board and the newly formed Workforce Strategy group will be monitoring the delivery of the action plan against the agreed key areas for improvement. The staff survey identifies the top and bottom ranking scores. The table below identifies these, alongside the scores (where available) from 2013.

Top 5 ranking scores	**2014**		**2015**	
	Trust	**National**	**Trust**	**National**
KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	93%	86%	92%	89%
KF29 Percentage of staff reporting errors, near misses or incidents witnessed in the last month	91%	92%	94%	92%
K28 Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	18%	25%	20%	22%
KF27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	41%	50%	50%	48%
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	22%	20%	21%	21%

Bottom 5 ranking scores	**2014**		**2015**	
	Trust	**National**	**Trust**	**National**
K10 Support from immediate managers	3.69	3.80	3.66	3.86
KF9 Effective team working	3.71	3.84	3.65	3.86
KF5 Recognition and value of staff by managers and the organisation	-	-	3.30	3.52
KF32 Effective use of patient / service user feedback	3.41	3.63	3.36	3.69
KF18 Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell	70%	61%	74%	60%

Staff told us that there were 3 areas that we needed to focus on to improve their experience of working for the Trust which were also confirmed within the 2014 staff survey results. We have focussed on developing these 3 areas during 2015 as follows and recognise there is still more to do.

Another area of improvement is access to and compliance with mandatory/professional training for staff. for example during 2015/16 compliance with MCA/DOLS training was not at an acceptable level. An improvement target of 75% has been set and at the 30 April 2016, the Trust was performing at 65% against this target. The Trust continues to closely monitor this key indicator.

Leadership, vision and values	• **We consulted with staff on a strategic framework which includes a proposed vision, values and strategic aims which has now been finalised.** • **An organisational development plan was developed with an action plan to help bring about some of the changes needed.** • **We agreed a leadership development programme with input from external support via Zeal Solutions which focuses on the development of supportive leadership behaviours. The programme has initially been used in specific service areas with very positive results and it will be rolled out within other areas of the Trust throughout the year.** • **We introduced a "new style" leadership forum and to date 4 events have taken place with around 100 attendees at each event.** • **The new care group structures are now in place which will help to improve the leadership within the organisation**
Meaningful communications	• The Trust engaged staff in the development of revised values during 2015. Staff's views were sought using various methods such as focus groups, written correspondence from the chief executive and in induction sessions for new staff. • We have developed a behaviour framework based on our agreed values with the aim of living our values in the workplace which we need to consult on. • A staff communications charter has been developed which will be rolled out. • The Director of Nursing has developed a revised director visibility programme, with all Board members aligned to service areas. More informal visits and pastoral visits by executive and non-executive directors also continue, with a number of visits across a range of services over the Christmas and New Year period including Christmas Day. • The new care group structure will help clarify lines of responsibility, accountability and improve communications within teams and across the organisation.
Improved information (electronic and non-electronic)	• An Information Technology (IT) strategy is in place which includes work to enable us to get the most out of our two clinical systems. • Various E-projects are being developed (eg total mobile and digital pens) which will help to support staff in their work.

Staff Awards

Our Staff Awards recognise and celebrate the inspiring and innovative work our staff do across the Trust every day to improve the lives of our patients and service users.

Staff from across the Trust were invited to nominate their colleagues and teams in any one of the following categories:

- Outstanding Team of the Year
- Outstanding Individual of the Year
- Innovation and Progress - sponsored by Safe at Home
- Improving Patient Dignity and Respect
- Improving Patient Safety - sponsored by Sewell
- Working in Partnership with other Agencies
- Delivering Compassionate Care - sponsored by Citycare
- Behind the Scenes
- Rising Star
- Championing Health and Wellbeing

In addition, there was also the Chairman's Award and Chief Executive's Award.

The winners and runners up were announced at a special ceremony on 2 December 2015. Our Trust's very own Strokestra, an amazing collaboration between our Hull Integrated Community Stroke Service and the Royal Philharmonic Orchestra, opened the ceremony with a moving performance that included a song they had written specially for the awards ceremony.

We were joined by a special guest, local BBC Health Reporter Vicky Johnson, who helped to present the awards to the winners.

This year our event was sponsored by Citycare, along with Sewell and Safe at Home who sponsored an award.

Strokestra

STROKESTRA is a pioneering collaboration between the Royal Philharmonic Orchestra (RPO) and Hull Integrated Community Stroke Service (HICSS) which uses group creative music-making to drive patient-led rehabilitation work in stroke survivors and their carers.

From May to October 2015, a total of 40 patients and carers took part in 16 days of intensive project work during which they tried out instruments, listened to music, conducted musicians, improvised and created music alongside world-class professional musicians, all supporting their work towards their stroke recovery goals.

Over a six month period, the team saw such a big difference in a lot of them – not just through mood but through physical movement, and also articulating. Some that have speech problems now are talking better – more fluent – it's given them a purpose and something to look forward to. The pilot programme (funded by the Hull City Council Public Health department) culminated in a high-profile performance outcome ahead of the Royal Philharmonic Orchestra's (RPO) season opening concert at Hull City Hall on Thursday 1 October 2015, featuring stroke survivors, carers, therapists and professional musicians performing original pieces of music in a celebratory showcase of their creative and rehabilitative successes with family and friends.

Watch this video here https://www.youtube.com/watch?v=0oroOmStN7M&feature=youtu.be to find out more about the positive effects STROKESTRA has had on stroke patients, their carers and Trust staff. Following the successful pilot last year, the RPO and members of our Stroke Service are continuing work on STROKESTRA and patients, carers, clinicians and musicians are working together to devise original pieces of music to be performed live in a public concert as part of the national BBC Music Day celebrations on Friday 3 June, 2016.

Recovery College

Our **Recovery College** was launched late last year and were delighted to see all 12 courses (including mind mapping, wellbeing through creativity and managing anger) **fill up within the space of a month.** The college is centred on three core principles:

- Hope that it is possible to work towards your own goals as defined by you
- Control of your own symptoms and future
- Opportunity to build a meaningful and satisfying life irrespective of your illness

It offers a range of recovery-focused educational courses and workshops free of charge for people who use our services and their carers/supporters as well as Trust staff. The courses are co-produced and co-delivered at community venues across Hull and the East Riding by people with personal and/or professional experience of mental health issues.

Proud to work for Humber

Wendy Cooper community nurse from the Beverley Neighbourhood Care Team has kindly shared her thoughts with us. Names and details have been changed for patient confidentiality.

“As a nurse I am from a breed that do not normally praise ourselves, in fact we are the opposite, always worried in case we could have done that better or should we have picked up on that sign...we are al-ways wanting to improve the care we give our patients, but this reflective piece is not about what I should have done that day but for once what I did do.
“At 10 am I arrived at the home of Simon and Sarah. Simon has battled with cancer for many years. On entering, the house was in chaos. Simon was an extremely poorly gentleman, he was semi-conscious and in his own bed, he was agitated, in pain and nauseous. Sarah was trying her hardest to hold her husband’s head up while offering him a vomit bowel and trying at the same time to help him take pain medication, which he clearly couldn’t swallow. Sarah was distressed and as I looked at her I could see tears streaming down her face. A truly desperate situation. “By 10.30am the “just in case” medication I had administered began to work and Simon became settled and was sleeping. “By 11am I had arranged an urgent GP visit and by 11.30am I had organised the same-day delivery of a profiling bed and air mattress.

“By 12 noon I had arranged a Marie Curie nurse to sit that evening and by 12.30pm I had arranged for a carer to visit later that day to care for Simon’s personal needs.

