Hull and East Yorkshire Hospitals
NHS Trust

NHS

ANNUAL REPORT AND ACCOUNTS

2015/16

Remarkable people.
Extraordinary place.

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ALTERNATIVE VERSIONS

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OVERVIEW

Statement from the Chief Executive

I am pleased to be reporting on our performance and achievements in 2015/16.

In last year's Annual Report, I stated that one of our priorities was to deliver our programme of cultural change to create the right environment for our staff to be able to deliver excellent patient care to the population that we serve. We believe that by improving the working lives of staff they will feel empowered to make suggestions and lead developments which will ensure that the care we provide is part of a continuous improvement cycle. I consider that we have made significant progress in 2015/16 against this agenda and this is evident from the results of the national staff survey, the national patient surveys and also our own quarterly staff friends and family survey.

We are beginning to see the benefits of our programme of cultural change being translated in to improved performance. 2015/16 has again been a challenging in delivering the NHS Constitution standards. However, at the end of the year we had made steady progress although we had not met all of our commitments. The delivery of the Emergency 4-hour wait target has been particularly challenging for us. Performance in April 2016 was 89.38% which was a big improvement and better performance than the whole of 2015/16. It was also ahead of the recovery trajectory agreed with NHS Improvement. We now need to demonstrate that we are able to sustain this improvement on an ongoing basis. We believe that we have the necessary building blocks in place to make this happen. We have a new Emergency Department, we have introduced a site management team of senior nurses covering the hospitals 24 hours a day and we have clinical teams of very dedicated staff who want to do the best for our patients. We recognise that we have some way to go to meet the national standard of 95% but this remains one of our key priorities in 2016/17.

We have also made steady progress in improving our performance against the 18-week treatment standard and the cancer standards. Whilst we did not meet all the standards in 2015/16, by the end of the year there were sufficient indicators showing positive improvement to demonstrate that the plans we have in place are beginning to deliver results. These indictors include the reduction in the number of people waiting for treatment over 18 weeks, the reduction in waits for cancer patients of over 104 days, reduction in the number of patients not treated within 28 days of last minute cancellations and people waiting over 52 weeks.

In May 2015 the Trust had a focussed re-inspection by the Care Quality Commission (CQC). The Trust has made good progress in responding to the issues raised. We are still rated as 'requires improvement' and the CQC is undertaking a comprehensive inspection in June 2016. The CQC identified 29 'must do' and 'should do' actions from May 2015 and we are able to demonstrate progress in the majority of these. Some of the recommendations require re-configuration of services such as the move from the paediatric ward from the top floor of the tower block at the Hull Royal Infirmary. This won't have happened by the time of the 2016 inspection, but we can show improvements in nurse staffing levels in the Emergency department, no longer outlying medical patients at Castle Hill Hospital, turnaround times for histopathology results, appointments times and staffing in echocardiography department, theatre environment, consultant paediatric surgeon establishment and many more.

In relation to our financial performance we ended the year in a much better position than planned and we met our statutory duty to break even for the three years ending 31 March 2016. Our outturn position was an £8.05m deficit, which was better than the projected deficit of £18.3m. However, we are not underestimating the challenge facing us in 2016/17. Our improved position was achieved through one off technical adjustments and therefore we are carrying an underlying deficit in to 2016/17. We know that we need to develop our plans further for addressing this and that there are external as well as internal risks to the delivery of the plan in the forthcoming year.

I am confident that we will see the improvements that we have made in 2015/16 being carried forward and sustained into 2016/17 and that by the end of the year we will be meeting our commitments. Our vision of Great staff, Great care and Great future is owned by our staff and our new values of care, honesty and accountability were chosen by them. There are many examples of where our staff have excelled during the year and we have much to be proud of.

Chris Long
Chief Executive
June 2016

PURPOSE AND ACTIVITIES OF THE TRUST

1. Introduction

Hull and East Yorkshire Hospitals NHS Trust (HEY Trust) is a large acute Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust was established in October 1999 through the merger of the former Royal Hull Hospitals and East Yorkshire Hospitals NHS Trusts. We employ just over 7,093 WTE staff, have an annual turnover of £555m and we have two main sites. The two main hospital sites are the Hull Royal Infirmary and Castle Hill Hospital. Outpatient services are also delivered from locations across the local health economy area.

2. Services provided

We provide a full range of urgent and planned general hospital services, covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These secondary care services are provided to a to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The Trust also provides specialist and tertiary services to a catchment population of between 1.05 million and 1.25 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services. The Trust is a designated as a Cancer Centre, Cardiac Centre, Vascular Centre and, Major Trauma Centre. The Trust is also a University Teaching Hospital and a partner in the Hull York Medical School.

In 2015/16 we:

- We assessed 137,126 people who attended our Emergency Departments (123,102 attended Hull Royal Infirmary and 14,024 attended Beverly Minor Injuries Unit)
- We had 706,914 attendances at our outpatient clinics
- We admitted 150,685 patients to our wards
- A further 13,926 re-attended our wards for a planned review following treatment

3. Vision, values and goals of the Trust

The vision of the Trust is 'Great Staff, Great Care, Great Future'. We believe that by developing an innovative, skilled and caring workforce, we can deliver great care to our patients and a great future for our employees, our Trust and our community. We have developed seven long term goals

- Honest, caring and accountable culture
- Valued skilled and sufficient workforce
- High quality care
- Great local services
- Great specialist services
- Partnership and integrated services
- Financial sustainability.

We have developed a set of organisational values – 'Care, Honesty, Accountability' in conjunction with our staff and these form the basis of a new Staff Charter which sets out the behaviours which staff expect from each other and what staff can expect from the Trust in return.

Great Staff - Great Care - Great Future

PURPOSE AND ACTIVITIES OF THE TRUST

4. Our catchment population

The local health system served by the Trust centres on the City of Kingston Upon Hull, its suburbs and the surrounding East Riding of Yorkshire, a rural area containing a number of market towns.

Hull is a geographically compact city of approximately 270,000 people. It was identified as the 3rd most deprived local authority in England in 2015 (Index of Multiple Deprivation, Department of Communities and Local Government). The health of people in Hull is generally worse than the England average, with life expectancy for both men and women being lower than the England average.

The East Riding of Yorkshire is predominantly a rural area populated by approximately 342,000 people. The geography of the East Riding makes it difficult for some people to access services. Life expectancy for men is higher than the England average. A larger proportion of the East Riding population is over 65 years of age compared to Hull.

Whilst the ethnicity of the two populations is predominantly white, Hull has a higher percentage of residents who are either South Asian, Black, mixed race, Chinese or other origin.

Although the two local authority areas are very different in their patient populations, health profiles, geographical landscape and distribution, common themes have emerged in respect addressing health inequalities, prevention and management of long term conditions. The higher incidence of deprivation in Hull and the ageing and increasing population of the East Riding requires the Trust to tailor its services to meet the needs of these two very different patient populations.

In order to address these challenges, the Trust is working with Clinical Commissioning Groups (CCGs) and health and care provider colleagues to develop integrated patient care pathways. We recognise that in order to improve services that we have to work together. We want to improve services for the frail elderly, patients with cardiac problems, those who have had a stroke and people who need cancer care. We also recognise that not all care will be delivered in hospital settings and that care will be delivered from an increasing number of community settings across Hull and the East Riding of Yorkshire.

KEY ISSUES AND RISKS THAT COULD AFFECT THE TRUST IN DELIVERING ITS OBJECTIVES

The Trust faced a challenging year in 2015/16 but has made steady progress in addressing the key issues. This section of the annual report sets out the background to the issues, the risk that they pose and the action we are taking.

The Care Quality Commission will be undertaking a comprehensive inspection of the Trust in June 2016. Good progress has been made in addressing the recommendations from the focussed re-inspection in May 2015. However the Trust has not had a full inspection since 2014 and the regulatory environment remains exacting. The Trust still has some further work to do but our national survey results for both staff and for patients are showing positive results. The Trust currently has an overall rating of 'requires improvement'. In 2016 the Trust is aiming to improve the ratings in the 3 areas that were deemed to be 'inadequate' and to maintain the ratings of 'good' where we were previously rated at this level. The Trust recognises the impact that a negative inspection can have both on the morale of the staff and also on its external reputation.

The Trust did not deliver all its key waiting times targets in emergency care, for elective patients and for cancer patients. During the year, external support has been provided whilst we have transformed our pathway for emergency medical patients and we now have comprehensive plans in place which will enable us to meet the required standard in 2016/17. We have also had external support for some surgical specialties that have struggled to reduce their waiting times for patients to be seen and treated. We still have a challenging year ahead and our success is dependent on a number of factors including whether we will be asked to see more patients than we have the capacity for, the ability of our partners to support us in discharging patients who no longer require hospital care and streamlining local health systems that can offer alternatives for those patient who do not need to be admitted.

The NHS national strategy is to integrate health and social care systems to provide better care for less cost with a focus on reducing demand on hospital services. In 2016 all providers have been allocated to a geographical area which will be required to produce a Sustainability and Transformation Plan (STP). The Treasury has set aside funding for investment into health which will increasingly be allocated on the basis of STPs. In 2016/17, the Trust has £14m non recurrent support from the STP. The plans of our two local commissioners are centred on the development of whole systems integrated care which will require significant transformational change and includes reducing the requirement for non-elective admission to hospital. The Trust will need to work closely with both commissioners as there is the potential that the Trust will need to reduce costs on a fairly large scale if the transformation plan delivers significant service change and demand is managed successfully to a lower level.

The Trust's overall financial position deteriorated in 2015/16 and we are carrying a recurrent deficit into 2016/17. Financial constraints will continue to be very challenging for health services in the coming years as the gap between forecast costs and the availability of funding is likely to grow. The Trust needs to identify a total CRES programme that delivers 3.5% of cost savings in 2016/17 when in the previous two years these have been at around the 2% level. The Trust needs to complete further work on how this will these be delivered. The Trust is working through recommendations of the Lord Carter Efficiency Review in addition to pursuing its own analysis of opportunities for increasing productivity and reducing cost.

The Trust faced difficulties in 2015/16 in recruiting staff in a number of key areas particularly Consultants in Emergency Medicine, Acute Medicine and Elderly Medicine. Whilst these problems are not unique to our Trust we have an additional challenge due to our relative geographic isolation. The impact of the introduction of the nursing bursary could reduce the number of nurses entering training and the Trust relies heavily on its ability to recruit nurses from the local school. We have developed a new recruitment programme, including a new approach to attracting new recruits to the Trust and early results indicate that this is having a positive impact. We are also developing new roles and asking our staff to adopt new ways of working and deliver services in innovative ways.

The Trust is in the process of implementing a major programme of cultural change. A focus of this is to ensure that we have the right level of accountabilities at every level of the organisation. Work is therefore being undertaken to more clearly define levels of responsibility and accountability and reviewing the layers of management so that there are fewer levels between front line clinical staff and the Board. There has also been a programme of re-centralising corporate functions (finance, human resources and clinical governance) to ensure consistency of systems and processes across the whole Trust. This will place the Trust in a better position for delivering the challenging agenda that lies ahead of us.

PERFORMANCE REPORT

This section of our Annual Report provides information about the Trust including its vision and values, the services that we provide and who we provide those services to. It also contains an overview of the challenges we face and how we are addressing them.

Chris Long
Chief Executive
28th July 2016

Performance Summary

The next section of the report sets out our performance against key targets and standards

- Key operational standards (see the table on page 17)
- Complaints performance (see page 15)
- Patient safety performance (see page 14)

Performance analysis

This section of the Annual Report sets out our most important performance measures and tells you how we did against them in 2015/16. They have been presented under our three values: Great Staff, Great Care, Great Future.

PERFORMANCE REPORT

Great Staff

Our staff are our greatest asset. Valuing, engaging and developing our staff is by far the most powerful approach we can have to achieving our vision. In 2014, we began to work to improve our culture beginning with the development of a new set of values for the organisation, which were developed by our staff. This work has continued throughout 2015/16. Our Chief Executive has made improving the organisation's culture his top priority and launched an ambitious programme of initiatives designed to create an environment true to our new values. The positive impact of this work has been recognised in our staff in the 2015 national staff survey.

There are 32 key findings in the national staff survey and an overall staff engagement score. Possible scores for the overall engagement score range from 1 to 5, with one indicating that staff are poorly engaged (with their work, their team and their Trust) and 5 indicting that staff are highly engaged. Our score was 3.74 which is a significant improvement in one year compared to 3.54 in 2014. Our performance is still just below the national average for acute trusts (3.79) and it is anticipated that this will improve further in the 2016 staff survey as our local survey results are showing positive progress.

Outcome	No. of questions	Question	2014	2015	National avge for acute Trusts 2015
Better than average	7	Recognition and value of staff by managers and the organisation	N/A	3.46	3.42
		Quality of non-mandatory training, learning or development	N/A	4.11	4.03
		% of staff experiencing physical violence from patients, relatives or the public in last 12 months	14%	12%	14%
		% of staff satisfied with opportunities for flexible working patterns	N/A	54%	49%
		% of staff experiencing harassment, bullying or abuse from patients relatives or the public	34%	25%	28%
		Fairness and effectiveness of procedures for reporting errors, near misses and incidents	N/A	3.74	3.70
		Support from immediate managers	3.54	3.70	3.69
Improved significantly	4	Staff recognising the organisation as a place to work or receive treatment	3.36	3.57	3.76
		Staff motivation at work	3.72	3.94	3.94
		Staff confidence and security in reporting unsafe clinical practice	3.46	3.62	3.62
		Effective use of patient/service user feedback	3.50	3.69	3.70
Bottom ranking scores	5	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	35%	38%	26%
		% of staff suffering work related stress in last 12 months	44%	45%	36%
		% of staff witnessing potentially harmful errors, near misses or incidents in last month	37%	35%	31%
		% of staff reporting errors, near misses or incidents witnessed in the last month	91%	87%	90%
		% of staff working extra hours	67%	76%	72%

PERFORMANCE SUMMARY
Great Staff

An action plan is in place to address key areas from the national staff survey where further improvements are required. Local staff surveys are undertaken quarterly and these demonstrate that we are continuing to make progress as a result of the initiatives in place, some of which are detailed below:

- **Mandatory briefing sessions:** over 700 staff attended these sessions in 2015/16. They outlined what was expected of our leaders to build their confidence in creating and sustaining an environment where staff can flourish
- **Staff Advice Line for staff (SAL's):** a confidential advice line was launched to enable staff to report inappropriate behaviour which was addressed immediately
- **Professional and Cultural Transformation training:** over 5000 staff attended these sessions which outlined the expected behaviours of our staff
- Revised leadership programme: The Trust's Great leaders programme was completed by 250 managers ensuring our leaders have the skills to lead and manage in accordance with the aims of our cultural change programme. A further programme is being developed based upon the Leadership Academy - 9 dimensions of leadership
- **Updated intranet site:** we have updated our intranet site to make it easier for staff to find the information they need. We are in the process of modernising a number of our paper based systems with electronic systems which will streamline systems, reduce bureaucracy and reduce costs.
- **Incident reporting system:** We have revised incident reporting processes so that we will be able to focus on those incidents that require investigation and other issues and concerns can be themed and used to support improvement work

The Trust has a number of workforce indicators that it monitors throughout the year. At the end of the year the Trust had met its performance targets for the following indicators:

- Staff sickness was below the 2014/15 level and was at 3.58% (previously 3.72%)
- Consultant appraisal had reached its target of 85%
- Statutory and mandatory training for all staff was at 86.6% (against a target of 85%)

The staff appraisal rate for those staff on Agenda for Change did not meet the target of 85%, although for 5 months of the year it was in excess of 80%. Managers receive monthly performance information on those staff who had not had their appraisal and a number of actions are in place which are aimed at improving performance in the forthcoming year. At the beginning of 2016/17 the Trust approved its People Strategy 2016-18 which sets out the action the Trust will take in relation to recruitment, innovation, learning and development. This includes the requirement that all staff should receive a quality appraisal using the on-line My Appraisal tool and have a personal development plan that is regularly reviewed by their manager.

The Trust saw turnover rates increase in the last three months of the year and exceeded the Trust target of 9.3% by 0.1%, although the target was met for 7 months of the year. The Trust recognises that the retention of qualified, skilled and experienced staff is critical to ensuring that we provide high quality, safe and effective care to our patients. The Trust's People Strategy sets out the initiatives that the Trust intends to take. This includes identifying and developing talented individuals, reviewing the induction programme particularly at team level so that new staff feel welcome and informed, delivering the Trust's Diversity and Inclusion action plan and launching our new Health and Wellbeing Strategy.