“On returning that afternoon, the GP had visited and completed the medication chart for me to commence the syringe driver and Simon was already sleeping on the profiling bed I had ordered that morning. With the help of a family member, we attended to Simon’s personal needs and combed his hair. “My shift was coming to an end and my work here was done. As Sarah thanked me and I opened the front door I looked around me and at that split second I felt like I was Nanny McPhee when she taps her stick on the floor and everything is in its place and calm has descended throughout the house.
“That night, Simon died peacefully in his sleep with his wife and the Marie Curie nurse by his side.
“I felt I had made a real connection with Simon and Sarah that day. Was it because they were similar age to me and my own husband? or was it because the care I gave Simon allowed him to have a “good” death? Or was it because of the resources I had available to me? Who knows? One thing I do know is how proud I am to work for the Trust ‘s adult services because the care we offer our patients in Beverley is truly outstanding.”

Annex 1: Statements from Commissioners, Local Healthwatch Organisations and Overview and Scrutiny Committees

NHS Hull Clinical Commissioning group welcomes the opportunity to review and comment on Humber NHS Foundation Trust's Quality Account 2015/16. It is pleasing to note that the report highlights the quality improvements made within the year which are contributing to the transformation of services.

We recognise that a new quality team and governance structure was established this year under the Director of Nursing, Quality and Patient Experience. We welcome the immediate impact and appreciate that the further changes will require time to embed and drive sustained improvements across the care groups.

We appreciate the Trust's support of the Hull 2020 transformation programme, especially the collaborative work on falls and are pleased to see the strengthened approach to patient safety. We welcome actions taken regarding the serious incidents process and we looks forward to ongoing assurance from the Trust regarding the sharing and embedding of lessons learnt across the health groups. Participation from an organisational representative in the commissioner led collaborative Serious Incident Panel will facilitate this.

We acknowledged the work that the Trust have completed arising from the priorities identified in previous years and we welcome the approach taken by the Trusts to consult with the CCG and the stakeholders in developing the priorities for 2016-17.

The report demonstrates participation in both local and national clinical audits in 2015-16 across the range of mental health and community services which reinforces Humber Foundation Trusts's commitment to improve practice through review and action. The audit outcomes and subsequent intended actions are acknowledges and we look forward to seeing these actions convert into improving clinical practice. The introduction of the research strategy 2015-17 and core funding for research demonstrates the Trust's desire to improve organisational engagement with research.

It was disappointing to note that Trust's Information Governance Assessment's Report overall score for 2015-16 grading as unsatisfactory due to the Trusts being unable to achieve compliance with Information Governance Training by the end of March 2016. Assurance in the actions being taken to rectify this would have enhanced the report.

The inclusion of examples of compliments received from in-patient and community services supports feedback from the Friends and Family Test and the Community Mental Health Survey. Whilst we are pleased to note the positive impact that the Trust is having on patient experience it would have been appropriate to mention areas of development or actions taken where services are not seemed as successful as the Trust would wish.

We are pleased to see that the organisation is focussing on improving staff experience in the three areas that were highlighted within the staff survey.

The draft report reflects an accurate picture on the Trusts on data included to date which in some areas is awaiting year end data. Taking that into account and the comments noted above, we can confirm that to the best of our knowledge, the report is a true and accurate reflection of the quality of care delivered by Humber NHS Foundation Trust and that the data and information contained in the report is accurate. NHS Hull CCG looks forward to continuing to work with the Trust to improve the quality of services available for our patients in order to improve patient outcomes.

Emma Latimer
Chief Officer
NHS Hull Clinical Commissioning Group

NHS East Riding of Yorkshire Clinical Commissioning Group is pleased to be given the opportunity ti review and comment on the Humber NHS Foundation Trust's Quality Report for 2015-16.

We are aware of the work the Trust has undertaken in the past year to restructure its services into care groups and are supportive of the work the Trust has done in the past year to establish a new quality team and a new governance structure to embed and drive quality improvements across the domains of patient safety, clinical effectiveness and patient and carer experience across the care groups.

We note the actions taken by the Trusts across the care groups in response to learning from complaints. We look forward to receiving assurance from the Trust that the actions and lessons learnt from Serious Incidents are shared across all care groups to ensure organisational learning from such incidents is consistently embedded in practice. An operational representative in attendance at the Serious Incidents Review panel with commissioners will be useful in achieving this.

Feedback from patients and carers through the Friends and Family Test and from the Community Mental Health Survey has shown that the majority of services provided by the Trust are regarded by those who use them as effective and as having a positive impact on the lives of people using them. It would be helpful to be made aware of the areas of development and actions which will be taken where services were not deemed as effective as the Trust would wish.

We acknowledge that work the Trust have completed arising from priorities identified in previous years and we welcomed the approach taken by the Trust to consult with the CCG and other key stakeholders in developing the priorities for 2016-17.

With regard to the Trust's Information Governance Assessment Report's overall score for 2015-16 graded as unsatisfactory due to the Trust being unable to achieve the requisite Information Governance training compliance standard by the end of March 2016, further information to explain the actions the Trust will be taking to resolve this would have been useful in this report

In relation to the staff survey, we note the ongoing commitment made by the Trust over the past year to improve Leadership, Vision and Values, Meaningful communications and improved Information Technology.

The Trust has continued to demonstrate participation in national and local clinical audits, confirming the Trust's ongoing commitment to improving practice through review and action. The audits are focused on both mental health and community services. The outcomes of the audits and actions taken have been acknowledged and provide an insight into the work undertaken.

Having reviewed the Quality Accounts there are areas within the submitted document for which we would like to see the inclusion of further information as follows:

The challenges the Trust continues to face regarding mandatory training compliance particularly in regards to Safeguarding and MCA/DOLS, this is not cited.

The ongoing challenges the Trust faces in the in the recruitment and retention of Nursing and Medical staff, this is not cited.

We are aware the Trust has faced adverse publicity within the local media from Serious Incidents which have been in the public domain via Coroners inquests, this is not cited.

Information about the closures of the Minor Injuries units due to staffing issues.

The draft reports reflects an accurate picture on the Trust based on data included to date which in some areas is awaiting year end data. Taking that into account and the comments noted above, we can confirm that to the best of our knowledge, that the report is a true and accurate reflection of the quality of care

delivered by Humber NHS Foundation Trust and that the data and information contained in the report is accurate.

NHS East Riding of Yorkshire Clinical Commissioning Group looks forward to working with the Trust to continue to improve the quality, safety and effectiveness of services for our patients and to continually improve patient outcomes.

Jane Hawkard
Chief Officer
NHS East Riding of Yorkshire Clinical Commissioning Group

We believe that the Quality Accounts are representative and give a comprehensive coverage of the services that the Humber NHS Foundation Trust provides.

We are happy with the progress that has been made in the areas of priorities identified in the 2014-2015 Quality Accounts. We recognise the difficulties faced in implementing a mobile working solution for mental health staff but welcome the focus on finding solutions to this challenge. In general we are satisfied that the ongoing priority actions will be completed in due course.

We are pleased that dementia remains a key priority in 2015-2016 and specifically dementia training for staff as this is an area we have identified as needing further improvement. We are also pleased that groups such as Mind and Rethink were involved in the consultation process and would recommend the strengthening of links with these and other VCS partner organisations.

It is disappointing that the Trust received an unsatisfactory rating in regards to Information Governance. However, we recognise that this was due to missing only one out of forty five requirements and we trust that this will be rectified very swiftly.

Despite the reported cases of Clostridium Difficile, we are satisfied that the Core Quality Indicator targets are being met, as are the National Key Priorities, and that patient safety remains a key priority of the Trust. We encourage the Trust to continue close surveillance in this area to ensure all targets are met and exceeded for the coming year.

In conclusion, we welcome the information provided in the Humber NHS Foundation Trust's 2015-2016 Quality Accounts and congratulate all members of staff for their hard work. We welcome any opportunities to work more closely with the Trust to facilitate greater engagement with patients and the public in relation to the services provided by the Trust.

Gail Purcell
Delivery Manager
Hull Healthwatch

Linsay Cunningham
Delivery Manager
East Riding of Yorkshire Healthwatch

The Humber Foundation Trust has engaged with the Council's Health, Care and Wellbeing Overview and Scrutiny Sub-Committee throughout its work programme 2015/16. This has included monitoring performance against the Trust's current priorities and previous CQC inspection outcomes. The Sub-Committee also welcomed the opportunity to participate and comment on the development of the 2015/16

Quality Accounts through an engagement workshop and were pleased to see that comments raised at that workshop have been taken into account.

The Draft Quality Accounts are set out in a clear and easy to understand format, with the progress made against previous year priorities clear to see. The Sub-Committee welcome the transparency of the Draft Quality Accounts, with the relevant evidence and data provided to support the outcomes.

Whilst the Sub-Committee recognise that a number of work streams are underway to improve and increase CAMHS provision across Hull and the East Riding, it is disappointing that CAMHS is not seen as a priority for 2016/17 Quality Accounts.

However, aside from that, the Sub-committee welcome the priorities set for 2016/17, particularly around the development of dementia training pathway for staff as with an ever increasing older population in the East Riding, this will area of work will be vital for future dementia patients and their families.

East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

Hull City Council's Health and Wellbeing Overview and Scrutiny Commission considered the Draft Quality Accounts on Friday, 15 April, 2016. The Commission supported the Draft Quality Accounts but raised wider concerns about the Trust's ability to recruit and retain staff as well as the financial pressures facing all healthcare providers and the potential impact on service users.

Hull City Council – Health and Wellbeing Overview and Scrutiny Committee

I believe that the Quality account is representative of the work which was undertaken by The Trust in the previous year.

It highlights many areas, some for concern and where new ways of working are striving to ensure that the best quality of care is provided to patients, carers, families and staff. Learning the lessons will be key to ensure a safe, sound and effective environment for all.

They are many innovative pieces of work being undertaken within the Trust, Research and Development will be key for the future, but innovative projects are making a difference now. One which struck a chord with so many people was the collaboration between the Royal Philharmonic Orchestra and Hull Integrated Stroke Services. The Recovery College has the potential to make a massive difference to enable and empower people to take control of their own future.

The comments from people who have received care from the Trust and the narrative from colleague Wendy Cooper from the Beverley Neighbourhood Team are inspirational and a testament to the continued hard work of staff and volunteers within the Trust.

Julie Hastings
Trust Governor

Annex 2: Statement of Directors' Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

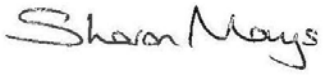
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

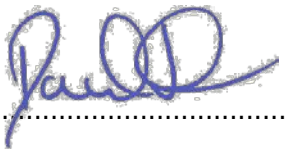
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2015 to April 2016
    - papers relating to Quality reported to the board over the period April 2015 to April 2016
    - feedback from commissioners April 2016, which the Trust has addressed in this final version of the accounts.
    - feedback from local Healthwatch organisations dated April 2016
    - feedback from Overview and Scrutiny Committee dated April 2016
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2016
    - the [latest] national patient survey2015
    - the [latest] national staff survey 2015
    - the Head of Internal Audit's annual opinion over the trust's control environment dated April 2016
    - CQC Intelligent Monitoring Report dated April 2015 to February 2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Trust has taken a number of steps to ensure itself of the robustness of data quality. Over the past 12 months the Data Quality policy has continued to be implemented. The Trust has met the data quality requirements of all our contracts. However our work in this area is not yet complete and we will continue to address the issues during 2016/17, this includes the set and implementation of an internal data quality group to oversee improvements
- the Quality Report has been prepared in accordance with Monitor's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

- The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board



26 May 2016.....Chairman



26 May 2016.....Chief Executive

Annex 3: Independent auditors report to the Council of Governors of Humber NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Humber NHS Foundation Trust to perform an independent assurance engagement in respect of Humber NHS Foundation Trust's quality report for the year ended 31 March 2016 (the "quality report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Humber NHS Foundation Trust as a body, to assist the Council of Governors in reporting Humber NHS Foundation Trust's quality agenda, performance and activities . We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Humber NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital; and
- Minimising delayed transfers of care.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the Monitor 2015/16 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated In all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period April2015 to April2016;
- papers relating to quality reported to the board over the period April 2015 to April 2016;
- feedback from the Commissioners dated May 2016 ;
- feedback from the Governors dated April2016;

- feedback from local Healthwatch organisations dated May 2016;
- feedback from the Overview and Scrutiny committee dated May 2016;
- Complaints report for 2015/16 Quarter 4;
- the latest national patient survey ;
- the latest national staff survey;
- Care Quality Commission Intelligence Risk Monitoring report dated February 2016; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April2016 .

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents "). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised)- "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included consideration of quality governance or non-

mandated indicators which have been determined locally by Humber NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the quality report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the quality report is not consistent in all material respects with the sources specified above; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte LLP
Chartered Accountants
Leeds
26 May 2016

Glossary

AIMS - Accreditation for Inpatient Mental Health Services	Accreditation which assures staff, patients and their carers of the quality of service that is being provided.
BMI - Body Mass Index	A measure of body fat based on height and weight.
Care Co-ordinators	A health care worker who is assigned a caseload of patients and is responsible for organising the care provided to them.
Care Plan	A document which plans a patient's care and can be personalised and standardised.
Care Review	A review of the care a patient is receiving, usually carried out between a healthcare professional and the patient to ensure that the care given is still meeting the needs of the patient.
CCG - Clinical Commissioning Group	NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Clostridium difficile	A type of bacterial infection affecting the digestive system.
Community Hospitals	The Trust has three Community wards providing short term 24 hour clinical care and rehabilitation Macmillan Wolds, Withernsea and East Riding Community Hospital.
CPA - Care Programme Approach	A multi-agency system used to assess, plan and co-ordinate care for a patients receiving mental health services.
CQC - Care Quality Commission	The independent regulator of health and social care services in England. The CQC monitors services by way of setting standards and carrying out inspections.
CQUIN - Commissioning for Quality and Innovation	A framework rewarding excellence in healthcare by linking achievement with income.
CRHT - Crisis Resolution Home Treatment	A way of treating patients at home who are requiring intensive mental health treatment rather than at hospital.
DoH - Department of Health	Responsible for Government policy on health and social care in England.
FFT - Friends and Family Test	A patient feedback survey used throughout the NHS asking whether patients would recommend services to their friends and family.
GP Practice RISC	A risk stratification tool that identifies patients who would benefit from preventative care
HDAT	High Dose anti-psychotic therapy
KPI - Key Performance Indicators	Indicators which help an organisation to measure progress towards goals.
Lorenzo	An electronic health record for patient records.