PERFORMANCE SUMMARY

Great Staff

Hull and East Riding Partnership – Nursing and Midwifery Strategy

A Nursing and Midwifery Strategy for Hull and the East Riding of Yorkshire has been developed in order to achieve a shared vision and strategic framework for nursing and midwifery across the local health economy. It encompasses the views of local nurses, midwives and leaders in health, social care, public health and education. The strategy sets out how local nursing and midwifery leaders will drive and support change to enable nurses, midwives and non-registered staff to be at the forefront of driving improvement at a local level. The key objectives are:

- Ensuring that we have the right staff, with the right skills and competencies, in the right place.
- Developing effective nursing and midwifery leadership.
- Promoting self-care, independence and optimising health outcomes.
- Delivering a positive experience of care and involving patients and service users in their care.
- Delivering safe, effective and high quality care.

As part of its commitment to delivery of the Nursing and Midwifery Strategy, the Trust is developing an implementation plan, with actions that contain specific and measureable outcomes. Progress towards these will be overseen by the local Senior Nurse Forum, which will also drive the development and delivery of any actions that are required across all organisations.

Golden Hearts Awards 2015

The Golden Hearts 2015 awards ceremony was held on 29th May 2015 at the Willerby Manor Hotel in Hull. The awards ceremony is held to recognise outstanding individuals and teams and the work that they do within the Trust.

- **Moments of Magic**
  Winner: Luke Singleton, Lisa Sleight, Sophie Crowther and Ellie Green (ICU)

- **Stronger Together: Partnership Working**
  Winner: Emergency Department Nursing and Support Staff

- **Great Leaders**
  Winner: Tina McDougall, Head of Nutrition and Dietetics

- **Making it Better**
  Winner: Perfusion Team

- **Volunteers of the Year**
  Winner: Graham Gedney and Marie Stern

- **Outstanding Individual – Scientific, Technical and Therapeutic:**
  Winner: Amy Lee (Pysiotherapy)

- **Outstanding Individual – Non Clinical:**
  Winner: Maria Penn (Human Resources)

- **Outstanding Individual – Clinical:**
  Winner: Mr Chittoor Rajaraman (Neurosurgery)

- **Outstanding Individual – Nursing and Midwifery**
  Winner: Vickie Quarshie, Headache Nurse Specialist

- **Outstanding Team – Non Clincial**
  Winner: Medical Education Technical Team

- **Outstanding Team – Clinical**
  Winner: Haematology Clinical Nurse Specialists

PERFORMANCE SUMMARY
Great Staff

Pioneer Teams September 2015 - March 2016
The projects below are currently being run as part of our Pioneer Team programme. The teams are a mixture of both clinical and non-clinical projects ranging from archiving processes, increasing number of patient scans, improving existing IT systems/processes or improving the patient experience by improving equipment or communications .

R&D Archiving Project
- **Project aims to reduce costs, improve environment and compliance with IG policies.**

- Vision: *"Streamline the archiving process with a 'one provider suits all' approach"*

Virtual MDT Project
- **Project aims to improve patient throughput by providing a single, robust process for the referral and MDT discussion of patients with bone and soft tissue infection.**

- Vision: *"A secure, web based platform to discuss the management of complex patients"*

MRI Project to Reduce Lost Scanning Time
- **Project aims to eliminate lost MRI scanning time with all patients escorted from wards in a timely manner and presenting fully prepped for scanning. The project will improve communications between wards and Radiology. It will reduce breaches, improve discharge rates and reduce LoS for patients who miss their scans.**

- Vision: *"Loss of scan time reduced to zero as patients have their best experience! A bespoke MRI service for all IPs. Identifying all individual patient needs and ensuring a 24 hour turn-around time for all Diagnostic IP MRI scans."*

Enabling Patients to Purchase OT Equipment On Site
- **Project aims to reduce length of stay, reduce patients anxiety and stress, increase patients confidence with hip precautions, improve patient experience and give some time back to OTs. We will establish way of enabling patients to have the opportunity to purchase essential small aids at pre-assessment appointment prior to hip surgery.**

- Vision: *"We are passionate about maintaining patient independence for their health and well-being. We believe that through providing elective orthopaedic patients with the means to easily purchase small aids onsite we can improve patient experience and facilitate timely discharge."*

Electronic Database to Minimise Never Events and Learn from SUIs
- **Project aims to design a clinical / management tool that can minimise never events (retained DJ stents after Surgery) and improve income of Paediatric Surgery.**

- Vision: *"Reduce never events through the creation of dedicated software to make the most of NHS clinical data — improving patient care through improved documentation. Paediatric Surgery will have an electronic database which has the capability to trawl through patients meeting a specific criteria, saving clinician time and improving the quality of care provided by our organisation."*

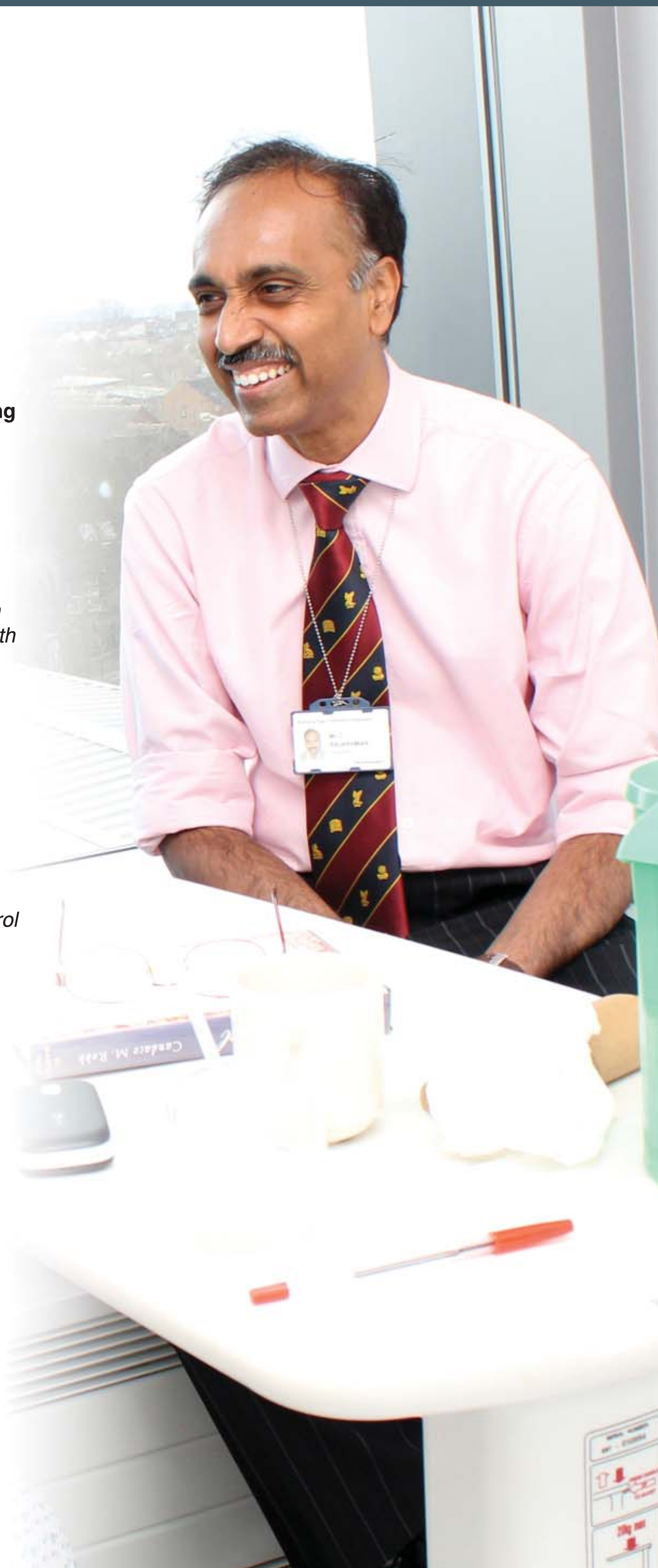
Decrease Vascular Referral Time
- **Project aims to decrease vascular referral time, increase number of booked referrals, decrease LoS, decrease in RTT times and improve discharge as a result.**

- Vision: *"Clinicians are patients too!' Referral process streamlining to develop and improve patient throughput within the vascular lab. Ensuring service is delivered in a timely manner, to improve patient experience and efficiency."*

Enable Staff to Easily Identify Clinical Trials Patients
- **Project aims to enhance staff awareness of patients involved in trials, increase the number of patients enrolled into trials and improve patient experience.**

- Vision: *"Patients' safety! Patients involved in clinical trials are extremely valuable to the future of medicine. We should ensure that their health and welfare is protected whilst in a trial. A green wristband will ensure that all staff who encounter and care for these patients are aware of their involvement in a trial."*

PERFORMANCE SUMMARY
Great Staff



Make It Possible for Patients to Charge their Mobile Phones in Hospital

- **Project aims to trial the use of a mobile charging station within the Trust, reduce the number of patients using personal device chargers within the ward area and understand the cost implications of using mobile stations and possible income generation for the Trust.**

- Vision: *"Reduce phone calls to ward areas freeing up nurse/midwife time, putting charging stations on patient/ward areas so patients can be in contact with family not using ward phones."*

Headache Education Programme

- **Project aims to encourage individuals to work collaboratively with GPs and become active managers of their condition, and to assist the GPs with an accurate diagnosis of primary headache and enable them to provide the most effective management plan in a timely manner.**

- Vision: *"Headache education program putting control back into the patients hands."*

PERFORMANCE SUMMARY

Great Care

The Trust uses a number of performance indicators to measure the quality of care that it provides to its patients. The Trust sets its own quality and safety priorities, following consultation with stakeholders and these are published in the Trust's Quality Accounts. In addition, the Trust Development Authority (now NHS Improvement) has a number of mandated indicators which cover patient safety, infection control, clinical effectiveness, maternity, patient experience and NHS Constitution standards.

Quality Accounts 2015/16

Each year the Trust publishes its Quality Accounts. These contain the details of the quality and safety priorities for 2015/16 and how we performed against them. The Quality Accounts are published on NHS Choices webpage and also on the Trust's intranet page. This Annual Report should be read in conjunction with the Quality Accounts.

PERFORMANCE SUMMARY

Great Care

Trust Development Authority (TDA) mandated indicators 2015/16

Patient Safety

The patient safety indictors used to measure performance relate to the reporting of incidents, the levels of harm free care, the completion of venous thromboembolism assessments and compliance with the Central Alert System (CAS).

Positive performance was reported against

- CAS alerts outstanding: The Trust met this target throughout the year and had no overdue alerts
- Proportion of reported patient safety incidents that are harmful: the Trust's performance was in line with peers

Areas where further improvements required:

Never Events:

The Trust reported 4 Never Events, although one occurred in 2013 but was not detected until 2016. All four incidents were due to staff not following established procedures. Procedures have been strengthened in the two departments where the incidents occurred. The Never Events occurring in 2015/16 are detailed below.

- Two wrong site surgery. Both incidents occurred in the Radiology Department and required the patients to return to hospital for the correct procedure to be undertaken
- There was one retained swab in the obstetric service. The patient returned to the hospital and the swab was removed during examination (a further Never Event was reported in 2016 but occurred in 2013. This was also a retained swab and procedures in the Trust had already changed since the incident occurred).

Venous thromboembolism assessment (VTE):

The Trust's formal reporting systems showed an underperformance throughout the year against the target of 95%. New reporting arrangements using an electronic system were introduced in 2015 and not all the assessments have been recorded on this system. It is therefore considered that actual performance is much higher than the formal system indicates. Arrangements have been put in place to resolve this issue so that reported performance in 2016/17 will improve.

Percentage of Harm free care (safety thermometer):

A target of 95% was set for 2015/16. The thermometer comprises of four indictors (pressure ulcers, falls, urinary infections and VTE). The Trust met this for 5 months of the year, with the remaining months recorded between 92.98% to 93.98%. The Trust is working with the Improvement Academy, part of the Yorkshire and Humber Academic Health Sciences Network to gain access to benchmarking data for the safety thermometer. Overall, the Trust considers that performance against the thermometer is positive.

Infection control:

The Trust measures 4 infections: clostridium difficle, Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia, Meticillin Staphylococcus Aureus (MSSA) bacteraemia and Escherichia-coli (E.coli) bacteraemi.

Clostridium difficle: In 2015/16 the Trust had 46 cases (deemed to be Trust apportioned by Public Health England) against an upper threshold of 53 and was one of 6 Trusts in the Yorkshire and Humber region to achieve positive performance (out of 14 Trusts). There were 28 wards that had not had a Clostridium difficile infection in over a year.

Methicillin Resistant Staphlococcus Aureus (MRSA) bacteraemia: The Trust reported 2 MRSA bacteraemias, one in May and one in June 2015. For the last 9 months of the year no other Trust apportioned MRSA cases were reported.

Meticillin Staphylococcus Aureus (MSSA) bacteraemia: There is no national guidance relating to data definition of MSSA bacteraemia cases enabling targets to be set. However the Trust was required by commissioners to have fewer case than in the previous year (2014/15). The Trust reported 39 cases against a threshold of 45, representing year on year positive performance.

Escherichia-coli (E.coli) bacteraemia: There is no national guidance relating to E.coli bacteraemia cases so again, the Trust was required to have less cases than the previous year. The Trust reported 95 cases against a threshold of 95.

During 2015/16 the Department of Infection was created with an aim of delivering a seamless service bringing together Infection Prevention & Control, Infectious Diseases and Microbiology supported by both medical and nursing leadership. The development of the service has provided the opportunity to identify key areas of improvement during 2015/16 which is reflected in the positive performance demonstrated within this report.

PERFORMANCE SUMMARY

Great Care

Trust Development Authority (TDA) mandated indicators 2015/16

Effectiveness:

There are 4 mortality indicators that the Trust is measured against. Information on mortality is published a number of months in arrears. The latest information relates to December 2015 and the Hospital Standardised Mortality rate was 74.23, (weekend 70), Risk Adjusted Mortality Indicator 77 and Summary Hospital Mortality indicator 112.50 (September 2015). The Trust has introduced systematic case note review with the support of the Improvement Academy.

Maternity:

The maternity dashboard contains 5 indicators and the Trust has performed well against these. The service reported a maternal death in January 2016. However, the death occurred following the patient's discharge from hospital and was unrelated to her obstetric care. National reporting requirements mean that this must still be recorded as a maternal death as the death occurred within 6 months of delivery. The Trust's midwife to birth ratio remains lower than the recommended ratio of 1: 28 but is within acceptable limits.

The results of the national maternity survey 2015 were also very positive. The Trust uses an external company to conduct the survey on its behalf. 410 patients were sent a questionnaire and 175 returned a completed questionnaire giving a response rate of 43%. The Trust had improved significantly compared to its results in 2014 for receiving appropriate advice and support from a midwife during labour and birth. The Trust results on the following four questions were also better than the average compared to other Trusts who used the same external company.

- Midwives asking mothers at the antenatal check-up how they were feeling emotionally
- Having a midwives telephone number during pregnancy
- Being offered a visit by a midwife post natal at home
- Confidence and Trust in the visiting midwife (post natal care at home)

The Trust did not receive any results in 2015 that were significantly worse than those received in the last survey in 2013.

Patient experience :

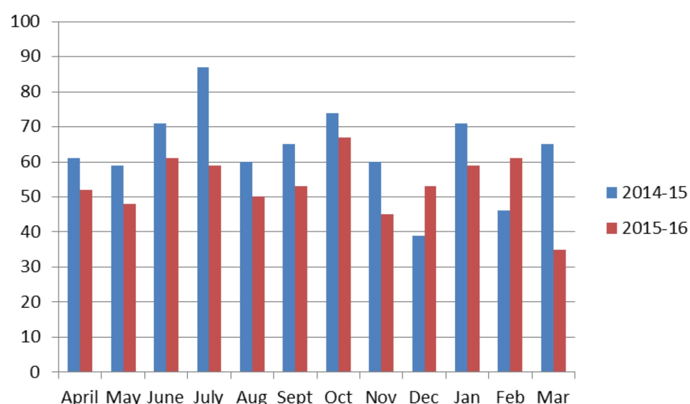
Patient, family and carer experience is very important to us. Listening and acting on feedback provided by our patients and their relatives is crucial to learning lessons and to further improve our services. We want our patients to have the best possible experience at what can be a very worrying time. There are 11 indicators that the Trust uses to measures performance. These relate to national patient surveys, the Friends and Family test, complaints and compliance with mixed sex accommodation requirements.