MONITOR	**Independent regulator for NHS Foundation Trusts**
MRSA - Methicillin-resistant staphylococcus aureus	A bacterial infection, resistant to a number of anti-biotics.
MSNAP	Memory Assessment Service Accreditation Programme
NCS - Neighbourhood Care Services	The Neighbourhood Care Team is a partnership between health and social services. It provides an integrated service which delivers services closer to home for people aged 18 and older who are registered with an East Riding of Yorkshire GP.
NHS England	NHS England is an executive non-departmental public body of the Department of Health.
NPSA - National Patient Safety Agency	Lead and contribute to improved, safe patient care by informing and supporting organisations and people working in the health sector.
Nursing Dashboard	Provides nurse sensitive indicators around patient safety
Palliative care	End of Life Care
PDSA	
PREM - Patient Reported Experience Measure	Assess the quality of care delivered to NHS patients from the patient perspective.
PROMS - Patient Reported Outcome Measures	Assess the quality of care delivered to NHS patients from the patient perspective.
SEQOHS - Safe Effective Quality Occupational Health Services	Accreditation which recognises Occupational Health services that provide safe, appropriate and effective care for staff.
SitReps – Situation Reports	A report on the current situation to inform of any issues within services at that time.
SystmOne	An electronic health record for patient records.
Talking Therapies	Talking Therapies is a friendly and approachable service that helps people with common problems such as anxiety, depression, stress and phobias
Trust Board	The Trust Board has overall responsibility for the activity, integrity and strategy of the Trust and is accountable, through its Chairman, to the NHS Trust. ...

Improving Health and Wellbeing

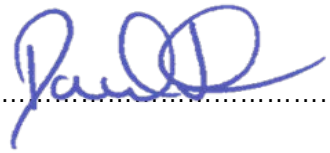
Humber NHS
NHS Foundation Trust

Humber NHS Foundation Trust
Financial Statements
2015/16

Foreword to the accounts

Humber NHS Foundation Trust

These accounts, for the year ended 31 March 2016, have been prepared by Humber NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed  ……

Name
Job title
Date **26 May 2016**

Statement of Comprehensive Income

	Note	2015/16 £000	2014/15 £000
Operating income from patient care activities	3	122,868	122,491
Other operating income	4	7,673	9,317
Total operating income from continuing operations		**130,541**	**131,808**
Operating expenses	5.1, 7	(133,742)	(129,996)
Operating (deficit)/surplus from continuing operations		**(3,201)**	**1,812**
Finance income	10	35	39
Finance expenses	11	(217)	(220)
PDC dividends payable		(1,860)	(1,943)
Net finance costs		**(2,042)**	**(312)**
Share of profit / (loss)		-	-
Gains/ (losses) arising from transfers by absorption	34	86	-
Movement in the fair value of investment property and other investments		-	-
Corporation tax expense		-	-
(Deficit) for the year from continuing operations		**(5,157)**	**(312)**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations		**-**	**-**
(Deficit) for the year		**(5,157)**	**(312)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(807)	(103)
Revaluations		3,554	2,292
Share of comprehensive income from associates and joint ventures		-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability/asset	30	4	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on available-for-sale financial investments		-	-
Recycling gains/(losses) on available-for-sale financial investments	10	-	-
Total comprehensive income/(expense) for the year		**(2,406)**	**1,877**

Statement of Financial Position

	Note	31 March 2016 £000	31 March 2015 £000
Non-current assets			
Intangible assets	14	594	536
Property, plant and equipment	15	66,146	66,985
Trade and other receivables	18	-	-
Other financial assets	29	-	-
Other assets		-	-
Total non-current assets		**66,740**	**67,521**
Current assets			
Inventories	17	99	109
Trade and other receivables	18	7,173	8,900
Other financial assets		-	-
Non-current assets for sale and assets in disposal groups	19	-	-
Cash and cash equivalents	21.1	14,659	12,348
Total current assets		**21,931**	**21,357**
Current liabilities			
Trade and other payables	22.1	(14,476)	(10,746)
Other liabilities	24	(508)	(1,045)
Borrowings	25	(255)	(255)
Other financial liabilities	23	-	-
Provisions	27	(527)	(768)
Liabilities in disposal groups	20	-	-
Total current liabilities		**(15,766)**	**(12,814)**
Total assets less current liabilities		**72,905**	**76,064**
Non-current liabilities			
Trade and other payables	22.1	-	-
Other liabilities	24	(58)	-
Borrowings	25	(4,468)	(4,723)
Other financial liabilities	23	-	-
Provisions	27	(1,020)	(974)
Total non-current liabilities		**(5,546)**	**(5,697)**
Total assets employed		**67,359**	**70,367**
Financed by			
Public dividend capital		43,693	44,293
Revaluation reserve		8,489	5,933
Available for sale investments reserve		-	-
Other reserves		4	-
Merger reserve		-	-
Income and expenditure reserve		15,173	20,140
Total taxpayers' equity		**67,359**	**70,366**

The notes on pages 8 to 44 form part of these accounts.

Signed 

Name David Hill
Position Chief Executive
Date **26 May 2016**

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

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**44,293**	**5,933**	**-**	**-**	**-**	**20,140**	**70,366**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	-	-	-	(5,157)	**(5,157)**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(191)	-	-	-	191	**-**
Other transfers between reserves	-	-	-	-	-	-	**-**
Impairments	-	(807)	-	-	-	-	**(807)**
Revaluations	-	3,554	-	-	-	-	**3,554**
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	4	-	-	**4**
Public dividend capital received	-	-	-	-	-	-	**-**
Public dividend capital repaid	(600)	-	-	-	-	-	**(600)**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	-	**-**
Other reserve movements	-	-	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2016	**43,693**	**8,489**	**-**	**4**	**-**	**15,174**	**67,360**

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

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

Information on reserves

Public dividend capital

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

Revaluation Reserve

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

Other Reserves

The balance of this reserve is the movement in the East Riding of Yorkshire Pension scheme, as far as, relates to the membership of the NHS foundation trust.

Income and Expenditure Reserve

The balance of this reserve is the accumulated surpluses and deficit of the NHS foundation trust.

Statement of Cash Flows

	Note	2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(3,201)	1,812
Non-cash income and expense:			
Depreciation and amortisation	5.1	2,730	2,453
Impairments and reversals of impairments	6	3,940	(194)
Loss on disposal of non-current assets	5.1	-	2
Income recognised in respect of capital donations	4	(36)	(98)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability	30	62	-
Decrease/ (increase) in receivables and other assets		90	(1,901)
Decrease/ (increase) in inventories		10	(12)
Increase in payables and other liabilities		2,811	521
(Decrease) in provisions		(216)	(620)
Tax (paid)/received		-	-
Operating cash flows movement of discontinued operations		-	-
Other movements in operating cash flows		-	2
Net cash generated from operating activities		**6,190**	**1,965**
Cash flows from investing activities			
Interest received		35	39
Purchase and sale of financial assets		-	-
Purchase of intangible assets		(212)	(306)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(2,351)	(4,200)
Sales of property, plant, equipment and investment property		1,809	1,000
Receipt of cash donations to purchase capital assets		-	-
PFI lifecycle prepayments		-	-
Investing cash flows of discontinued operations		-	-
Net cash generated (used in) investing activities		**(719)**	**(3,467)**
Cash flows from financing activities			
Public dividend capital received		-	493
Public dividend capital repaid		(600)	-
Movement on loans from the Department of Health		(255)	(255)
Movement on other loans		-	(10)
Capital element of finance lease rental payments		-	-
Capital element of PFI, LIFT and other service concession payments		-	-
Interest paid on finance lease liabilities		-	-
Interest paid on PFI, LIFT and other service concession obligations		-	-
Other capital receipts		-	-
Other interest paid		(185)	(198)
PDC dividend paid		(2,120)	(1,889)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated (used in) financing activities		**(3,160)**	**(1,859)**
Increase/(decrease) in cash and cash equivalents		**2,311**	**(3,361)**
Cash and cash equivalents at 1 April		**12,348**	**15,709**
Cash and cash equivalents at start of period for new FTs		**-**	**-**
Cash and cash equivalents transferred under absorption accounting	34	-	-
Cash and cash equivalents at 31 March	22.2	**14,659**	**12,348**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

Monitor is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the FT ARM which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow 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 Interests in other entities

Humber NHS Foundation Trust does not have any interest in other entities.