At the time of writing this report, the Trust is still awaiting the publication of the 2015 in-patient survey. However, we have received some initial feedback from the organisation that conducts the survey on our behalf. The early results indicate that we have improved significant compared with our results in 2014 on the following questions:

- Patients having enough privacy when being examined or treated in the Emergency Department
- Time to get a bed on a ward following the decision to admit
- The number of nurses on duty
- Patients wanting to be more involved in decisions
- Having enough privacy when discussing condition or treatment
- Receiving an explanation of what would be done during an operation
- Questions before surgery being fully answered.

Complaints:

The Trust saw a 17% reduction in formal complaints received in 2015/16 (642) compared to the previous year (769). During 2015/16, 650 complaints were closed (some relating to the previous year). Of these 207 complaints were not upheld, 161 were partly upheld and 282 upheld. There was also an improvement in the number of complaints closed within 40 days in each of the 4 Health Groups.



Number of complaints by month

PERFORMANCE SUMMARY

Great Care

Trust Development Authority (TDA) mandated indicators 2015/16

The key issues raised in complaints were:

- Treatment
- Delays in receiving treatment
- Care provided

Set out below are some the actions taken as a result of complaints received:

- The medical elderly service has appointed 2 apprentices in the roles of recreational coordinators with the aim of improving the patient experience
- A "ticket home" system has been introduced on the medical elderly wards to improve communication with discharge planning. This contains an estimated date of discharge with useful information that relatives or the patient can discuss in preparation for their discharge.
- Following a complaint regarding pain management a post-operative care leaflet for patients undergoing tonsillectomy is being produced.
- Ward 70 at Hull Royal Infirmary has put in place visiting time walkrounds by the senior nurse to ensure patients and their relatives can discuss any concerns on a daily basis to allow immediate actions to be taken where possible.
- A daily consultant cardiologist presence is now provided at Hull Royal Infirmary. Cardiology services are provided at Castle Hill Hospital but this resulted in long waits for patients requiring a cardiology opinion who presented through the emergency pathway. This has now improved and enables patients who need to be transferred to the care of a cardiologist to happen more quickly.

Friends and Family:

The Trust had received very positive feedback from those patients completing the Friends and Family Test.

- 96.12% of inpatients scored positively in the Friends and Family Test (March 2016).
- 82.16% of patients attending A&E scored positively (March 2016).
- 100% of patients attending obstetric services reported a positive experience (March 2016).

PERFORMANCE SUMMARY

Great Care

Care Quality Commission Inspection:

The Trust received a comprehensive inspection by the Care Quality Commission (CQC) in February 2014. A follow up inspection was undertaken in May 2015 in response to concerns that had been identified in 2014 and subsequently. The 2015 inspection report was published in October 2015, with the Trust receiving an overall rating of 'requires improvement'.

A Quality Improvement Plan was developed in 2015/16 which defined the improvement goals that the Trust is working towards. The quality improvement goals were aligned with the national and local requirements under the 'Sign up to Safety' Campaign, the priorities within the Trust's Quality Accounts and the Care Quality Commission's 5 key domains of quality and safety. There were 29 separate projects agreed as part of the Quality Improvement Plan. These covered risk/incident management, staffing, infection control, nutrition, dementia and medicines management and are detailed in our Quality Accounts 2015/16.

The Trust will be re-inspected by the CQC in June 2016 and any recommendations arising from the inspection will be incorporated into the 2016/17 Quality Improvement Plan. The Trust has made good progress against the 'must do' and the 'should do' actions from the CQC inspection.

One of the issues raised following the CQC inspection was to improve the organisational learning from incidents and events, the Trust has established a Lessons Learned intranet site for staff to access a range of resources including a lessons learned newsletter, a library of executive summaries of completed Serious Incident investigations and links to the National Reporting and Learning (NRLS) information website. In addition, from April 2016 the Trust will be making significant improvements to its incident reporting process to make incident reporting easier for all staff. A series of awareness and training sessions are being implemented to ensure that staff are briefed on these changes and encouraged to report incidents, errors and near misses.

NHS Constitution Standards :

Operational performance during 2015/16 presented significant challenges for the Trust and not all the standards were met. The table below details the Trust's performance against key indicators and national targets, comparing 2014/15 with 2015/16

PERFORMANCE HEADLINES					
Metric		**Threshold**	**2014/15**	**Threshold**	**2015/16**
MRSA		0	0	0	2
C. Difficile		57	57	53	46
Emergency Department < 4 hour wait	National	≥95%	83.30%	≥95%	78.50%
Referral to Treatment Time Pathway (18 weeks)	Admitted	≥90%	82.70%	≥90%	73.04%
	Non-admitted	≥95%	89.60%	≥95%	87.38%
	Incomplete	≥92%	89.60%	≥92%	85.35%
Diagnostic 6 week breaches		≤1.0%	0.60%	≤1.0%	0.70%
Cancer - GP 2 week wait	All cancers	≥93%	94.10%	≥93%	92.31%
	Breast	≥93%	95.00%	≥93%	86.49%
Cancer - 31 days to first treatment	All cancers	≥96%	96.40%	≥96%	97.60%
Cancer - 31 days to second or subsequent treatment	Drug	≥98%	99.30%	≥98%	99.30%
	Radiotherapy	≥94%	96.90%	≥94%	97.42%
	Surgery	≥94%	94.90%	≥94%	94.17%
Cancer - 62 days GP to first treatment	All cancers	≥85%	79.52%	≥85%	77.55%
Cancer - 62 days screening to first treatment	All cancers	≥90%	84.40%	≥90%	87.92%
Stroke - % of patients spending at least 90% of their time on a Stroke Ward		≥80%	87.80%	≥80%	87.15%
Stroke - % of patients admitted to a Stroke Ward within 4 hours via A&E		≥90%	86.90%	≥90%	78.16%
Stroke - TIA Service: % of high risk patients treated within 24 hours		≥60%	99.20%	≥60%	98.90%
Stroke - TIA Service: % of low-moderate risk patients receiving specialist assessment and brain scan within 7 days		≥95%	100%	≥95%	100%

Great Care

The Trust's performance against the 4 hour Emergency Department target was disappointing; however, a considerable amount of work has been undertaken to transform the emergency admission pathway. At the beginning of 2015/16 the medical wards at Castle Hill Hospital transferred to the Hull Royal Infirmary. This was planned to coincide with the opening of the new Emergency Department. The new department provides state of the art facilities and addresses privacy and dignity issues that had been present in the old facility. A number of different models of care have been introduced to ensure that patients presenting to the Emergency Department are seen in the most appropriate environment. This has included the establishment of an ambulatory care unit, a clinical decision unit and an elderly assessment Unit. Patients are now seen in the most appropriate assessment area to meet their needs. As a result of these changes, performance at the end of April 2016 had improved significantly and was above trajectory at 89.38%. Performance data also indicated improvements in triage time within 15 minutes, time to be seen by a doctor within 60 minutes, patients waiting over 4 hours and ambulance wait times over 30 minutes.

A comprehensive action plan has been agreed to achieve the Emergency Department access standard. The development of this plan has been overseen by the Emergency Care Improvement Programme (ECIP) and also had oversight from the local System Resilience Group (SRG) and at regional tripartite level. There are 5 work streams that support the delivery of the in-hospital element of the plan. These are the Emergency Department pathway (programme 1), Ambulatory care, medical/surgical short stay assessment and Short Stay (programme 2), frailty pathway (programme 3), reducing patient waits and improving discharge (programme 4) and escalation (programme 5). The tripartite action plan allocates the lead for ensuring that only patients who require emergency care attend the Emergency Department to Hull CCG, that the necessary arrangements are in place to enable patients to be discharged promptly to East Riding CCG, and the in-hospital arrangements to the Trust. A trajectory has been agreed with NHS Improvement which will require the Trust to achieve the 95% target.

Sustained improvement has been made by the Trust in relation to the incomplete 18 week standard in the second half of 2015/16. The Trust's plans for 2015/16 had anticipated additional capacity being deployed in a number of service areas. In some of these areas the deployment of the additional capacity was delayed, primarily due to problems in recruiting new members of staff. This affected the achievement of elective workload targets. It is anticipated that the incomplete 18 week target will be achieved in the last quarter of the year. The Trust has developed its workload forecasts and service delivery plans for 2016/17 using recognised systems, including the Intensive Support Team's (IST) capacity and demand model at a service level.

The Trust has established a Transformation Programme, with Director level leadership and dedicated project management resource, to drive service changes. The two projects being taken forward will contribute to the delivery of the 18 week target. These are the theatres and outpatients projects. The theatre transformation programme aims to review and improve existing scheduling, planning and booking processes within all elective surgical specialties. This is expected to improve efficiency and session utilisation, reduce the number of premium paid sessions, increase patient throughput and contribute to the delivery of national waiting time thresholds. The Trust is undertaking a review of its outpatient services on both of its main sites and at a number of peripheral locations with a view to optimising the use of our outpatient estate, maximising session utilisation, increasing consultant productivity, reducing waiting times, reducing DNA rates and hospital-initiated cancellations, and improving the patient experience.

A focus of this work is to reduce the number of cancellation of outpatient appointments by the hospital, as well as reducing the number of appointments where the patient does not attend, reducing the number of appointment slots that are not used and increasing the amount of patients we are able to see within our clinic capacity. The project has started in four specialties; orthopaedics, cardiology, cardiothoracic surgery and oncology. After a slow start all four are making progress towards the achievement of the goals set and there has been a lot of learning which is being shared with other teams to promote improvement across the Trust. The work in the project has also led us to the creation of an outpatients management team, which is being put in place from September 2016 and will strengthen the operational management of outpatients and help ensure that the improvements made in the project are sustained.

Steady progress was also made against the cancer standards. It is anticipated that all of the cancer targets will be achieved sustainably by September 2016.

PERFORMANCE SUMMARY

Great Care

Other Performance

Financial performance:

The Trust uses a number of key performance measures to monitor delivery of its financial plan. There were a number of indicators in the Trust Development Authority Accountability Framework which the Trust was required to report against during 2015/16. These were:

Indicator Description	Plan £000's	Actual/ Forecast £000's	Variance £000's	RAG Rating
Forecast Outturn, compared to plan	(18,300)	(8,051)	10,249	Green
Actual efficiency recurring/non-recurring, compared to plan • Total efficiencies for year to date compared to plan • Recurrent efficiencies for year to date compared to plan	28,424 23,495	23,505 19,144	(4,191) (4,351)	Amber
Forecast underlying surplus/deficit, compared to plan	(20,729)	(19,662)	1,067	Green
Forecast year end change to capital resource limit	12,440	12,357	83	Green

From a financial perspective 2015/16 was a very challenging year for the Trust. At the start of the year the Trust set a deficit plan totalling £21.9m which reflected the deterioration in the Trust's underlying financial position over the past couple of years and the prospect of significant cost inflation in certain areas and limited opportunities for income growth in 2015/16. This plan was rejected by the NHS Trust Regulator, the Trust Development Authority and a revised deficit of £18.3m deficit was agreed.

The year-end actual deficit of £8.0m was significantly beneath this forecast. This was entirely due to two non-recurrent factors:

- Valuation of an asset held for sale of £8.3m
- was not able to achieve a Capital to revenue resource transfer of £2.0m

Whilst the Trust break-even position in year, it was able to record an aggregate surplus of £0.85m over the 3 year period ending 31 March 2016.

In addition, the Trust met its external financing limit of £11.4m and did not exceed its capital resource limit spending £12.36 against a maximum allowable limit of £12.44.

There were a number of factors which heavily influenced the 2015/16 financial year. The most significant of these being as follows:

1. At the outset of the financial year, the Trust agreed a block contract with its two largest Commissioners which provided certainty over a large element of the Trusts income.

   The introduction of a new Patient Administration system (Lorenzo) in June 2015 caused problems in the second half of the year in terms of income and activity recognition. The block contract was helpful in mitigating this risk although it did mask a significant under trade in planned elective and out-patient activity. To a lesser extent it also masked an over trade in emergency and non-elective activity which the Trust had to respond to over the winter period. Both these factors will continue to cause problems for the Trust and local commissioners as we move into 2016/17.

2. Agency costs increased significantly in year, most notably in relation to doctors. An increased number of vacancies in a number of key specialities forced the Trust to use agency staffing in order to sustain service provision. On a positive note, the use of agency staffing for Nursing remains relatively low (1.16% against a target of 3%) and well below national averages.

3. In overall terms there was a 4.75% increase in operating expenses in year. This included a 3.8% increase in pay costs and a 4.1% increase in non pay expenses. Within this was a significant increase in clinical negligence costs, which increased by £6m or 55% on the previous year. This was offset by a 21% reduction in depreciation which resulted from a review of the asset base by an external valuation agency in year.

4. The Trust demonstrated satisfactory performance in terms of delivering efficiencies in year totalling approximately 83% of its £28m target.

5. The Trust was able to maintain a satisfactory liquidity position throughout the year despite generating a sizeable loss in its Statement of Comprehensive Income. Principally this was due to the receipt of new revenue support loans from the Department of Health totalling £13.68m.

PERFORMANCE SUMMARY

Great Care

Other Performance

Lorenzo Implementation:

On June 8th 2015 the Trust went live with Lorenzo, the new Electronic Patient Record (EPR). Lorenzo is the system which manages patients through their journey in the Trust, from emergency admission or planned referral to discharge and subsequent follow-up. From Lorenzo, our staff can see referral information, Pathology test results, Radiology test results, clinical correspondence and discharge letters, drug's prescribed and medication history and allergies from the GP record. Lorenzo replaced a system that has been in use for 16 years and is fundamental to achieving the Government's target of paper-free at the point of care, the aim of which is to improve clinical effectiveness and remove the risks around paper records not being available to anyone giving care to our patients.

This was by far the biggest and most complex systems deployment the Trust has ever undertaken. Over 100 million records, totalling over 1 billion pieces of data were successfully migrated from the old system. 2000 PC's and printers were replaced or upgraded. Multiple clinical systems interfaces have been re-written to ensure that other systems such as Radiology, Pathology, Theatres and Maternity are linked to the core patient record. Over 5000 staff have been trained and are using the system daily. From the outset, Hull and East Yorkshire Hospitals had a greater proportion of clinical staff using the system than any other Trust.

A complex and far-reaching project such as this brings with it significant challenges. Lorenzo works differently to our old system, requiring changes to the way some traditional processes have operated. This has taken time to get used to, but many areas are now beginning to see the advantages of the new system and the benefits it can bring in the way in which we manage the care of our patients. One of these is the linking of Lorenzo to the national Summary Care Record (SCR) which enables Trust clinical staff to check patients' GP prescribing history and allergies; HEY is now the biggest user of the SCR in the country.

With specific regards to managing patient flow through Lorenzo, from go-live (June 2015) to September 2015 there was an increase in open RTT pathways. This was due to a variety of factors which the Trust understood and could quantify, enabling us to reduce open pathways to pre Lorenzo levels. The Trust was able to maintain its activity reporting capability from go-live, albeit with caveats. There was initially a negative impact on RTT reporting (incomplete standard 92%) for the 4 months post-go live. Although Reported performance initially deteriorated it has now improved from our previous go-live position.

HEY has been recognised as the best Lorenzo migration so far and the only Trust that could run reports the day after Lorenzo go-live. HEY has made the most progress of any Trust post migration and our technical capability to evidence confidence in the data is second to none.

The Trust will achieve significant savings through the Lorenzo system over the life of the contract. These will mainly be achieved through the elimination of paper records, the improved availability and sharing of information digitally and savings from decommissioning some existing systems. Collectively these will contribute to an overall cost saving of over £1m per year.

Sustainability Performance:

As an NHS organisation, and as a spender of public funds we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28% by 2020 using 2013 as the baseline year.

Great Care

Other Performance

Policies:

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

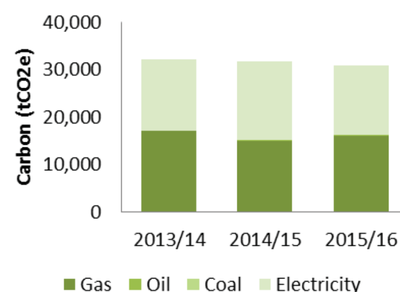
Area	Is sustainability considered?
Travel	No
Procurement (environmental)	Yes
Procurement (social impact)	No
Suppliers' impact	Yes

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff. Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples in recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The organisation has identified the need for the development of a board approved plan for future climate change risks affecting our area.