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 health care services.
Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. Humber NHS Foundation Trust does not receive income under the NHS Injury Cost Recovery Scheme.

Note 1.3 Expenditure on employee benefits

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

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

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

Local Government Pension Scheme
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 the Trust;
• it is expected to be used for more than one financial year;
• the cost of the item can be measured reliably, and the item has a cost of at least £5,000; or

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

• Items form part of the initial equipping and setting-up cost of a new 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.

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 fair value. 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 of IFRS 5.

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

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

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. Humber NHS Foundation Trust undertook a revaluation of the Estate by an independent valuer, Clark Weightman on 31 March 2016. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) appraisal and valuation manual.

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

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

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating 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.

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

Useful Economic lives of property, plant and equipment

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

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

Note 1.6 Intangible assets

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

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised 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;
• the Trust intends to complete the asset and sell or use it;
• the Trust has the 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
• the Trust 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. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of 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 - internally generated		
Information technology	-	5
Intangible assets - purchased		
Software	-	5

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 the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.
Financial assets are recognised when Humber NHS Foundation Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

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

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

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

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

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

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

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

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

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

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

Financial liabilities
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 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.
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, the 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 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 the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 27.2 but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.12 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 28 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.13 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 dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (I) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.14 Value added tax

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

Note 1.15 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 the 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 the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

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

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

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

Note 1.17 Third party assets

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

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.19 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted
The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:

IFRS 11 (amendment) – acquisition of an interest in a joint operation
IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation
IAS 16 (amendment) and IAS 41 (amendment) – bearer plants
IAS 27 (amendment) – equity method in separate financial statements
IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of assets
IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception
IAS 1 (amendment) – disclosure initiative
IFRS 15 Revenue from contracts with customers
IFRS 9 Financial Instruments

Note 1.21 Critical accounting estimates and judgements
In the application of Humber NHS Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

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

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

Note 1.22 Consolidation of Charitable Funds

Humber NHS Foundation Trust is the Corporate Trustee of the Humber NHS Foundation Trust Charitable Funds - Registered charity number 1052727. The Charitable Funds have not been consolidated into the accounts of Humber NHS Foundation Trust on the basis of immateriality. The balance of the funds at 31 March 2016 is £468k.

Note 2 Operating Segments

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

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2015/16	2014/15
	£000	£000
Mental health services		
Cost and volume contract income	1,794	281
Block contract income	66,624	67,681
Clinical partnerships providing mandatory services (including S75 agreements)	3,432	4,559
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	3,718	5,524
Community services		
Community services income from CCGs and NHS England	42,956	42,475
Community services income from other commissioners	861	1,023
All services		
Additional income for delivery of healthcare services	600	-
Private patient income	-	-
Other clinical income	2,883	948
Total income from activities	**122,868**	**122,491**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2015/16	2014/15
	£000	£000
CCGs and NHS England	110,800	112,263
Local authorities	8,379	7,833
Department of Health	-	56
Other NHS foundation Trusts	148	351
NHS Trusts	1,445	1,967
NHS other	-	-
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	-	-
NHS injury scheme (was RTA)	40	21
Non NHS: other	1,456	-
Additional income for delivery of healthcare services	600	-
Total income from activities	**122,868**	**122,491**
Of which:		
Related to continuing operations	122,868	122,491
Related to discontinued operations	-	-

Additional income for the delivery of healthcare services includes £600k received from the Department of Health as non recurrent support

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

	2015/16	2014/15
	£000	£000
Income recognised this year	-	-
Cash payments received in-year	-	-
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2015/16	2014/15
	£000	£000
Research and development	496	644
Education and training	3,668	3,571
Receipt of capital grants and donations	36	98
Charitable and other contributions to expenditure	-	-
Non-patient care services to other bodies	1,859	2,153
Support from the Department of Health for mergers	-	-
Profit on disposal of non-current assets	-	-
Reversal of impairments	1,201	1,708
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	245	808
Other income	168	335
Total other operating income	**7,673**	**9,317**
Of which:		
Related to continuing operations	7,673	9,317
Related to discontinued operations	-	-

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2015/16	2014/15
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	128,395	128,215
Income from services not designated as commissioner requested services	2,146	3,593
Total	**130,541**	**131,808**

Note 5.1 Operating expenses

	2015/16	2014/15
	£000	£000
Services from NHS Foundation Trusts	44	25
Services from NHS Trusts	179	177
Services from CCGs and NHS England	-	-
Services from other NHS bodies	-	-
Purchase of healthcare from non NHS bodies	1,090	815
Purchase of social care	-	-
Employee expenses - executive directors	812	1,065
Remuneration of non-executive directors	102	123
Employee expenses - staff	102,409	102,841
Supplies and services - clinical	4,157	4,547
Supplies and services - general	1,504	1,492
Establishment	3,494	3,114
Research and development	486	554
Transport	2,605	2,767
Premises	3,009	3,221
Increase/(decrease) in provision for impairment of receivables	(1)	27
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	-	-
Inventories written down	-	-
Drug costs	785	637
Inventories consumed	-	-
Rentals under operating leases	2,708	2,316
Depreciation on property, plant and equipment	2,577	2,301
Amortisation on intangible assets	153	152
Impairments	5,141	1,514
Audit fees payable to the external auditor		
audit services- statutory audit	67	56
other auditor remuneration (external auditor only)	20	-
Clinical negligence	358	384
Loss on disposal of non-current assets	-	2
Legal fees	243	314
Consultancy costs	615	307
Internal audit costs	93	87
Training, courses and conferences	1,024	733
Patient travel	40	36
Car parking & security	-	-
Redundancy	27	382
Early retirements	-	-
Hospitality	-	-
Publishing	-	-
Insurance	-	-
Other services, eg external payroll	-	-
Grossing up consortium arrangements	-	-
Losses, ex gratia & special payments	1	7
Other	-	-
Total	**133,742**	**129,996**
Of which:		
Related to continuing operations	133,742	129,996
Related to discontinued operations	-	-

Internal audit costs of £87k have been seperately shown in the 2014-15 figures, this was previously included in the establishment figure.

Operating expenses include an impairment expense of £5,141k (2014-15 £1,514k)

Note 5.2 Other auditor remuneration

	2015/16	2014/15
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	20	-
Total	**20**	**-**

Other Auditors Remuneration costs relate to an Informatics Advisory Workshop.

Note 5.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2015/16 or 2014/15.

Note 6 Impairment of assets

	2015/16	2014/15
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	3,940	(194)
Other	-	-
Total net impairments charged to operating surplus / deficit	**3,940**	**(194)**
Impairments charged to the revaluation reserve	807	103
Total net impairments	**4,747**	**(91)**

Humber NHS Foundation Trust revalued its Land and Buildings during the period, resulting in an impairment charge to revaluation reserve of £807k (2014-15 £103k), £5,141k as an operating expense (2014-15 £2,292k) and £1,201k reversal of impairments credited to operating income in the statement of comprehensive income (2014-15 £1,708k). This resulted in a net impairment of loss £4,747k (2014-15 gain £91k)

Note 7 Employee benefits

	Permanent	Other	2015/16 Total	2014/15 Total
	£000	£000	£000	£000
Salaries and wages	73,117	9,681	**82,798**	83,208
Social security costs	6,002	-	**6,002**	6,043
Employer's contributions to NHS pensions	9,953	-	**9,953**	9,768
Pension cost - other	126	-	**126**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	27	-	**27**	382
Agency/contract staff	-	4,769	**4,769**	5,379
Total gross staff costs	**89,225**	**14,450**	**103,675**	**104,780**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**89,225**	**14,450**	**103,675**	**104,780**
Of which				
Costs capitalised as part of assets	-	-	**-**	-

Note 7.1 Retirements due to ill-health

During 2015/16 there was 1 early retirement from the Trust agreed on the grounds of ill-health (10 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £32k (£419k in 2014/15). This information has been supplied by NHS Pensions.