Energy:

Hull and East Yorkshire Hospitals NHS Trust has spent £4,577,012 on energy in 2013/14, which is an 11.1% decrease on energy spend from last year.

Resource		2013/14	2014/15	2015/16
Gas	Use (kWh)	80,729,427	71,368,422	76,389,427
	tCO_2e	17,126	14,973	16,027
Oil	Use (kWh)	0	268,577	345,175
	tCO_2e	0	86	110
Coal	Use (kWh)	0	0	0
	tCO_2e	0	0	0
Electricity	Use (kWh)	26,683,468	26,736,655	27,104,104
	tCO_2e	14,940	16,559	14,755
Green Electricity	Use (kWh)	16,578,639	16,202,456	25,664,100
	tCO_2e	-9,283	-10,035	-14,755
Total Energy CO_2e		22,784	21,583	16,137
Total Energy Spend		£ 6,035,057	£ 5,150,982	£ 4,577,012



Grid supplied electricity usage has seen an 8% reduction below 2014/15 usage, part of this reduction is attributed to the optimisation of Building Management Systems in a number of large buildings improving their efficiency, in combination with rationalisation of the estate. The total figure above includes on site generation with was not reported in previous years.

The Trust has managed to reduce the energy spend over the last three years due to a falling market in combination with an effective risk management strategy enabling the Trust to benefit from this.
Carbon emissions have fallen dramatically primarily due to electricity provided to site being provided from renewable and exempt sources.

The Trust held a Sustainability day to educate Trust staff on all aspects of sustainability and how they could make savings both at home and in the workplace, with over 20 exhibitors attending a two day event.

PERFORMANCE SUMMARY

Great Care

Other Performance

Travel:

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services. Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness.

Category	Mode	2013/14	2014/15	2015/16
Patient and visitor Travel	km	0	0	0
	tCO_2e	467	398	463
Business Travel and fleet	km	1,425,097	1,292,816	1,780,197
	tCO_2e	327	295	382
Staff commute	km	0	0	0
	tCO_2e	0	0	0

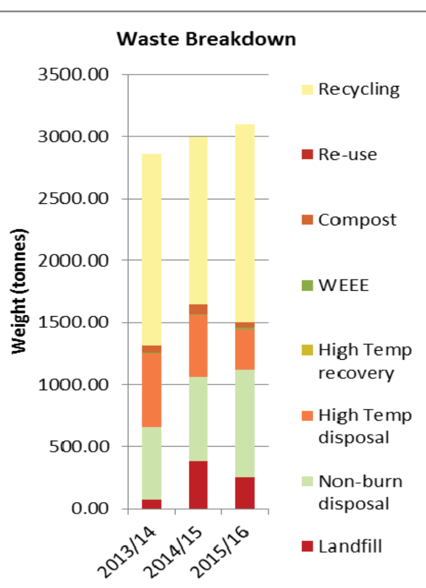
Trust business travel has increased substantially over the last twelve months. This is potentially due to greater recording accuracy but at this time is being investigated further to establish any other changes that may support this increase.

In April 2015 the Trust went live with a new non-patient transport contract provided by ERS Medical after many years of this service being carried out by Yorkshire Ambulance Service. The service is working well and within budget.

A vehicle cleaning contract has been established to improve the appearance of the Fleet and provide an improved patient experience.

Waste:

Waste		2013/14	2014/15	2015/16
Recycling	(tonnes)	1548.00	1345.00	1591.42
	tCO_2e	32.51	28.25	33.42
Re-use	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
Compost	(tonnes)	54.00	83.00	47.28
	tCO_2e	0.32	0.50	0.28
WEEE	(tonnes)	7.10	8.00	15.60
	tCO_2e	0.15	0.17	0.33
High Temp recovery	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
High Temp disposal	(tonnes)	589.00	493.00	320.59
	tCO_2e	129.58	108.46	70.53
Non-burn disposal	(tonnes)	587.00	680.00	860.55
	tCO_2e	12.33	14.28	18.07
Landfill	(tonnes)	73.00	384.00	259.22
	tCO_2e	17.84	93.86	63.36
Total Waste (tonnes)		2858.10	2993.00	3094.66
% Recycled or Re-used		54%	45%	51%
Total Waste tCO_2e		192.73	245.51	185.99



2015-16 has seen the Trust's total waste production rise 3.4% over the previous year. This has been in part due to the building and refurbishing projects that have taken place throughout the last 12 months but also the increased number of patients. The Trust has improved segregation of healthcare waste enabling a higher percentage to be treated via a non-burn facility. The Trust presently achieves 98% landfill diversion of its general waste.

The Trust changed waste contractor in December to Mitie Environmental Services, the contract change over and ongoing service is going well.

PERFORMANCE SUMMARY
Great Care
Other Performance

Water:
The Trust has had a 10% increase in water use throughout the Trust much of this is due to water leaks at the Castle Hill site throughout the year, these continue to be repaired by the Trust and a plan of replacement is being developed to minimise future leaks. Hull Royal water use has seen an increase due to leaks and the transfer of services from CHH to HRI.

The Trust has also had an increase in the unit cost of water and sewerage impacting on the total cost.

Water		2013/14	2014/15	2015/16
Mains	m^3	279813	286136	312672
	tCO_2e	255	261	285
Water & Sewage Spend		£ 570,315	£ 615,692	£ 702,795

PERFORMANCE SUMMARY

Great Future

Trust Strategy:

In April 2016 the Trust set out its achievement of its vision. Long term goals were scoped as well as the level of ambition for each goal over the next 5 years. This is included in the Trust Strategy 2016 – 2021 document Trust Strategy 2016-2021. The Trust's long term goals are as follows:

Honest, caring and accountable culture

Over the next 5 years we will:

- Move our staff satisfaction survey results into the top 20% of trusts
- Improve overall engagement score on the staff satisfaction survey to the top 20% of trusts
- Evidence that we are a learning organisation, as per the objective set under our patient safety goal
- Increase proportion of positive media stories about the Trust to 75% of the total

Valued, skilled and sufficient workforce

Over the next 5 years we will:

- Increase the percentage of staff recommending us a place to work to 80%
- Reduce our vacancies to less than 5% of posts
- Reduce our staff turnover to less than 8% per annum
- Create a range of new rules and working arrangements to improve cover in our hardest pressed teams

High Quality Care

- Over the next 5 years we will:
- Reduce avoidable deaths within the Trust by 50%
- Reduce avoidable harm within the Trust by 50%
- Increase incident reporting to the highest 25% compared to our peers
- Reduce the occurrence of moderate, severe and catastrophic harm to patients to less than the peer average.
- Increase 7 day working within our urgent care services

Great Local Services

- Over the next 5 years we will
- Achieve sustained deliver of the emergency care standards from 2016/17 onwards
- Collaborate with our patients and partners to transform our services for older people with complex needs
- Involve our patient in the development of their future care plans, giving them chance to influence the way they access and receive care
- Improve the number of patients who are able to die in their place of choice
- Reduce unnecessary admissions to hospital and length of stay to below peer average
- Ensure our integrated teams have access to shared care records
- Deliver further improvements to our acute pathways
- Reduce our over 18 week RTT waiting list and achieve sustained compliance with the 92% incomplete target in 2016/17
- Reduce our longest waits from referral to treatment to 40 weeks by 2017/18
- Achieve sustained delivery of cancer waiting times standards in 2016/17
- Move our benchmark score in the national outpatient survey into the to 20% of Trusts
- Ensure we provide our elective patient with a choice of appointment and operation date
- Work with our commissioners on the 'Right Care' programme
- Broaden the range and volume of services we offer in the community

PERFORMANCE SUMMARY

Great Future

Great Specialist Services

Over the next 5 years we will:

- Improve our patients' experience of cancer, as measured by the cancer patient survey and increase our 1 and 5 year survival rates
- Move our Major Trauma Centre into the top 50% of centres in the National Peer Review
- Work with our provider partners to create a portfolio of high quality, network and commissioner supported specialist services

Partnership and Integrated Services

- Over the next 5 years we will:
- Support the development and delivery of the STP and Hull and the East Riding transformation plans
- Provide clinical expertise and leadership to local and regional collaborations to redesign pathways and service models
- Develop clinical and service networks and partnership arrangements to support the sustainability of acute and specialist services across our region.

Financial Sustainability

- Over the next 5 years we will:
- Agree and implements plans with partners to achieve financial balance across our health system
- Make savings in our cost of supplies and purchases
- Remodel our workforce to optimise our use of human resources
- Increase our productivity in our theatres and outpatient clinics
- Reduce our overall estate size, whilst increasing our activity
- Eliminate paper usage and facilitate mobile working
- Modernise our 'back office' functions, reduce cost and improve performance

The Strategy has been developed through a process of engagement with staff from across the Trust and in discussion with our patients and partners.

The Strategies that will enable these long term goals to be realised are the People Strategy, the IT Strategy (this was presented to the Board in March 2016) and the Estates Strategy which is currently being developed.

ACCOUNTABILITY REPORT

Directors' report:

The Chairman of the Trust is Mr Mike Ramsden and the Chief Executive is Mr Chris Long.

The Trust Board comprises the Chairman, 5 voting Executive Directors and 6 voting Non-Executive Directors. The five Executive Directors with voting rights are the Chief Executive, Chief Nurse, Chief Financial Officer, Chief Medical Officer and the Chief Operating Officer. Four other Directors attended the Board in 2015/16 but they do not have voting rights. These were the Director of Strategy and Planning, the Director of Workforce and Organisational Development, the interim Chief of Infrastructure and Development and the Director of Governance. Four Board members have a clinical background. These are the Chief Nurse, the Chief Medical Officer and two Non-Executive Directors (the Dean of the Hull York Medical School and a Non-Executive with a nursing background).

Terms of Office of Non-Executive Directors:

The Non-Executive Directors are appointed to the Board by the Trust Development Authority (TDA), now NHS Improvement. Non-Executive Directors can be appointed for a maximum of 3 terms (up to 9 years). All Non-Executive Directors apart from Mr Snowden are in their first terms of office. Details on appointment dates and when their current term of office comes to an end are set out below.

Terms of office – Non-Executive Directors

Name	Position	Term Commenced	Term Ends
Mr M Ramsden	Chairman	February 2015	January 2017
Mr A Snowden	Non Executive Director	April 2013	March 2017
Mr M Gore	Non Executive Director	January 2015	December 2016
Mr S Hall	Non Executive Director	January 2015	December 2016
Prof. T Sheldon	Non Executive Director	January 2015	December 2016
Mrs V Walker	Non Executive Director	July 2015	June 2017
Mrs T Christmas	Non Executive Director	July 2015	June 2017

The biographies of the Chairman and the Chief Executive together with other Board members is set out overleaf.

ACCOUNTABILITY REPORT

Chairman and Non-Executive Directors

Mike Ramsden – Chair

Mike was appointed in February 2015. He is currently Chair of Leodis Health and is a Director of Waring Health Ltd. He has previously held a number of senior executive positions, including Chief Executive of Leeds Health Authority between 1999 and 2002. He has established the Smartrisk Foundation UK which is a registered charity focusing on reducing injuries, particularly amongst young people. His more recent positions include Chair of Health and Social Care Information Centre (2005-13) and Chief Executive of the National Association of Primary Care (2006-12).

Andy Snowden – Vice Chair

Andy was appointed in January 2015 as Vice Chair. He has been a Non Executive Director with the Trust since April 2013 and before that was an Associate Non Executive Director (since November 2011). Prior to this he was a Non Executive Director at NHS Hull. He has been a corporate director with two local Councils (Hull City and Middlesbrough). He runs his own consultancy business which provides leadership and development expertise to health, local government and other organisations.

Trevor Sheldon – Non Executive Director

Trevor was appointed in January 2015 after spending six months working with the Trust Board as an Associate Non Executive Director. Trevor is a Professor of Health Services Research & Policy at the University of York, with over 25 years' experience in this field. He is also the current Dean of the Hull York Medical School and Board Chair of the York Health Economics Consortium.

Martin Gore – Non Executive Director

Martin was appointed in January 2015. His previous role was at the Humberside Probation Trust as a Director of Corporate Services. He is a qualified accountant. He brings with him more than 25 years' experience of working at board level and in senior finance roles, as well as extensive experience of the private sector.

Stuart Hall – Non Executive Director

Stuart was appointed in January 2015. He has spent a large part of his career working with FTSE 100 company, Santander. A fellow of the Chartered Institute of Bankers, Stuart is experienced in a range of areas from governance and HR to strategy development, and a Director of a Community Interest Company specialising in vocational training and end of life care.

Vanessa Walker – Non Executive Director

Vanessa was appointed in July 2015. She was previously employed as a Non Executive Director with Humber NHS Foundation Trust. Vanessa has more than 30 years experience working across the NHS, civil services and local government. She has a strong track record of leading strategic change programmes designed to improve organisational culture and performance.

Tracey Christmas – Non Executive Director

Tracey was appointed in July 2015. Tracey has extensive knowledge of both the public and private sectors, predominantly in finance and corporate services roles. Tracey is a Finance Business Partner for the Ministry of Justice/National Offender Management Service working within the Yorkshire Region at HMP Full Sutton and HMP Hatfield. She is also a past president of the ACCA Women's Society and International Assembly UK Representative, and is currently an elected representative for Yorkshire and the North East on the ACCA's Strategy Implementation Committee. Tracey has previously served as a Non Executive Director of Eastern Hull NHS Primary Care Trust.

ACCOUNTABILITY REPORT
Executive Team

Chris Long – Chief Executive Officer
Chris has a wealth of NHS experience, including four years with the former Scarborough and North East Yorkshire Hospitals NHS Trust as Executive Director of Operations and, more recently, seven years as Chief Executive of Hull Teaching Primary Care Trust (PCT) between 2006 and 2013. Prior to joining the NHS, Chris spent 12 years in the Army, and before joining Hull and East Yorkshire Hospitals NHS Trust he worked as the Area Director for NHS England's Locality Team in Yorkshire and the Humber.

Lee Bond – Chief Financial Officer
Lee was appointed in March 2013. Prior to this he was a Director of Business Delivery within the Trust and before that Director of Finance at Central Manchester University Hospitals NHS Foundation Trust. His previous financial posts include Sherwood Forest Hospitals NHS FT and Sheffield Children's NHS FT.

Mr Kevin Phillips - Chief Medical Officer
Kevin commenced as Chief Medical Officer in 25 August 2015 following a short period in the interim post. Prior to this appointment has was the Medical Director of the Family and Women's Health Group within the Trust. He has been a Consultant at the Trust for 19 years in obstetrics/gynaecology with a special interest in keyhole gynaecological surgery. He has worked in many managerial roles as well a full time clinical roles. Nationally he recently received a term as President of the British Society for Gynaecological Endoscopy.
He qualified from Leeds University in 1986 and pursued a career in obstetrics and gynaecology working in Leeds, Australia, New Zealand and Scotland before returning to Yorkshire to take up his Consultant post. He is committed to working for our local population and bringing high quality safe care to our patients.

Mike Wright – Chief Nurse
Mike was appointed in April 2015. His previous appointment was Chief Nurse and Deputy Chief Executive at County Durham and Darlington NHS Foundation Trust. He is a registered Nurse and has 34 years experience working in clinical, managerial and leadership roles. These have included various clinical roles up to and including senior nurse manager level, four years Directorate Manager/Head of Nursing at Guy's and St Thomas' Hospital and three years as a Deputy Director of Nursing at Guy's and St Thomas' Hospital before his Chief Nurse role in 2003.

Jacqueline Myers – Director of Strategy and Planning (non voting).
Jacqueline was appointed in July 2013 as Director of Strategy and Planning. She was previously Director of Planning at Leeds Teaching Hospitals NHS Trust as well as Divisional General Manager and the Lead Cancer Manager and held a range of general management positions at University College Hospitals Foundation Trust and Guys and St Thomas's Foundation Trust. She has experience in strategic vision, business and service planning, project management and service redesign.

Simon Nearney – Director of Workforce (non voting)
Simon joined the Trust in September 2012 from his previous post as Director of Human Resources at Leicestershire County Council. Simon has held several senior HR and Organisational Development management roles in large public sector organisations.
Simon has a track record of transforming services, leading major organisational change programmes and improving the customer experience.

Executive Team

Liz Thomas – Director of Governance and Corporate Affairs (non voting)

Liz joined the Trust in 1992 having previously worked in the New Zealand health service for 8 years. She has worked in a number of operational management roles in both new Zealand and in Hull, leading medical and surgical services. More recently her has role has included clinical governance responsibilities as well as fulfilling the role of Trust Secretary. She is a qualified Company Secretary (ICSA).