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

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2015/16	2014/15
	£000	£000
Salary	796	1198
Taxable benefits	20	25
Performance related bonuses	15	0
Employer's pension contributions	83	251
Total	**914**	**1,474**

Further details of directors' remuneration can be found in the remuneration report.

Note 7.3 Staff Sickness Absence	2015/16	2014/15
	Number	Number
Total FTE Days Lost	26,719	27,671
Total FTE Days Available	2,421	2,414
Average Sick Days per FTE	11	11

The 2014-15 sickness figures has been recalculated on the same basis as the 2015-16 figures. The previous 2014-15 FTE days available calculated was 1,487 and the average sick days was 19. Staff
Sickness Absence figures are calculated on a calendar year basis.

Note 7.4 Management Costs	2015/16	2014/15
	£000	£000
Management Costs	7,536	7,426
Income	130,541	131,808

Management costs show the costs of running the organisation in comparison to the operating income of the organisation

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 designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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)

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.

Note 8.2 Local government superannuation scheme

East Riding of Yorkshire Pension Scheme

Further disclosure of the East Riding of Yorkshire Council Pension scheme relating to the Trust is shown in note 30.

Note 9 Operating leases

Note 9.1 Humber NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Humber NHS Foundation Trust is the lessor.

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

Note 9.2 Humber NHS Foundation Trust as a lessee

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

Following the NHS reforms as part of the Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, the lease for properties that the Humber NHS Foundation Trust occupied during 2015/16 are held by NHS Property Services. Although the Humber NHS Foundation Trust does not have a formal lease agreement in place with NHS Property Services, substance over form dictates that this is disclosed in the accounts as an operating lease. The minimum lease payment represents the recharge by NHS Property Services to the Humber NHS Foundation Trust in year.

	2015/16	2014/15
	£000	£000
Operating lease expense		
Minimum lease payments	2,708	2,316
Contingent rents	-	-
Less sublease payments received	-	-
Total	**2,708**	**2,316**

	31 March 2016	31 March 2015
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,799	2,286
- later than one year and not later than five years;	1,517	1,461
- later than five years.	3,304	3,343
Total	**7,620**	**7,090**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

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

	2015/16	2014/15
	£000	£000
Interest on bank accounts	35	39
Interest on loans and receivables	-	-
Interest on impaired financial assets	-	-
Interest on available for sale financial assets	-	-
Interest on held-to-maturity financial assets	-	-
Fair value gains / (losses) on other financial assets held at fair value through the income and expenditure	-	-
Recycling of gains / (losses) on available for sale financial instruments	-	-
Other	-	-
Total	**35**	**39**

Note 11.1 Finance expenditure

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

	2015/16	2014/15
	£000	£000
Interest expense:		
Loans from the Department of Health	195	198
Commercial loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	-	-
Other - Unwinding of discount	21	22
Other	-	-
Main finance costs on PFI and LIFT schemes obligations	-	-
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	**216**	**220**
Other finance costs	1	-
Total	**217**	**220**

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

	2015/16	2014/15
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Corporation tax

Humber NHS Foundation Trust is not subject to Corporation Tax during 2015-16.

Note 13 Discontinued operations

Humber NHS Foundation Trust had no discontinued operations during 2015-16

Note 14.1 Intangible assets - 2015/16

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**956**	**219**	**1,175**
Transfers by absorption	-	-	**-**
Additions	-	212	**212**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Reclassifications	431	(431)	**(0)**
Revaluations	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	-	-	**-**
Gross cost at 31 March 2016	**1,387**	**-**	**1,387**
Amortisation at 1 April 2015 - brought forward	**639**	**-**	**639**
Transfers by absorption	-	-	**-**
Provided during the year	154	-	**154**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Reclassifications	-	-	**-**
Revaluations	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	-	-	**-**
Amortisation at 31 March 2016	**793**	**-**	**793**
Net book value at 31 March 2016	**594**	**-**	**594**
Net book value at 1 April 2015	**317**	**219**	**536**

Note 14.2 Intangible assets - 2014/15

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

Note 15.1 Property, plant and equipment - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**9,915**	**50,235**	**-**	**3,955**	**1,292**	**121**	**8,402**	**1,128**	**75,048**
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	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2016	**8,010**	**53,282**	**-**	**1,894**	**1,939**	**121**	**9,705**	**1,128**	**76,079**
Accumulated depreciation at 1 April 2015 - brought forward	**(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	-	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	-	-	-	-	-	**-**
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**	**50,142**	**-**	**3,955**	**863**	**15**	**1,196**	**706**	**66,985**

Note 15.2 Property, plant and equipment - 2014/15

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

Note 15.3 Property, plant and equipment financing - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016									
Owned	8,128	52,185	-	1,894	649	-	2,051	572	**65,479**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	-	-	**-**
Donated	80	487	-	-	90	9	-	1	**667**
NBV total at 31 March 2016	**8,208**	**52,672**	**-**	**1,894**	**739**	**9**	**2,051**	**573**	**66,146**

Note 15.4 Property, plant and equipment financing - 2014/15

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

Note 15.5 Donations of property, plant and equipment
During 2015/16 Humber NHS Foundation Trust received a £36k for the purchase of ultrasound equipment.

Note 15.6 Revaluations of property, plant and equipment
All land and buildings are restated to current value using professional valuations in accordance with IAS 16.

Note 15.7 Investments - 2015/16
Humber NHS Foundation Trust held no investments in 2015/16 (2014/15 £Nil).

Note 15.8 Investment property income and expenses
Humber NHS Foundation Trust held no investment property in 2015/16 (2014/15 £Nil).

Note 16.1 Investments - 2015/16

	Investment property	Investments in associates (and joint ventures)	Other investments
	£000	£000	£000
Carrying value at 1 April 2015	**-**	**-**	**-**
At start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	-
Acquisitions in year	-	-	-
Share of profit/(loss)	-	-	-
Movement in fair value	-	-	-
Impairments	-	-	-
Reversal of impairment	-	-	-
Reclassifications to/from PPE	-	-	-
Transfers to/from assets held for sale	-	-	-
Disposals	-	-	-
Other equity movements	-	-	-
Carrying value at 31 March 2016	**-**	**-**	**-**

Note 16.2 Investments - 2014/15

	Investment property	Investments in associates (and joint ventures)	Other investments
	£000	£000	£000
Carrying value at 1 April 2014	**-**	**-**	**-**
Prior period adjustment	-	-	-
Carrying value at 1 April 2014 - restated	**-**	**-**	**-**
At start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	-
Acquisitions in year	-	-	-
Share of profit/(loss)	-	-	-
Movement in fair value	-	-	-
Impairments	-	-	-
Reversal of impairment	-	-	-
Reclassifications to/from PPE	-	-	-
Transfers to/from assets held for sale	-	-	-
Disposals	-	-	-
Other equity movements	-	-	-
Carrying value at 31 March 2015	**-**	**-**	**-**

Note 16.3 Investment property income and expenses

	2015/16	2014/15
	£000	£000
Investment property income	-	-
Direct operating expense arising from investment property which generated rental income in the period	-	-
Direct operating expense arising from investment property which did not generate rental income in the period	-	-
Total	**-**	**-**

Humber NHS Foundation Trust has no investments in 2015-16.