Duncan Taylor – Interim Chief of Infrastructure and Development (non voting)

Duncan was appointed in July 2013. Before that he was Director of Estates Development covering the Infrastructure and Development Directorate. He has worked in the Trust since 1985, and has been closely involved in the majority of the capital projects across the Trust from small upgrades up to the major projects at Castle Hill Hospital. He is the Project Director for the Tower Block Encapsulation and Emergency Department Upgrade. He has a passion for the redesign of health care facilities and the use of innovative products and design techniques to improve the facilities and experience for patients, visitors and staff.

Trust Board meetings

The Trust Board met on 10 occasions during 2015/16. No meetings were held in August and December 2015. A record of attendance of kept for each Board meeting and the table below sets out the attendance of Board members during the year.

Trust Board Attendance 2015/16

Name / Title	Total
M Ramsden – Chairman	10/10
A Snowden - Vice Chair /Non-Executive Director	10/10
T Sheldon – Non Executive Director	8/10
M Gore - Non Executive Director	9/10
S Hall - Non Executive Director	10/10
V Walker - Non Executive Director (Commenced July 2015)	6/7
T Christmas - Non Executive Director (Commenced July 2015)	7/7
C Long – Chief Executive Officer	9/10
L Bond – Chief Financial Officer	10/10
M Wright – Chief Nurse	8/10
K Phillips – Interim / Chief Medical Officer (commenced June 2015)	8/8
I Philp – Chief Medical Officer (Left the Trust May 2015)	1/2
J Myers – Acting Chief Operating Officer / Director of Strategy & Planning	9/10
D Taylor – Interim Chief of Infrastructure & Development (to September 2015)	4/5
E Thomas – Director of Governance & Corporate Affairs	10/10
S Nearney – Director of Workforce	8/10

The Executive Director team is relatively new and there has been significant change in the Non-Executive team over the last 12 months. A programme of Board Development is in place. The Board development sessions have focussed on building relationships and refreshing the Trust's overall strategy. The Board has used the Discovery Insights tool to understand the strengths and preferences of each of the Board members. This has allowed the Board to reflect on its effectiveness and to determine the areas where it feels that changes are required. A questionnaire has also been conducted around the functioning of Board meetings.

Board Committees

The Trust Board has established a number of committees to support it in discharging its responsibilities. These are an Audit Committee, Quality Committee, Performance and Finance Committee and a Remuneration Committee. The Board conducts an annual review of its committees' effectiveness. This comprises of a questionnaire and a review of papers received and adjustments to terms of reference.

Audit Committee

The Audit Committee comprises of 3 Non-Executive Directors. Other individuals attend the meeting but are not members of the committee. These are Internal Audit (MiAA), External Audit (KPMG), the Chief Financial Officer, the deputy Director of Finance and the Director of Governance.

The Audit Committee provides assurance on the Trust's systems of internal control, integrated governance and risk management. A tracking system of agreed actions is in place and the internal auditors follow up recommendations to provide assurance to the Audit Committee that the issues raised have been addressed. There were 7 meetings of the Audit Committee in 2015/16 which included 1 extra ordinary meeting to consider the Annual Accounts. All meetings were quorate.

Members	Attendance
Mr M Gore	7/7
Mr S Hall	7/7
Mrs T Christmas (commenced July 2015)	4/4

The Committee reviewed relevant disclosure statements in particular the draft Governance Statement, financial Accounts and the Quality Accounts.

The internal audit programme for 2015/16 was informed by the Trust's own risk and assurance framework, discussion with a wide range of officers and the broader context of the NHS. It was developed around the Trust's strategic objectives and its business critical systems and was risk based. A draft Director of Audit Opinion and Annual Report 2015/16 gave an overall opinion of limited assurance. This was provided in the knowledge of the significant challenges that the Trust has faced over the year in terms of operational performance and financial pressures.

No critical actions were identified for those audits that received limited assurance. Limited assurance audits included infection prevention, incident reporting, medical staff planned absence, consultant job planning and responding to the Francis report. Two audits identified that centralised systems were much stronger than the Health Group processes (strategy/planning and performance management/NHS target reporting), with the Health Group processes only receiving limited assurance. The four locality reviews covering sterile services, wards 1, 8, 9 and 90 also received limited assurance.

Minutes and other updates from the work of the Quality Committee and the Performance & Finance Committee were considered by the Audit Committee which contributed to the overall view of governance and internal control.

Work to prevent or counter fraud continued and reports were received throughout the year. The Committee reviewed the Board Assurance Framework and other documents in respect of risk. These included Reference Costs, Losses and Special Payments and the Register of Gifts and Hospitality.

Remuneration Committee

The Board's Remuneration and Terms of Service Committee is responsible for setting the pay and conditions for the voting Executive Directors (Chiefs) and the Director who report to the Chief Executive. The Remuneration Committee met 5 times during 2015/16, which was one more meeting than stated in its Terms of Reference. The additional meeting was called due to changes in Executive Directors. The Committee was quorate at all meetings. Membership of the Committee comprises the Trust Chairman and all Non-Executive Directors. The Chief Executive, Director of Workforce and Organisational Development and Director of Governance also attend the Committee. Non-Executive Director attendance is detailed below:

Member	Post	Meetings attended
M Ramsden	Trust Chairman	5/5
A Snowden	Non-Executive Director	5/5
M Gore	Non-Executive Director	5/5
S Hall	Non-Executive Director	5/5
V Walker	Non-Executive Director	3/3
T Christmas	Non-Executive Director	3/3
T Sheldon	Non-Executive Director	4/5

The Trust complies with the Trust Development Authority's (TDA) guidance on pay for Very Senior Managers which was re-issued in September 2015 following new requirements set out by the Department of Health. Executive Directors are employed on contracts of service and are substantive employees of the Trust. Their contracts are open ended and can be terminated by the Trust by up to 6 month's notice. The new guidance issued in 2015 requires NHS Trusts to include in the remuneration package an element of earn-back pay ie a requirement to meet agreed performance objectives. The Chief Medical Officer has this requirement built in to his remuneration package as he was appointed after the guidance was published. Other Executive Directors in post during 2015/16 did not have a component of performance related pay.

The Remuneration Committee considered whether the VSM posts covered by the Remuneration Committee should have the 2015/16 pay award of 1% applied to their salary package. The Committee agreed that in line with TDA advice and mindful of the general economic environment and challenges facing the Trust, a salary uplift would not be applied. Non Executive Director salaries are not covered by the Remuneration Committee. These are set nationally.

Key items discussed by the Committee during the year were the terms, conditions and salary of new and interim Executive Directors, the appraisal of the Chief posts, changes to the executive structure, the mutually agreed resignation scheme and the Trust Development Authority VSM guidance. The Committee also approved a secondment of a VSM to work with the Trust and local CCGs, the redundancy of a Chief post and a contractual settlement agreement.

Details of the remuneration, including salary and pension entitlements of the Directors is set out on page 40

Details of company Directorships which may conflict with management responsibilities are included in the Annual Accounts 2015/16 (see seperate document).

Personal Data related incidents

The Trust has Information Governance arrangements in place to ensure that information is handles in a secure and confidential manner. It covers personal information relating to 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 March each year NHS Organisations are required to submit a self-assessment return via the toolkit. The return and supporting evidence are independently audited. For 2015/16 the Trust were awarded 'limited assurance' for compliance level 2 or above by the Auditors.

The Trust is required to score all Information Governance Incidents. Any incident that scores a Level 2 or above is required to be reported via the IG Toolkit Incident Reporting Tool which sends automatic notification to the Information Commissioner. The Information Governance Serious Incident requiring reporting to the Information Commissioner during 2015-16 are detailed opposite...

SUMMARY OF SERIOUS INCIDENT REQUIRING INVESTIGATIONS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONERS OFFICE IN 2015-2016				
Date of Incident	**Nature of Incident**	**Nature of data involved**	**Number of data subjects affected**	**Notification steps**
May 2015	Unauthorised access	Patient data	One	Individual reported
Further action on information risk	The medical record of a member of staff was accessed for a non-medical purpose. The Trust Disciplinary Procedure was followed resulting in no formal action being taken against the staff member involved in this incident. All staff in the department were reminded about the lawful basis for accessing patient information.			
Date of Incident	**Nature of Incident**	**Nature of data involved**	**Number of data subjects affected**	**Notification steps**
July 2015	Unauthorised access	Patient data	One	Manager reported
Further action on information risk	A temporary agency member of staff accessed their own record on the Trust PAS System. Investigation resulted in the termination of the temporary employment. All staff in the department were reminded about the lawful basis for accessing patient information.			
Date of Incident	**Nature of Incident**	**Nature of data involved**	**Number of data subjects affected**	**Notification steps**
Dec 2015	Unauthorised access	Patient data	One	Manager reported
Further action on information risk	Member of staff inappropriately accessed family member's record Investigation resulted in the staff member receiving a formal letter which will remain on file for 12 months. All staff in the department were reminded about the lawful basis for accessing patient information.			
Date of Incident	**Nature of Incident**	**Nature of data involved**	**Number of data subjects affected**	**Notification steps**
Jan 2016	Loss of paperwork	Patient data	100+	
Further action on information risk	An envelope containing a number of patients IDL's were found on Hull Train Station Platform. HRI Security collected it from the Station. Investigation complete awaiting decision/outcome from the ICO.			
Date of Incident	**Nature of Incident**	**Nature of data involved**	**Number of data subjects affected**	**Notification steps**
Jan 2016	Loss of paperwork	Patient data	1	
Further action on information risk	GP surgery rang to say a member of the public had handed an envelope in containing a paediatric record. The envelope was found on Wheeler Street and handed to Kingston Medical Centre. Investigation complete awaiting decision/outcome from the ICO.			

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS in 2015-16		
Category	**Nature of Incident**	**Total**
A	Corruption or inability to recover electronic data	0
B	Disclosed in Error	41
C	Lost in transit	3
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	5
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	3
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	3
K	Other	8

Directors' disclosure

Each Director knows of no information which would be relevant to the auditors for the purposes of their audit report and of which the auditors are not aware, and has taken all the steps that he/she ought to have taken to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Statement of Accounting/Accountable Officer's responsibilities

The Accounting Officer has overall responsibility for the financial statements. The statements are prepared through the Chief Financial Officer's office. The Audit Committee is updated on the progress in preparing the Accounts. The Chief Financial Officer presented a report to the Audit Committee in May 2016 to discuss and review the Trust's status as a going concern. The Audit Committee approved the Chief Financial officer's recommendation that the Accounts should be prepared on a going concern basis.

As Accounting Officer I confirm that, as far as I am aware, there are no relevant Audit information of which the Trust's auditors are unaware and I have taken all the steps that I should take to make myself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

Chris Long
Chief Executive
June 2016

Scope of Responsibility

As Chief Executive and the Accountable Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's goals whilst safeguarding quality standards and public funds. I ensure that the Trust meets its three principal functions as set out in the Accountable Officer Memorandum. These are to:

- enter into and fulfil agreements with commissioning bodies
- meet statutory duties
- maintain and develop relationships with patients, local partner organisations and the wider local community, their commissioning agencies and their suppliers.

In carrying out these functions I am responsible for the proper stewardship of public funds and assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

The Governance Framework of the Organisation

The Trust Board is accountable for all aspects of the performance of the Trust. The Trust Board met in public on 10 occasions during 2015/16 and was quorate at all meetings. The attendance of each individual Board member is set out on page 29 of the Annual Report.

The Board has five committees which support it in discharging its responsibilities. In addition to the statutory requirement for an Audit Committee and a Remuneration and Terms of Service Committee, the Board has a Performance and Finance Committee and a Quality Committee. A Charitable Funds Committee is in place for the management of funds held on trust. All Board committees are chaired by a Non-Executive Director. An attendance record is kept for the Board and each of its committees.

The Audit Committee met 7 times during 2015/16 and was quorate for all meetings. Its work plan for 2015/16 was received at its March 2015 meeting and was also periodically reviewed during the year to ensure it remained relevant and current. The first part of the Audit Committee agenda is comprised of standing items which include an overview of the work of the Quality Committee and the Performance and Finance Committee, an update from the external auditor followed by the internal auditor reports. Other agenda items are scheduled at regular intervals during the year and these include the preparation and submission of the Annual Accounts and Quality Accounts, Going Concern status, review of the Board Assurance Framework, Board members' expenses, off payroll expenses, losses and special payments register and debts above £50,000. The Audit Committee chair fed back to the Board key issues following each meeting. These included concerns about consultant job plans following an internal audit report which gave limited assurance, compliance with RIDDOR reporting, procurement of interpretation services and conclusion of the financial governance review which was received at the Board in June 2015. The financial governance review concluded that the Audit Committee did not consider there to be any serious issues or gaps in control that would cause concern.

The Performance and Finance Committee met on 12 occasions in line with its Terms of Reference and was quorate at all meetings. Following a self-assessment of its effectiveness the Committee reviewed its Terms of Reference to ensure that the focus of each meeting remained on progress in achieving the key NHS Constitution standards and delivery of the financial plan, which are standing agenda items discussed at each meeting. Key issues included performance and action related to achievement of the 4 hour Emergency Department target, delivery of the Cash Releasing Efficiency Savings programme, cancer waiting time targets and capital expenditure. The Non-Executive Chair of the meeting provided a briefing to the Board each month on areas where further assurance was required on delivery.

The Quality Committee met on five occasions which is one meeting less than its Terms of Reference. This was due to a visit to the Trust by an external dignitary and the cancellation of one meeting. Key issues discussed related to Quality Improvement Programme, Major Trauma peer review, incident reporting, claims activity, clinical audit (as part of the Quality Accounts) and outpatient quality issues. The Committee received annual reports relating to medicines optimisation, claims, Serious Incidents and safeguarding children. Each meeting also received a briefing report on issues discussed at the Operational Quality Committee and at Health Group governance meetings. The Board was advised of issues arising following each meeting. This included notification of the publication of a new national Never Events Framework, concerns about outpatient cancellation rates, issues relating to the management of sepsis, actions to address the backlog on overdue incident investigations and assurance on action to be taken to address issues arising from the Major Trauma peer review visit.

The Remuneration Committee met five times during 2015/16 and was quorate for all meetings. The Terms of Reference were reviewed in April 2015. Issues discussed included changes to Chief Officer posts, annual performance reviews, the top earners in the Trust and the executive management structure.

The Board held four development sessions during the year. The Board used the 'Discovery Insights tool' together with a questionnaire on its performance to inform the development sessions. The Board recognises that there is a need to build a strong, unified team particularly given the turnover in both Executive and Non-Executive posts. Consideration has therefore been given to understanding the personal styles of Board members and their communication needs. The Well-led framework has informed the content of the sessions. Time was given for the Board to consider the development of its strategy, challenges relating to the emergency pathway and how it intends to further engage its stakeholders. A session was also held on understanding performance data in light of new appointees to the Board.

Quality governance arrangements are in place which provide assurance on the content and the publication of the Quality Accounts. The Quality Accounts are reviewed by the Audit Committee, the Quality Committee and the external auditors. The external auditors concluded that they were satisfied that there was sufficient evidence to provide a limited assurance opinion on the content of the Accounts. One recommendation was made in 2015 relating to the completeness of information relating to venous thromboembolism.

A Quality Report is received at each Board meeting. The report is divided into four sections which set out patient safety matters, healthcare associated infections, patient experience matters and other quality updates. The patient safety matters section contains information about Never Events and action taken, Serious Incidents and improvement activities. In 2015/16 the Trust declared four Never Events. One of these Never Events (retained swab) occurred in 2013. The three Never Events that happened in 2015 were a retained swab in maternity services, a wrong site plural biopsy and a wrong site nephrostomy procedure. As a consequence of these incidents enhanced checking procedures have been introduced, audit processes are in place and a video has been made to share across the Trust so that staff can learn from what went wrong and understand the impact that such events have on both the patient and the staff.

Arrangements for the discharge of statutory functions have been checked for irregularities and were found to be legally compliant. One issue was identified in relation to the timely reporting of RIDDOR incidents and this has been addressed.

Risk assessment

All risks are categorised using the same risk matrix and framework based on the likelihood of the risk occurring and the severity of impact, with the highest risk having a score of 25 (almost certain and catastrophic) and the lowest risk of 1 (rare and negligible). The Trust uses a web based system (Datix) and designated members of staff have authority to identify and enter risks on the risk register. Each Health Group has arrangements for the review of risks on the risk register and the outcome is recorded in Health Group governance meetings. The Non-Clinical Quality Committee reviews all risks within their Terms of Reference. The top rated risks are reviewed at the Executive Management Committee.

There were 198 risks on the risk register at the end of March 2016. Of these, 32 risks have been rated as high, 129 as moderate and 14 as low risk. The highest rated risks at the year-end were related to the emergency department (meeting the 4 hour target and medical staffing) and the replacement of ageing radiology equipment.

The risks that could threaten achievement of the Trust's strategic objectives are set out in the Board Assurance Framework which is reviewed by the Trust Board throughout the year and also by the Audit Committee. The Board Assurance Framework includes an assessment of the source and level of assurance received as well as gaps in assurance. Any increase or decrease in a risk score is agreed by the whole Board. There were 12 risks on the Board Assurance Framework at the start of the 2015/16 year which were aligned to the 6 corporate objectives. The top three risks related to compliance with the Care Quality Commission (CQC) regulations, delivery of the financial plan and delivering the benefits of the medical pathway transformation programme. At the end of the year, the risk relating to CQC compliance had reduced to reflect the progress made against the CQC recommendations following the May 2015 inspection. The financial risks had also reduced to reflect the improved outturn position at the end of the year.

The Trust has a number of controls in place to address the risks identified in the Board Assurance Framework. A Quality Improvement Programme was developed during the year to respond to the issues raised following the focussed CQC inspection in May 2015. The governance

arrangements have been strengthened resulting in more robust monitoring of agreed milestones and good progress has been made against these. There are Board approved action plans for improving performance against the NHS Constitution standards. External advice was sought to support the planned changes in the emergency care pathway and an overarching system-wide plan was developed which also included lead responsibilities for the local CCGs for both pre-hospital pathway actions and discharge arrangements.

The Board Assurance Framework also contained 4 risks relating to delivery of the financial plan. The Board's Performance and Finance Committee has maintained close overview of the delivery plan throughout the year. Health Groups have attended the meetings to provide information on the delivery and robustness of their financial plans.

During the year new clinical risks emerged in relation to Never Events and Serious Incidents. The Trust lowered its threshold for reporting Serious Incidents as part of encouraging an open and transparent approach to patient safety. This identified areas of concern relating to hospital acquired pressure damage, failure to follow agreed procedures and outpatient cancellations. Trust wide actions were implemented for pressure ulcers personally led by the Chief Nurse, an Improvement Project was established for outpatients and arrangements strengthened for dissemination of information relating to adverse events.

There were five Serious Incidents Requiring Investigation (SIRI) during 2015/16. These were data security breaches which were all reported to the Information Commissioner. Three incidents related to inappropriate access to a patient's record. One involved an employee accessing a family member's record and the investigation resulted in the member of staff receiving a formal warning. The second involved an employee accessing a patient record for a non-medical purpose and the Trust Disciplinary procedure resulted in no formal action being taken. The third incident, involved a temporary agency worker who accessed their own record which resulted in the Trust terminating their employment. These incidents were highlighted in the Chief Executive's monthly briefing to all staff to remind them of the consequences of accessing records that they are not entitled to view. The remaining two incidents related to patient documents that were lost in transit. One involved an envelope containing copies of patient documentation which was left in a train station and the second involved a patient record which was handed into a GP Surgery as it was found in the street outside. Both incidents are complete awaiting decision/outcome from the ICO.

The risk and control framework

The system of internal control is designed to manage risk to a reasonable level. All risks that are entered on the Trust risk management system are assigned initial, current and target risk rating. Controls are identified to mitigate the level of risk and where there are gaps in the controls, action plans are developed. Risks are identified and reviewed on an ongoing basis across Health Groups. Risks are identified from a number of different sources, including day to day operational working practices and trends arising from incidents, complaints and regulatory compliance. Line managers are responsible for on-going investigation and assessment of risks.

There is a mechanism for Health Groups and Directorates to escalate risks. New high level risks are notified to the Health Group triumvirates to be dealt with immediately whilst lower level risks are discussed at the Health Group Governance meetings. The Executive Management Committee reviews the highest rated risks. There is a process in place that reviews the risks on the risk register and aligns these to Board Assurance Framework risks.

There are a number of mechanisms in place which are designed to prevent or minimise the potential of risks occurring. The Trust's incident reporting system records near misses as well as actual incidents. The learning from Serious Incidents is shared at Health Group Governance meetings. The Trust's Mortality Committee commissions case note reviews. Training is provided to staff who use the Datix system. Root Cause Analysis training is provided to senior managers involved in investigating Serious Incidents. The Trust's intranet site contains information to support staff in managing risks. The Trust's formal communication systems are used to remind staff of their responsibilities and when specific initiatives or incidents have occurred. These include anti-fraud activities relating to employment, bank or agency staff and publishing the outcome of investigations.

A comprehensive programme is in place called the 'three Gs' which audits practice on the ward and is aligned to the Care Quality Commission's Key Lines of Enquiry. This gives a rating to each ward and identifies areas of potential risk. Risks are also identified from patient complaints, the fraud work undertaken, through the internal audit programme and the clinical audit programme.

A framework is in place for managing and controlling risks to data security. There is a Senior Risk Owner at Board

level and a network of information risk owners across the organisation. Information Governance training is a mandatory requirement for all staff to complete.

The Trust continues to strengthen current systems and processes to ensure that it can demonstrate the best standards in research governance and delivery. The Trust adheres to national Health Research Authority (HRA) systems to manage the studies in proportion to risk. A suite of standard operating procedures provide a framework to demonstrate adherence to the UK Clinical Trial Regulations and Research Governance Framework (RGF) and these procedures will be updated in line with the publication of the HRA UK Policy Framework for Health & Social Care Research in the summer of 2016. The Trust's third routine MHRA Good Clinical Practice (GCP) inspection is due in 2016. A risk based monitoring programme is in place to ensure compliance to Good Clinical Practice. Common findings from the monitoring include the need for dedicated research nurse support, ensuring participant research visits are appropriately documented and demonstrating that appropriate version control for research documentation is maintained.

Review of the effectiveness of risk management and internal control

The effectiveness of risk management and internal control has been determined through a number of mechanisms. The Trust's internal auditors has provided an opinion on the Trust's Assurance Framework and has confirmed that it meets the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.

The internal audit programme for 2015/16 was informed by the Trust's own risk and assurance framework, discussion with a wide range of officers and the broader context of the NHS. It was developed around the Trust's strategic objectives and its business critical systems and was risk based. The Director of Audit Opinion and Annual Report 2015/16 gave an overall opinion of limited assurance. This was provided in the knowledge of the significant challenges that the Trust has faced over the year in terms of operational performance and financial pressures.

No critical actions were identified for those audits that received limited assurance. Limited assurance audits included infection prevention, incident reporting, medical staff planned absence, consultant job planning and responding to the Francis report. Two audits identified that centralised systems were much stronger than the Health Group processes (strategy/planning and performance management/NHS target reporting), with the Health Group processes only receiving limited assurance. The four locality reviews covering sterile services, wards 1, 8, 9 and 90 also received limited assurance. A common themes arising from these audits was completion of mandatory training.

The Audit Committee, comprising Non-Executive Directors, gives independent assurance to the Board. It receives all audit reports from internal and external auditors and monitors progress against agreed recommendations. Where gaps in control are identified management action is agreed. A tracking system of agreed actions is in place and the internal auditors follow up recommendations to provide assurance to the Audit Committee that the issues raised have been addressed.

The Trust faced a number of challenges in 2015/16. There continued to be changes at Board level. All Non-Executive Directors (apart from one) were new to the Trust in 2015, including the Chairman. Three of the 5 Executive Directors changed. These were the Chief Medical Officer, Chief Nurse and the Chief Operating Officer. In recognition of the need to build a strong unitary Board, time has been spent in the Board Development sessions specifically around building relationships, increasing knowledge and jointly developing the Trust strategy. All Executive Directors have been checked in accordance with the Fit and Proper Persons requirement (CQC Regulation 5) and that the Board duly approved these individuals to hold office.

There have also been changes at Health Group level with 2 of the 4 Operation Directors changing and one of the Nurse Directors. The Chief Executive has held a number of development sessions with the Health Group senior management teams. These have been used to discuss organisational priorities, strengthen performance management arrangements, listen to feedback from management teams and foster a way of working that extends beyond each individual Health Group.

The Trust's performance against the Emergency Department 4 hour wait target has resulted in significant external scrutiny. The Trust has received external support in developing its plans. The acute medical pathway has now been transformed and April 2016 performance exceeded its agreed trajectory.

The Trust did not meet the 18 week referral to treatment time (incomplete pathway) or all the cancer targets during 2015/16. However, steady progress has been made. Plans are in place at specialty level to meet the 18 week target during 2016/17. The majority of the cancer targets were being met at the time of writing this report. The exceptions

were the 62 day standard (which is in part due to referrals being received late in the pathway), 31 day standard and 104 day waits.

The Trust received a focussed re-inspection from the CQC in May 2015.This inspection did not assess those services which were rated as good in 2014, only inspecting those services rated as requires improvement. The Trust received an overall rating of 'requires improvement' and a comprehensive Quality Improvement Plan was developed which included all the CQC 'should do' and 'must do' actions. A Quality Summit was held on the 11 April 2016, hosted by the CQC with invited stakeholders, to review the progress made. Positive feedback was received from stakeholders and there will be full comprehensive assessment of the Trust in June 2016. Regular engagement meetings have been held between the Trust and the CQC throughout 2015/16 to monitor progress against the actions.

In addition, the Trust uses benchmarking information from a variety of sources to gauge the effectiveness of its risk management and internal control processes. The 2015 national staff survey results demonstrated significant improvement. Whilst a number of questions show that the Trust has further work to do, its overall engagement score had improved and there had been positive movement across a number of questions. In addition, the initial feedback from the national inpatient survey also demonstrates that patients have responded positively to the way that care is being delivered and the Trust is awaiting the publication of the final report from the Care Quality Commission.

Information is also used from external agencies visiting the Trust. The Trust invited the Royal College of Surgeons to review systems in place following two Never Events in the neurosurgery department. The conclusion was that there were no systemic issues but there was some action that the Trust could take to strengthen its systems. An action plan was developed and is now being delivered.

2015/16 saw three responsive visits to the Trust by the Health and Safety Executive (HSE) following incidents reported under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. The first visit was to assess the Trust's compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013; the second visit was to assess the adequacy of facilities and protocols in use in the Trust's Pathology Laboratories for dealing with 'high risk' samples (in this case tuberculosis). The HSE inspectors involved in both visits were satisfied that the Trust was complying with its statutory obligations. The HSE undertook a third visit on the 31 March 2016 which resulted in an Improvement notice. This related to staff adhering to protection requirements in the mortuary.

Significant issues

Having reviewed the areas of risk I consider that the following are significant issues:

The Trust's failure to meet the Emergency Department 4 hour wait target has impacted negatively on the patient experience and has continually resulted in patients remaining in the Emergency Department for longer than expected. Systems have been put in place to ensure that patient safety is not compromised and the nursing establishment was increased. However, we are aware that the Trust's relationship with its commissioners and the Trust Development Authority (now NHS Improvement) has been challenging. A major programme of transformation of the acute medical pathway has been delivered in 2015 which has put in place the necessary building blocks to enable the Trust to meet its planned trajectory in 2016/17. The performance for the year was 78.5% against a national target of 95%.

The Trust did not meet all of the remaining NHS Constitution standards. Whilst steady progress has been made against the referral to treatment 18 week target, performance at the end of the year was 85.19% against a 92% target. In addition the 62 day cancer standard was also not met for the full year. Action plans have been developed and presented at the Board's Performance and Finance Committee. Trajectories have been set and agreed for meeting these targets in the forthcoming year.

The Trust's approved financial plan for 2015/16 forecast a deficit of £18.3m. Actual performance in year improved with the deficit at year end being £8m. This improvement was due to two non-recurrent issues relating to an asset valuation and an agreement to transfer resources from capital to revenue. The Trust however, is carrying an underlying deficit of circa £20m. In 2015/16 the Trust's liquidity was supported by a combination of internal resources and a £15m working capital loan from the Department of Health.

Looking ahead, the Trust has a balanced financial plan in place for 2016/17 but this is dependent on the receipt of £14m from the national STF (Sustainability and Transformation Fund) and the achievement of circa £20m of efficiencies. The achievement of this level of efficiency is a significant risk to the Trust. In addition, our local commissioners are also reporting significant risks in their

ANNUAL GOVERNANCE STATEMENT 2015/16

plans and as such the local health economy as a whole faces a degree of risk that hitherto it has not had to face.

The Trust commenced a major programme of cultural transformation following the CQC visit in May 2014 which identified that there was a bullying culture within the Trust. Significant progress has been made which was recognised when the CQC revisited the organisation in 2015. The Trust performance in December, 2014 was 3.54 (out of 5) which placed the organisation in the bottom 20% of Trusts nationally, however from the recent survey in February, 2016 performance has improved to 3.8 which is slightly above national average (3.79) for acute Trusts. A number of key actions have been delivered including leadership development so that managers and staff have the necessary skills to manage and lead in accordance with the cultural change programme, embedding values and behaviours and clarifying roles and responsibilities, including the development of a staff charter. The focus of this work has now moved from anti-bullying to embedding a strong performance management culture within the Trust.

The CQC inspection of the Trust in May 2015 resulted in a rating of 'requires improvement' and 20 'must do' actions and further 'should do' actions. Good progress has been made against the recommendations but the Trust recognises that it has more work to do to ensure that staff can learn from adverse events and that the systems and processes, which have been designed to keep patients safe, are followed at all times. The declaration of Never Events in 2015/16 and Serious Incidents with the same common themes highlights that further work is required and a Quality Improvement Programme is in place.

The Trust Board acknowledges that 2016/17 will be a challenging year. This will be the first time that all substantive posts on the Board have been filled at the start of the year (April 2016), for a number of years. Board members need to build mutually supportive relationships at the same time as gaining knowledge and seeking assurance that key objectives are being met. A programme is in place to support the development of the whole Board so that there is an appropriate balance of experience and skills leading to confidence in the delivery of the agenda.

Accountable Officer: Mr C Long
Organisation: Hull and East Yorkshire Hospitals NHS Trust

June 2016

This section of the Annual Report sets out the Trust's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers.

REMUNERATION TABLE - ANNUAL REPORT

This table has been subject to audit	**Current Year: 2015-16**				**Prior Year: 2014-15**			
Name and title	**(a)**	**(b)**	**(c)**		**(a)**	**(b)**	**(c)**	
	Salary (bands of £5,000)	**Expense payments (taxable) total to nearest £100**	**All pension - related benefits (bands of £2,500)**	**TOTAL (a to c) (bands of £5,000)**	**Salary (bands of £5,000)**	**Expense payments (taxable) total to nearest £100**	**All pension - related benefits (bands of £2,500)**	**TOTAL (a to c) (bands of £5.000)**
	£000	**£00**	**£000**	**£000**	**£000**	**£00**	**£000**	**£000**
Ramsden, Mike: Chairman	35-40		-	35-40	5-10			5-10
Christmas, Tracy: Non Executive Director from 6-Jul-15	0-5		-	0-5				
Gore, Martin: Non Executive Director	5-10		-	5-10	0-5			0-5
Hall, Stuart: Non Executive Director	5-10		-	5-10	0-5			0-5
Sheldon, Trevor: Non Executive Director	5-10		-	5-10	5-10			5-10
Snowden, Andy: Non Executive Director & Vice Chair	5-10		-	5-10	5-10			5-10
Walker, Vanessa: Non Executive Director from 6-Jul-15	0-5		-	0-5				
Long, Chris: Chief Executive Officer	175-180	1500	60-62.5	240-245	90-95	3400	60-62.5	150-155
Bond, Lee: Chief Financial Officer	135-140		20-22.5	160-165	135-140		17.5-20	155-160
Philp, Ian: Chief Medical Officer from 1 April15 to 5-Jul-15	60-65		-	60-65	160-165			160-165
Phillips, Kevin: Chief Medical Officer (Interim) 8-Jun-15 to 31-Aug-15	40-45		95-97.5	140-145				
Phillips, Kevin : Chief Medical Officer from 1-Sep-15	125-130		242.5-245	365-370				
Wright, Mike: Chief Nurse from 6-Apr-15	140-145		-	140-145				
Ledger, Joanne: Chief Nurse (Interim)from 1 April to 30-Apr-15	5-10	100	12.5-15	20-25	55-60	100	45-47.5	100-105
Lewin, Pauline: Chief of Infrastructure & Developmentfrom 1 April to 24-Jul-15 (1)	15-20		-	15-20	95-100		20-22.5	115-120
Taylor, Duncan: Chief of Infrastructure & Development (Acting) from 1 April to 31-Jan-16	80-85		2.5-5	85-90	95-100		57.5-60	155-160
Adamson, Jayne: Chief of Workforce & Organisational Development from 1 April to 30-Jun-15	45-50	100	-	45-50	135-140	100	37.5-40	175-180
Myers, Jacqueline: Chief Operating Officer (Acting) from 1 April to 30-Jun-15	30-35	100	10-12.5	45-50	115-120	100	92.5-95	210-215
Thomas, Liz: Director of Governance & Corporate Affairs	95-100		5-7.5	105-110	95-100		37.5-40	135-140
Nearney, Simon: Director of Workforce & Organisational Development	105-110		72.5-75	175-180				

1. Following a Board restructure the post of Chief of Infrastructure and Development no longer exists
2. Following the Board reorganisation Jayne Adamson was made redundant and received salary of £34,944 plus £10,337 pay in lieu of annual leave which are included above. She also received a payment of £70,000 compulsory redundancy which has been included in the exit package note to the Trust's annual accounts but is not shown here.
3. The amount shown for Pauline Lewin includes £10,000 in lieu of annual leave and £7,500 salary. She also received £120,000 of contractual payments due on the severance of her contract and a non contractual payment of £120,000, both of these have been disclosed in the exit package note in the Trust's annual accounts but are not shown above.
4. Taxable expenses comprise of assets made available to office holders for private use and include motor vehicles and IT equipment
5. The post of Chief Operation Officer was vacant from 1 July 2015. The post was filled substantively from 1 April 2016.
6. The Trust made no pension contributions during the year for Ian Philp and Jayne Adamson.