Note 16.4 Disclosure of interests in other entities

Humber NHS Foundation Trust has no interest in any other entity in 2015-16 (2014-15 £Nil).

Note 17 Inventories

	31 March 2016 £000	31 March 2015 £000
Drugs	-	-
Work In progress	-	-
Consumables	99	109
Energy	-	-
Inventories carried at fair value less costs to sell	-	-
Other	-	-
Total inventories	**99**	**109**

Inventories recognised in expenses for the year were £1,803k (2014/15: £2,016k). Write-down of inventories recognised as expenses for the year were £0k (2014/15: £0k).

Note 18.1 Trade receivables and other receivables

	31 March 2016 £000	31 March 2015 £000
Current		
Trade receivables due from NHS bodies	3,939	4,173
Receivables due from NHS charities	-	-
Other receivables due from related parties	1,559	1,611
Capital receivables	273	2,093
Provision for impaired receivables	(42)	(63)
Deposits and advances	-	-
Prepayments (non-PFI)	787	798
PFI prepayments:		
Capital contributions	-	-
Lifecycle replacements	-	-
Accrued income	401	196
Interest receivable	-	-
Corporation tax receivable	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
PDC dividend receivable	183	-
VAT receivable	73	92
Other receivables	-	-
Total current trade and other receivables	**7,173**	**8,900**
Non-current		
Trade receivables due from NHS bodies	-	-
Receivables due from NHS charities	-	-
Other receivables due from related parties	-	-
Capital receivables	-	-
Provision for impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments:		
Capital contributions	-	-
Lifecycle replacements	-	-
Accrued income	-	-
Interest receivable	-	-
Corporation tax receivable	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
VAT receivable	-	-
Other receivables	-	-
Total non-current trade and other receivables	**-**	**-**

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

Note 18.2 Provision for impairment of receivables

	2015/16	2014/15
	£000	£000
At 1 April as previously stated	**63**	**39**
Transfers by absorption	-	-
Increase in provision	26	37
Amounts utilised	(20)	(3)
Unused amounts reversed	(27)	(10)
At 31 March	**42**	**63**

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

Note 18.3 Analysis of impaired receivables

	31 March 2016		31 March 2015	
	Trade receivables	Other receivables	Trade receivables	Other receivables
Ageing of impaired receivables	£000	£000	£000	£000
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	42	-	63	-
Total	**42**	**-**	**63**	**-**
Ageing of non-impaired receivables past their due date				
0 - 30 days	572	-	504	-
30-60 Days	810	-	317	-
60-90 days	167	-	173	-
90- 180 days	75	-	225	-
Over 180 days	325	-	165	-
Total	**1,949**	**-**	**1,384**	**-**

Note 19 Non-current assets for sale and assets in disposal groups

	2015/16					2014/15
	Intangible assets	Property, plant & equipment	Investments in associates & joint ventures	Investment properties	Total	Total
	£000	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**	**-**	**-**	**-**	**3,191**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	**-**	**-**
Plus assets classified as available for sale in the year	-	-	-	-	**-**	**94**
Less assets sold in year	-	-	-	-	**-**	**(3,094)**
Less impairment of assets held for sale	-	-	-	-	**-**	**-**
Plus reversal of impairment of assets held for sale	-	-	-	-	**-**	**-**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	-	-	-	-	**-**	**(191)**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**	**-**	**-**	**-**	**-**

Note 20 Liabilities in disposal groups

	31 March 2016 £000	31 March 2015 £000
Categorised as:		
Provisions	-	-
Trade and other payables	-	-
Other	-	-
Total	**-**	**-**

Note 21.1 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.

	2015/16 £000	2014/15 £000
At 1 April	**12,348**	**15,709**
Transfers by absorption	-	-
Net change in year	2,311	(3,361)
At 31 March	**14,659**	**12,348**
Broken down into:		
Cash at commercial banks and in hand	235	197
Cash with the Government Banking Service	14,424	12,151
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**14,659**	**12,348**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**14,659**	**12,348**

Note 21.2 Third party assets held by the NHS Foundation Trust

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

	31 March 2016 £000	31 March 2015 £000
Bank balances	312	320
Monies on deposit	-	-
Total third party assets	**312**	**320**

Note 22.1 Trade and other payables

	31 March 2016 £000	31 March 2015 £000
Current		
Receipts in advance	-	-
NHS trade payables	1,676	1,519
Amounts due to other related parties	-	-
Other trade payables	2,187	367
Capital payables	1,929	1,470
Social security costs	1,373	1,316
VAT payable	-	-
Other taxes payable	1,839	1,832
Other payables		
Accruals	5,472	4,165
PDC dividend payable	-	77
Total current trade and other payables	**14,476**	**10,746**
Non-current		
Receipts in advance	-	-
NHS trade payables	-	-
Amounts due to other related parties	-	-
Other trade payables	-	-
Capital payables	-	-
VAT payable	-	-
Other taxes payable	-	-
Other payables	-	-
Accruals	-	-
Total non-current trade and other payables	**-**	**-**

Note 22.2 Early retirements in NHS payables above
Humber NHS Foundation Trust made no payments for early retirements in 2015-16

Note 23 Other financial liabilities
Humber NHS Foundation Trust held no other financial liabilities in 2015-16

Note 24 Other liabilities

	31 March 2016 £000	31 March 2015 £000
Current		
Deferred grants income	-	-
Deferred goods and services income	-	-
Deferred rent of land income	-	-
Other deferred income	508	1,045
Deferred PFI credits	-	-
Lease incentives	-	-
Total other current liabilities	**508**	**1,045**
Non-current		
Deferred grants income	-	-
Deferred goods and services income	-	-
Deferred rent of land income	-	-
Other deferred income	-	-
Deferred PFI credits	-	-
Lease incentives	-	-
Net pension scheme liability	58	-
Total other non-current liabilities	**58**	**-**

Note 25 Borrowings

	31 March 2016 £000	31 March 2015 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health	255	255
Other loans	-	-
Obligations under finance leases	-	-
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	-	-
Total current borrowings	**255**	**255**
Non-current		
Loans from the Department of Health	4,468	4,723
Other loans	-	-
Obligations under finance leases	-	-
Obligations under PFI, LIFT or other service concession contracts	-	-
Total non-current borrowings	**4,468**	**4,723**

Note 26 Finance leases

Humber NHS Foundation Trust had no Finance leases in the year 2015-16 (£Nil 2014-15).

Note 27.1 Provisions for liabilities and charges analysis

	Pensions - former directors	Pensions - other staff	Other legal claims	Agenda for change	Re-structurings	Continuing care	Equal pay	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2015	**-**	**427**	**123**	**-**	**-**	**-**	**-**	**196**	**996**	**1,742**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	-	-	-	-	-	**-**
Arising during the year	-	174	-	-	-	-	-	27	-	**201**
Utilised during the year	-	(81)	(12)	-	-	-	-	(192)	(84)	**(369)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	(44)	-	-	-	-	(4)	-	**(48)**
Unwinding of discount	-	7	1	-	-	-	-	1	12	**21**
At 31 March 2016	**-**	**527**	**68**	**-**	**-**	**-**	**-**	**28**	**924**	**1,547**
Expected timing of cash flows:										
- not later than one year;	-	88	68	-	-	-	-	28	343	**527**
- later than one year and not later than five years;	-	325	-	-	-	-	-	-	178	**503**
- later than five years.	-	114	-	-	-	-	-	-	403	**517**
Total	**-**	**527**	**68**	**-**	**-**	**-**	**-**	**28**	**924**	**1,547**

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.
Redundancy- This provision totalling £28k, relates to 3 posts.
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;
Onerous contract – lease costs for an unused property;
Insurance Provision – an estimate potential costs not covered by insurance in relation to repairing a flood damaged building;
Legacy invoices - relates to any potential outstanding invoices arising from the demise of PCTs.