Exit packages

Exit Packages agreed in 2015-16

	2015/16							
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Cost of compulsory redundancies**	**Number of other departures agreed**	**Cost of other departures agreed**	**Total number of exit packages**	**Total cost of exit packages**	**Number of departures where special payments have been made**	**Cost of special payment element included in exit packages**
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**	**£**
Less than £10,000	0	0	5	24,115	5	24,115	0	0
£10,000 - £25,000	7	115,191	6	102,399	13	217,590	0	0
£25,001-£50,000	8	318,488	3	134,279	11	452,767	0	0
£50,001-£100,000	3	170,738	2	124,874	5	295,612	0	0
£100,001-£150,000	0	0	0	0	0	0	1	120,000
£150,001-£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	1	253,200	1	253,200	0	0
Total	**18**	**604,417**	**17**	**638,867**	**35**	**1,243,284**	**1**	**120,000**

In 2014/15 there were no exit packages.

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda for change handbook. The Trust also ran a mutually agreed resignation scheme during the year.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Amounts paid to one employee included contractual payments for termination of employment and a non contractual payment in respect of compensation.

PENSIONS TABLE

This table has been subject to audit

	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31/03/2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31/03/2016 (bands of £5,000)	CETV at 01/04/15	Real increase in CETV	CETV at 31/03/16
	£000	£000	£000	£000	£000	£000	£000
Long, Chris	2.5-5	10-12.5	45-50	145-150	890	85	985
Bond, Lee	0-2.5	-2.5-0	35-40	110-115	571	20	597
Phillips, Kevin	15-17.5	47.5-50	70-75	220-225	1008	307	1398
Wright, Michael	0-2.5	0-2.5	60-65	185-190	1142	20	1176
Myers, Jacqueline	0-2.5	-2.5-0	25-30	70-75	372	12	388
Ledger, Joanne	0-2.5	0-2.5	20-25	55-60	211	9	321
Thomas, Elizabeth	0-2.5	2.5-5	25-30	85-90	620	26	653
Nearney, Simon	2.5-5	0-0	5-10	0-0	39	41	81
Lewin, Pauline	-2.5-0	-5--2.5	55-60	170-175	1234	0	0
Duncan Taylor	0-2.5	0-2.5	35-40	110-115	701	17	729

The values relating to increases in pension and lump sum in the table above have been apportioned according to the time in office where the time in office is less than one year. All other values relate to the full period of employment regardless of the office held.

Pauline Lewin has been in receipt of her pension since she retired on 24 July 2015 and the increase in CETV has been reported as zero. The negative values for increase in pension and lump sum result from a slight reduction in annual salary between 2014-15 and 2015-16.

Simon Nearney was originally in the 2008 scheme and is now in the 2015 scheme, neither of which have mandatory lump sums hence the zero values in the lump sum columns.

Pay Multiples

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

Our highest paid Board Director was the Chief Executive however if the Chief Medical Officer had been in post for a full 12 months he would have been the Highest paid Board Director. We have therefore made the calculations below based on the full year salary of the Chief Medical Officer.
The banded remuneration of the highest paid Board Director in Hull and East Yorkshire Hospitals in the financial year 2015/16 was £210,000- £215,000 (2014/15, £255,000- £260,000). This was 7.7 times (2014/15 - 9.4 times) the median remuneration of the workforce, which was £27,778 (2014/15, £27,622).

No employees received more than the highest paid Board Director in 2015/16 or in 2014/15.
Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.
The median salary of our employees has remained stable at £27,778 however the remuneration of the Chief Medical Officer has reduced by around £40,000.

Staff report

Number of Senior Managers by Band

Band	WTE
Band 8b	12
Band 8c	13
Band 8d	5
Band 9	2
VSM	13

Staff Numbers

Staff Group	Average 15/16
Medical and Dental	959
Ambulance Staff	0
Administration and Estates	1364
Healthcare Assistants and Other Support Staff	638
Nursing, Midwifery and Health Visiting Staff	2739
Nursing, Midwifery and Health Visiting Learners	16
Scientific, Therapeutic and Technical Staff	1279
Social Care Staff	0
Other Staff	1
Trust Total	6996

Staff Composition

Trust Total

Gender	Headcount	%
Male	1959	23
Female	6713	77

Director Grade

Gender	Headcount	%
Male	9	69
Female	4	31

Sickness Absence Data

% Sickness (2015/16)	Average FTE 2015/16	FTE-Days Available 15/16	FTE-Days Lost to Sickness Absence 15/16	Average Sick Days per FTE
3.6%	6,996	1,574,001	56,349	8.1

Staff policies applied during the financial year

The Trust is committed to working in partnership with employees, staff side representatives and other agencies to ensure that there are robust policies and procedures in place to provide assistance to managers and employees on a wide range of topics that are aligned to legislative requirements, good practice and the Trust's values - care, honesty and accountability.

All policies are written to ensure that staff are treated fairly and equitably, regardless of whether an individual displays any of the protected characteristics (age, disability, gender reassignment, marriage/civil partnership, pregnancy/ maternity, race, religion or belief, sex, sexual orientation).

There are a number of policies to support this ethos, for example:

- Equality and Diversity in Employment Policy
- Recruitment and Selection Policies
- Managing Attendance Policy
- Redeployment Policy
- Education and Development Policy

The Equality and Diversity in Employment Policy highlights the duties and rights of employees with regards to equality and diversity, namely the right to be treated fairly, equally and free from discrimination, the right to fair treatment regarding pay and the duty not to discriminate against patients or staff and to adhere to equal opportunities and Equality and Human Rights legislation.
Full and fair consideration is given to applications for employment by the Trust made by disabled persons (having regard for their particular aptitudes and abilities) through a range of measures including;

- All members of the interview panel must have received equality and diversity training
- The interview panel should include a minimum of two people one of whom must have attended the Trust Recruitment and Selection training
- Candidates do not have to specify if they represent one of the protected characteristics during the pre-employment or post-employment stage. All candidates are asked whether any reasonable adjustments or workplace adjustments would be required for them to take up the specific role applied for, however, this does not impact on the decision in terms of shortlisting, interviewing or determining the successful candidate
- Managers making adjustments if a disabled person is attending for interview or a candidate indicates that they have a disability, even if the manager does not know in advance of the disability.

The Trust's Managing Attendance and Redeployment Policies provide a framework for managing the continued employment of, and for arranging appropriate training for, employees of the Trust who have become disabled during the period when they are employed by the Trust. The policies reflect the overall ethos of supporting employee health and well-being.

The Redeployment Policy compliments the Managing Attendance Policy in terms of offering an alternative role as a reasonable adjustment to employees where their substantive post is no longer suitable. The policy states that under the requirement to make reasonable adjustments, the Trust may give a greater priority to individuals with a disability as defined by the Equality Act 2010. In these cases, any decision will be made dependent upon individual circumstances.

Training and development opportunities are available for all staff. All staff have equal access to education and development opportunities. Agreement of Personal Development Plans are part of the annual appraisal process for Trust employees. These are reviewed on an ongoing basis to ensure any additional training needs are highlighted.

REMUNERATION AND STAFF REPORT

Consultancy Fees 2015/16

Description	Supplier	£000's	Percentage
Programme Management for NTDA unscheduled care pathway work	Gibbons C	11	3
Opportunity search	KMand T Ltd	200	50
Finance review	RJC Financial Solutions Ltd	33	8
Coding and income review	Capita Business Services	23	6
T&O Deep dive project	Four Eyes Insight Ltd	96	24
KPMG System work	Humber NHS recharge	38	9
Prof subscriptions, salary sacrifice, retirement gifts, long service awards, CIS	Brown Consulting Associates Ltd	1	0
Total		402	100

Off payroll engagements

From time to time the Trust uses the services of individuals who are self employed or who trade through a personal services company At 31 March the Trust received services from 12 such individuals. 6 of these individuals charged an equivalent daily rate of £220 or more and had been engaged by the Trust for more than 6 months. Those engagements are set out in the table below. The Trust has sought and received assurances from all 6 individuals that they are paying the correct amount of UK tax and have not been involved in tax avoidance schemes.

Three of the 6 individuals have a formal contract which is clear on the Trusts expectations in relation to paying tax in the UK and sets out the Trust's right to receive assurances that taxes have been paid appropriately. We are in the process of drawing up contracts for 3 individuals. All outstanding contracts are planned to be in place by 30 June 2016.

	Number
Number of existing engagements at 31 March 2014	6
Of which, the number have existed :	
For less than 1 year at the time of reporting	1
For between 1 and 2 years at the time of reporting	2
For between 2 and 3 years at the time of reporting	
For between 3 and 4 years at the time of reporting	1
For more than 4 years at the time of reporting	2

Where the daily rate exceeds £220 a day and the engagement has lasted for more than 6 months

	Number
Number of new engagements between 1 April 2015 and 31 March 2016	1
Number of engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations.	0
Number for whom assurance has been requested	1
Of which assurances received	1

No Board members were engaged on an “off payroll” basis during 2015/16

Chris Long,
Chief Executive

ANNUAL ACCOUNTS

FOR THE PERIOD 1ST APRIL 2015 TO 31ST MARCH 2016

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

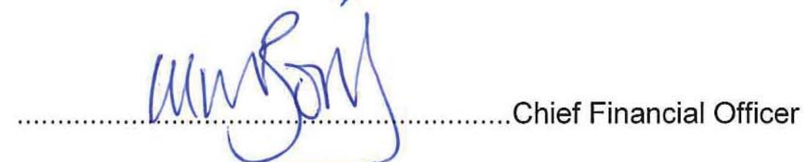
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

26 May 2016 ....Chief Executive

26 May 2016  ....Chief Financial Officer

Remarkable people.
Extraordinary place.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF HULL and EAST YORKSHIRE HOSPITALS NHS TRUST

We have audited the financial statements of Hull and East Yorkshire Hospitals NHS Trust for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Board of Directors of Hull and East Yorkshire Hospitals NHS Trust as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, 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 Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the Statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014, to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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 Directors; and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts 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.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Hull and East Yorkshire Hospitals NHS Trust as at 31 March 2016 and of the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

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

Other matters on which we report by exception: Adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

Basis for qualified conclusion

The Trust's outturn position for 2015/16 was an £8.0 million deficit. Whilst this is better than the projected deficit of £18.3m, this was primarily achieved through one off technical adjustments including a capital to revenue transfer of £2m agreed with the Trust Development Authority and the revaluation of investment land at Castle Hill by £8.2m. Action towards addressing the underlying deficit of £22.2m by recurrent measures has been limited.

The Trust is planning to achieve a break even outturn for 2016/17. However, this will only be achieved with the delivery of £19.2m efficiency savings, £14m conditional support from the Sustainability and Transformation Fund and £5m of income from commissioners which is considered to be at risk. Of the £19.2m cost improvement programme, £14.2m has been identified, of which £3.2m are one-off savings, leaving a further £5m still to be identified.

The additional non-recurrent support of £14m from the Sustainability and Transformation Fund is dependent on hitting an agreed set of trajectories which will ultimately lead to the Trust hitting the national performance targets for the four hour Emergency Department action, 62 day Cancer Waits and 18 weeks Referral to Treatment (RTT). This will require a significant improvement in performance, returning to levels last achieved in 2013/14. There are detailed plans in place and agreements of activity with commissioners to deliver these improvements but there is a £5m affordability gap between available resources and contract levels still to be addressed. The funding also depends on the Trust achieving certain levels of activity.

The plan itself also does not fully address the overall underlying deficit. It is expected that the underlying deficit will be £14m by the end of 2016/17 if all other plans are achieved.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the C&AG in November 2015, with the exception of the matters reported in the basis for qualified conclusion paragraphs above, we are satisfied that, in all significant respects, Hull and East Yorkshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Certificate

We certify that we have completed the audit of the accounts of Hull and East Yorkshire Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

John Graham Prentice FCCA MBA
for and on behalf of KPMG LLP, Appointed Auditor

1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA

1 June 2016

STATEMENT OF COMPREHENSIVE INCOME FOR YEAR ENDED 31 MARCH 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	8.1	**(316,821)**	(305,195)
Other operating costs	6	**(215,178)**	(206,629)
Revenue from patient care activities	3	**496,105**	490,344
Other operating revenue	4	**30,148**	36,215
Operating surplus/(deficit) before impairments		**(5,746)**	14,735
Impairments		**(6,700)**	
Reversal of Impairment		0	321
Total Impairment		(6,700)	321
Operating Surplus/(Deficit)		(12,446)	15,056
Investment revenue	10	**55**	62
Other gains and (losses)	11	**8,300**	28
Finance costs	12	**(4,899)**	(4,892)
Surplus/(deficit) for the financial year		**(8,990)**	10,254
Public dividend capital dividends payable		**(5,925)**	(6,394)
Retained surplus/(deficit) for the year		**(14,915)**	3,860

Other Comprehensive Income	2015-16 £000s	2014-15 £000s
Impairments and reversals taken to the revaluation reserve	**(16,694)**	182
Total comprehensive income for the year*	**(16,694)**	**182**

Financial performance for the year		
Retained surplus/(deficit) for the year	**(14,915)**	3,860
IFRIC 12 adjustment (including IFRIC 12 impairments)	**(11,623)**	0
Impairments (excluding IFRIC 12 impairments)	**18,323**	(321)
Adjustments in respect of donated asset reserve elimination	**201**	(613)
Adjusted retained surplus/(deficit)	**(8,014)**	2,926

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- Value for money is achieved from the resources available to the trust;

- The expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- Effective and sound financial management systems are in place; and

- Annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

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

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed Chief Executive

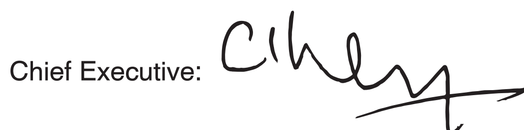
26 May 2016

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2016

	NOTE	**31 March 2016 £000s**	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	13	**265,895**	287,706
Intangible assets	14	**2,163**	2,181
Investment property	16	**8,371**	149
Trade and other receivables	20.1	**2,385**	2,483
Total non-current assets		**278,814**	292,519
Current assets:			
Inventories	19	**12,392**	10,765
Trade and other receivables	20.1	**21,131**	21,649
Cash and cash equivalents	21	**2,692**	4,504
Total current assets		**36,215**	36,918
Total assets		**315,029**	329,437
Current liabilities			
Trade and other payables	22	**(50,245)**	(42,413)
Provisions	26	**(233)**	(704)
Borrowings	23	**(1,886)**	(2,859)
DH capital loan	23	**(1,260)**	(1,260)
Total current liabilities		**(53,624)**	(47,236)
Net current liabilities		**(17,409)**	(10,318)
Total assets less current liablilities		**261,405**	282,201
Non-current liabilities			
Provisions	26	**(722)**	(895)
Borrowings	23	**(53,987)**	(55,869)
DH revenue support loan	23	**(13,677)**	0
DH capital loan	23	**(15,727)**	(16,987)
Total non-current liabilities		**(84,113)**	(73,751)
Total assets employed:		**177,292**	208,450
FINANCED BY:			
Public Dividend Capital		**208,405**	208,378
Retained earnings		**(44,344)**	(29,429)
Revaluation reserve		**13,231**	29,501
Total Taxpayers' Equity:		**177,292**	208,450

The notes on page x to x form part of this account.