The other figure of £924k include the following provisions:

	£k
Injury Provision	553
Merger Provision	83
Onerous Contract	111
Insurance Provision	75
Legacy Invoices	90
Unwinding of Discount (Other)	12
Total Other Provisions	924

Note 27.2 Clinical negligence liabilities

At 31 March 2016, £68k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Humber NHS Foundation Trust (31 March 2015: £1,149k).

Note 28 Contingent assets and liabilities

	31 March 2016 £000	31 March 2015 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	(32)	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**(32)**	**-**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(32)**	**-**
Net value of contingent assets	**-**	**-**

At 31 March 2016, Humber NHS Foundation Trust did not hold any contingent assets (2014-15 £Nil)

Note 29 Contractual capital commitments

	31 March 2016 £000	31 March 2015 £000
Property, plant and equipment	1,214	1,247
Intangible assets	-	-
Total	**1,214**	**1,247**

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

Note 30 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.

The 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 International Accounting Standard 19 (IAS19).

In the financial year 2015-16 Humber NHS Foundation Trust contributed £126k to the fund.

A pension deficit of £58,000 is included in the Statement of Financial Position as at 31st March 2016

Note 30.1 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 2016	01 December 2015
Pension Increase Rate	2.20%	2.50%
Salary Increase Rate	3.70%	3.90%
Discount Rate	3.60%	3.80%

Note 30.2 The estimated Fund asset allocation as at 31 March 2016 is as follows:

	31 March 2016	01 December 2015
	£000	£000
Equities Securities	40.5	-
Debt Securities	9.3	-
Private Equity	4.7	-
Real Estate	10.9	-
Investment Funds & Unit Trusts	25.0	-
Cash & Cash Equivalents	2.6	-
	93.0	-

Note 30.3 Changes in the defined benefit obligation and fair value of plan assets during the year

	2015/16	2014/15
	£000	£000
Present value of the defined benefit obligation at 1 April	**-**	**-**
Transfers by normal absorption	-	-
Current service cost	(126)	-
Interest cost	(1)	-
Contribution by plan participants	(28)	-
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains)/losses	4	-
Benefits paid	-	-
Past service costs	-	-
Business combinations	-	-
Curtailments and settlements	-	-
Present value of the defined benefit obligation at 31 March	**(151)**	**-**
Plan assets at fair value at 1 April	**-**	**-**
Transfers by normal absorption	-	-
Interest income	1	-
Remeasurement of the net defined benefit (liability) / asset		
- Return on plan assets	-	-
- Actuarial gain/(losses)	-	-
Contributions by the employer	64	-
Contributions by the plan participants	28	-
Benefits paid	-	-
Business combinations	-	-
Settlements	-	-
Plan assets at fair value at 31 March	**93**	**-**
Plan (deficit) at 31 March	**(58)**	**-**

Note 30.4 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

	2015/16	2014/15
	£000	£000
Present value of the defined benefit obligation at 31 March	**(151)**	**-**
Plan assets at fair value at 31 March	**93**	**-**
Fair value of any reimbursement right at 31 March	-	-
The effect of the asset ceiling at 31 March	-	-
Net (liability) recognised in the SoFP at 31 March	**(58)**	**-**

Note 30.5 Amounts recognised in the SoCI

	2015/16	2014/15
	£000	£000
Current service cost	(126)	-
Interest expense / income	-	-
Past service cost	-	-
Losses on curtailment and settlement	-	-
Total net (charge) recognised in SOCI	**(126)**	**-**

Note 31 On-SoFP PFI, LIFT or other service concession arrangements

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

Note 32 Financial instruments

Note 32.1 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

Credit risk

Because the majority of Humber NHS Foundation Trust's income comes from contracts with other public sector bodies, Humber NHS Foundation Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

Humber NHS Foundation Trust's operating costs were incurred under contracts with Clinical Commissioning Groups in 2015-16, 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 32.2 Financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2016					
Embedded derivatives	-	-	-	-	**-**
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 2016	**20,388**	**-**	**-**	**-**	**20,388**

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

Note 32.3 Financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
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**

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

Note 32.4 Maturity of financial liabilities

	31 March 2016	31 March 2015
	£000	£000
In one year or less	17,717	9,102
In more than one year but not more than two years	-	974
In more than two years but not more than five years	-	-
In more than five years	-	-
Total	**17,717**	**10,076**

Note 33 Losses and special payments

	2015/16		2014/15	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	10	1	22	6
Stores losses and damage to property	-	-	6	1
Total losses	**10**	**1**	**28**	**7**
Special payments				
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	-	-	-	-
Special severance payments	-	-	-	-
Ex-gratia payments	-	-	-	-
Total special payments	**-**	**-**	**-**	**-**
Total losses and special payments	**10**	**1**	**28**	**7**
Compensation payments received		-		-

During 2015-16 Humber NHS Foundation Trust had 10 bad debts written off totalling £1k (22 totalling £6k in 2014-15) and 6 cases of other totalling £1k (6 in 2014-15 totalling £1k).There have been no special payments made in 2015-16 (2014-15 £Nil)

Note 34 Transfers by absorption

As part of the commencment of the contract on 1st March 2015 for community services in Whitby, plant and machinery assets of £86k from York Teaching Foundation Trust transferred into Humber NHS Foundation Trust via transfer by absorption.

	£000
PPE : Cost	579
PPE : Accumulated Depreciation	(493)
Net Book value of transferred Assets	**86**

Note 35 Prior period adjustments

Humber NHS Foundation Trust has no prior period adjustment in 2015-16.

Note 36 Events after the reporting date

Humber NHS Foundation Trust has no events after the reporting date.

Note 37 Related parties

The Department of Health is regarded as a related party. During the period Humber NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	2015/16				2014/15			
	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000
Health Education England	3,328		414		3,533		425	
Hull & East Yorkshire Hospitals NHS Trust	1,291	1,118	263	281	1,771	964	319	307
Humber NHS Trust Charitable Funds	36				98			
NHS East Riding Of Yorkshire CCG	55,594		895		56,443	48	1,538	
NHS England	15,599	1	412		17,876	4	348	
NHS Hull CCG	36,014		592	43	35,115	26	743	
NHS Pensions Agency		9,953		1,373		9,293		
NHS Property Services	522	752	612	941	335	824	64	964
NHS Vale of York CCG	2,147		42		2,333		145	
Northern Lincolnshire & Goole Hospitals NHS Foundation Trust		34	83	8	335		86	9
York Teaching Hospital NHS Foundation Trust	60	810	45	152	22	761	10	81
Yorkshire Ambulance Service NHS Trust	177	155	77	13	205	335	47	34
Local Government Bodies								
Kingston Upon Hull City Council	1,613	556	285		3,028	258	201	2
East Riding of Yorkshire Council	6,789	1,027	406	49	5,333	1,318	715	

In addition, Humber NHS Foundation Trust has had a number of material transactions with other Government Departments and other central Government bodies. Humber NHS Foundation Trust had no transactions with related parties of senior staff of Humber NHS Foundation Trust.

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