The financial statement on pages x to x were approved by the board, on 26th May 2016 and signed on its behalf by

Chief Executive:  Date: 26/05/2016

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDING 31 MARCH 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**208,378**	**(29,429)**	**29,501**	**208,450**
Changes in taxpayers' equity for 2015-16				
Retained deficit for the year		(14,915)		**(14,915)**
Net loss on revaluation of property, plant, equipment			(16,270)	**(16,270)**
Permanent PDC received - cash	1,027			**1,027**
Permanent PDC repaid in year	(1,000)			**(1,000)**
Net recognised expens) for the year	**27**	**(14,915)**	**(16,270)**	**(31,158)**
Balance at 31 March 2016	**208,405**	**(44,344)**	**13,231**	**177,292**

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
Balance at 1 April 2014	**207,493**	**(33,289)**	**29,319**	**203,523**
Changes in taxpayers' equity for the year ended 31 March 2015				
Retained surplus for the year		3,860		3,860
Net gain on revaluation of property, plant, equipment			182	182
New temporary and permanent PDC received - cash	885			885
Net recognised revenue for the year	**885**	**3,860**	**182**	**4,927**
Balance at 31 March 2015	**208,378**	**(29,429)**	**29,501**	**208,450**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(12,446)**	15,056
Depreciation and amortisation	6	**11,666**	14,860
Impairments and reversals	15	**6,700**	(321)
Donated Assets received credited to revenue but non-cash	4	**(446)**	(1,111)
Interest paid		**(4,883)**	(4,860)
PDC Dividend (paid)/refunded		**(6,233)**	(6,117)
(Increase)/Decrease in Inventories		**(1,627)**	435
(Increase)/Decrease in Trade and Other Receivables		**616**	(2,607)
Increase/(Decrease) in Trade and Other Payables		**7,543**	9,295
Provisions utilised		**(781)**	(320)
Increase/(Decrease) in movement in non cash provisions		**429**	620
Net Cash Inflow from Operating Activities		**538**	24,930
Cash Flows from Investing Activities			
Interest Received		**55**	62
(Payments) for Property, Plant and Equipment		**(12,048)**	(24,574)
(Payments) for Intangible Assets		**(505)**	(445)
Proceeds of disposal of assets held for sale (PPE)		**110**	0
Net Cash Outflow from Investing Activities		**(12,388)**	(24,957)
Net Cash Outflow before Financing		**(11,850)**	(27)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received		**1,027**	885
Gross Temporary (2014/15 only) and Permanent PDC Repaid		**(1,000)**	0
Loans received from DH - New Revenue Support Loans		**27,677**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(1,260)**	(1,260)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(14,000)**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(2,038)**	(1,980)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**446**	1,111
Net Cash Inflow/(Outflow) from Financing Activities		**10,852**	(1,244)
NET DECREASE IN CASH AND CASH EQUIVALENTS		**(998)**	(1,271)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**3,685**	4,956
Cash and Cash Equivalents (and Bank Overdraft) at year end	**21**	**2,687**	3,685

1. NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be
'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to
another.

1.3 Interests in Trading Companies

Interests in trading companies will be carried at market value, where that value can be measured. Where there is no market value available investments will be valued at cost in line with the requirements of IAS39. Where the Trust has a holding in an associated company it will account for that holding as required by IAS28.

1.4 Charitable Funds

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as the Trust is the corporate trustee of the linked NHS Charity Hull and East Yorkshire Hospitals NHS Trust General Charitable fund, it effectively has the power to exercise control so as to obtain economic benefits. However the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties' notes.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the 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, but only if the revision affects the current period, future periods, or both.

The main uses of accounting estimates are in respect of:

- the lives and values of assets (notes 1,13 and 14)
- provisions needed and the amounts of these (note 26)
- the current value of future costs under PFI and other finance lease contracts (note 28)
- amounts to be accrued as expenditure

Specific details are provided in the notes relating to these items. Where possible the trust makes use of professional skills where critical judgements are required for accounting purposes. These include:

- reliance on the Valuer to assess the value and probable lives of buildings and land, and
- the use of assessments from the NHS Litigation Authority in making provision for liabilities

Specific estimates and judgements are detailed separately.

The key assumption about the future is that the Trust continues to be a going concern. This assumption underpins the most significant areas of estimation uncertainty at the end of the reporting period, and if changed would have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities and other amounts reported in these accounts.

NOTES TO THE ACCOUNTS

1.6 Revenue Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services provided under local agreements. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay. The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer.

The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.7 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 leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.8 Other expenses

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

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the 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 cost of at least £5,000. However there are some circumstances where an individual item with a value of less than £5,000 will be capitalised:
- where 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 interdependent, they had 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.
- PFI lifecycle costs.

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

Valuation

Property, plant and equipment is stated at fair value at the Statement of Financial Position date. Many of the Trust's buildings are of a specialised nature for which there is no readily available market information therefore the buildings are subject to full valuations every five years, with interim valuations also taking place after three years or where the Trust believes there has been an impairment in value. "Housekeeping" valuations are undertaken in between formal valuations where there has been significant capital expenditure.

Assets in the course of construction are valued at cost. Where the construction period spans more than one financial year the buildings are not re-valued until they are brought into use. These assets include land and buildings that are under the control of a contractor.

Buildings currently provided by private finance initiative have been brought onto the Statement of Financial Position where they fulfil the criteria of a finance lease as set out in International Accounting Standard 17 (IAS 17). These buildings have been brought on to the Statement of Financial Position at depreciated replacement cost valuation, as determined by the valuers.

Operational equipment is carried at fair value. Where assets are of low value, and/or have short useful economic lives, these are carried at depreciated historic cost as a proxy for fair value. Equipment surplus to requirements is valued at net recoverable amount.

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

Depreciation, amortisation and impairments
Property, plant, and equipment is depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets that are carried on the statement of financial position at a value that is not in excess of their residual value. Depreciation is charged quarterly, commencing in the quarter following the period in which the asset is brought into use. Useful lives are allocated on a per asset basis, within the following parameters and are subject to annual review:

- Medical Equipment 5-17 years*
- Plant and Machinery 5-30 years*
- Buildings (incl internal fixtures & fittings) 1-88 years
- Transport 5-12 years
- IT Equipment 5-12 years*

*assets lives listed above do not reflect where assets have fully depreciated, but are still in use and have been brought back on to the Statement of Financial position with an appropriate life, usually 1-2 years.

Assets in the course of construction are not depreciated until the asset is brought into use.

Buildings, installations and fittings are depreciated, based on their fair value, over the remaining life of the asset as advised by the independent Valuer, Cushman and Wakefield. Leaseholds are depreciated over the primary lease term. Equipment is depreciated replacement cost (as a proxy for fair value), evenly over the estimated life of the asset. Impairment losses resulting from changes in price are taken to the revaluation reserve in so far as a balance exists for the impaired asset, with any residual value being charged directly to the Statement of comprehensive Income. These include impairments resulting from the revaluation of buildings from their cost to their fair value when they become operational.

A revaluation decrease that does not result from a loss of economic value or service potential 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. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments
Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.10 Intangible assets

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000. The two main categories of intangible assets are computer software licences and development expenditure. Both are amortised over the shorter of the period of the licence, their useful economic life, or 20 years.

Intangible fixed assets are carried at depreciated historic cost, being a proxy for fair Value. Annual impairment reviews are undertaken where there is an indication that the fair value of intangible assets may have been impaired.

1.11 Donated assets

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.12 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to the retained earnings reserve. Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

Where the terms of a lease for property plant or equipment fulfil the criteria of a finance lease, under the requirements of IAS17(and IFRIC 4), the asset is recorded as an asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The interest element of the finance lease payment is charged to the Statement of Comprehensive Income over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the Statement of Comprehensive Income on a straight-line basis over the term of the lease. The same assessment criteria used for property plant and equipment leases, is used for land leases.

1.14 Private Finance Initiative (PFI) transactions

Buildings currently provided by private finance initiative have been brought onto the Statement of Financial Position where they fulfil the criteria of a finance lease as set out in IAS 17, and IFRIC 12. These buildings have been brought on to the Statement of Financial Position at a value determined by the independent valuers, Cushman and Wakefield. The buildings are subject to a depreciation charge on the same basis as non PFI funded assets. The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs;

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in

accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income. An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Contracts for "Private Finance Initiative" assets include provision for the replacement and refurbishment of these assets. These "lifecycle replacement" costs form part of the Unitary Payment. That payment was determined by the contract, and is independent of the actual cost of works to the contractor. The cost of lifecycle maintenance costs to the Trust is the element of the unitary payment allocated for this purpose, and the Trust capitalises this element of the payment in respect of those assets. Assets held under Private Finance Initiative arrangements are revalued annually to ensure that these are carried at fair value, in line with the Trust's policy on valuing non- current assets.

Assets contributed by the NHS trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

1.15 Inventories

Inventory is valued using the AVCO method at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover. Partially completed contracts for patient services are not accounted for as work-in- progress. Where payment for inventory has been deferred, the additional cost of the inventory is recognised as an expense in the Statement of Comprehensive Income.

1.16 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 1.55% in real terms.

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

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

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS 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 Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 26.

1.19 Non-clinical risk pooling

The 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 as and when they become due.

1.20 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.21 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote. A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable. Where the time value of money is material, contingencies are disclosed at their present value.

1.22 Financial assets

Financial assets are recognised when the 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 derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; 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.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method. Fair value is determined by reference to quoted market prices where possible, otherwise by formal valuation. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset. At the end of the reporting period, the trust assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised 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.

1.23 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de- recognised when the liability has been discharged, that is, the liability has been paid or has expired. Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value. After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.24 Value Added Tax

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

1.25 Foreign currencies

The Trust’s functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.26 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 35 to the accounts. The Trust benefits from Charitable donations that are held separately to the Trusts own finances. The Trust has opted not to consolidate its charitable funds until such time that they are material to the accounts.

1.27 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument. An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. Prior to 2009/10 the PDC dividend was determined using forecast average relevant net assets and a note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

1.28 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 trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.29 Changes in Accounting Policy

The Trust follows the requirements of IAS 8 and adopts a change in accounting policy where:

1. The change is required by an accounting standard or interpretation; or
2. Required by the Department of health or as part of the Treasury FREM; or
3. Results in the financial statements providing reliable and more relevant information about the effects of transactions

Where the change in accounting policy is required by a new IASB standard or interpretation, the change is accounted for as required by that new pronouncement. If the new pronouncement does not include specific transition provisions, then the change in accounting policy is applied retrospectively. Retrospective application means adjusting the opening balance of each affected component of the statement of financial position for the earliest prior period presented and the other comparative amounts disclosed for each prior period presented as if the new accounting policy had always been applied. However, where it is impracticable to determine either the period-specific effects or the cumulative effect of the change for one or more prior periods presented, the new accounting policy will be applied to the carrying amounts of assets and liabilities as at the beginning of the earliest period for which retrospective application is practicable. Where it is impracticable to determine the cumulative effect, at the beginning of the current period, of applying a new accounting policy to all prior periods, the new accounting policy will be applied prospectively from the earliest date practicable.

1.30 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.31 Investment Property

Investment are only recognised where it is probable that future economic benefits will flow to the Trust and the cost can be easily measured. Investments are initially

1.32 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue for Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. INCOME GENERATION ACTIVITIES

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Summary Table - aggregate of both activities	**2015-16 £000s**	2014-15 £000s
Income	**4,043**	3,781
Full cost	**(3,640)**	(3,692)
Surplus	**403**	89

Staff and Visitor Catering	**2015-16 £000s**	2014-15 £000s
Income	**2,489**	2,235
Full cost	**(2,793)**	(2,788)
Surplus/(deficit)	**(304)**	(553)

Parking for Staff and Visitors	**2015-16 £000s**	2014-15 £000s
Income	**1,554**	1,546
Full cost	**(847)**	(904)
Surplus/(deficit)	**707**	642

3. REVENUE FROM PATIENT CARE ACTIVITIES

	2015-16 £000s	2014-15 £000s
NHS Trusts	**209**	78
NHS England	**156,249**	156,956
Clinical Commissioning Groups	**320,765**	322,050
Foundation Trusts	**5,303**	1,520
Department of Health	**2,961**	2,144
NHS Other (including Public Health England and Prop Co)	**1,569**	206
Additional income for delivery of healthcare services	**2,000**	0
Non-NHS:		
Local Authorities	**0**	404
Private patients	**450**	495
Overseas patients (non-reciprocal)	**180**	210
Injury costs recovery	**2,381**	1,950
Other	**4,038**	4,331
Total Revenue from patient care activities	**496,105**	490,344

4. OTHER OPERATING REVENUE

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	**1,564**	1,973
Education, training and research	**21,709**	25,866
Charitable and other contributions to revenue expenditure -non- NHS	**0**	8
Receipt of donations for capital acquisitions - Charity	**446**	1,111
Non-patient care services to other bodies	**2,097**	2,035
Income generation (Other fees and charges)	**4,332**	5,222
Total Other Operating Revenue	**30,148**	36,215
Total operating revenue	**526,253**	526,559

5. OVERSEAS VISITORS DISCLOSURE

	2015-16	2014-15
	£000	£000s
Income recognised during 2015-16 (invoiced amounts and accruals)	180	210
Cash payments received in-year (re prior year receivables)	91	28
Cash payments received in-year (re current year receivables)	132	118
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	13	16
Amounts added to provision for impairment of receivables (iro invoices issued 2014-15)	50	38
Amounts written off in-year (irrespective of year of recognition)	42	69

6. OPERATING EXPENSES

	2015-16	2014-15
	£000s	£000s
Purchase of healthcare from non-NHS bodies	10,104	13,446
Trust Chair and Non-executive Directors	78	52
Supplies and services - clinical	125,934	117,079
Supplies and services - general	14,848	14,831
Consultancy services	402	168
Establishment	6,686	6,278
Transport	1,341	1,447
Service charges - ON-SOFP PFIs and other service concession arrangements	1,839	1,689
Total charges - Off-SOFP PFIs and other service concession arrangements	81	81
Business rates paid to local authorities	2,834	2,729
Premises	19,059	17,174
Hospitality	5	0
Insurance	494	267
Legal Fees	358	403
Impairments and Reversals of Receivables	327	147
Depreciation	11,143	14,094
Amortisation	523	766
Impairments and reversals of property, plant and e 15057	3,780	(321)
Audit fees	78	104
Other auditor's remuneration - Quality accounts	11	11
Clinical negligence	17,108	11,038
Research and development (excluding staff costs)	735	928
Education and Training	1,190	2,126
Other	0	1,771
Total Operating expenses (excluding employee benefits)	**218,958**	206,308
Less (Impairments) and reversals of Property, Plant and Equipment	(3,780)	321
Expenses as disclosed in the statement of comprenensive income	215,178	206,629
Employee Benefits		
Employee benefits excluding Board members	315,779	303,961
Board members	1,042	1,234
Total Employee Benefits	**316,821**	305,195
Total Operating Expenses	535,779	511,503

*Services from NHS bodies does not include expenditure which falls into another category

7. OPERATING LEASES

All leases disclosed below are in respect of the Trust as a lessee.
Leases comprise medical equipment and systems and the lease terms vary form 1 to 10 years.
Lease payments for medical equipment are fixed. Contingent rent is determined according to inflationary increases.

7.1. Hull and East Yorkshire Hospitals NHS Trust as lessee

			2015-16	
	Buildings £000s	**Other £000s**	**Total £000s**	2014-15 £000s
Payments recognised as an expense				
Minimum lease payments	307	2,364	**2,671**	2,960
Summary of Future Minimum lease payments				
Payable:				
No later than one year	81	1,293	**1,374**	1,782
Between one and five years	324	2,457	**2,781**	2,708
After five years	1,863	316	**2,179**	1,958
Total	**2,268**	**4,066**	**6,334**	6,448

Remarkable people.
Extraordinary place.

8. EMPLOYEE BENEFITS AND STAFF NUMBERS

8.1. Employee benefits

2015-16	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**267,982**	248,115	19,867
Social security costs	**20,456**	20,456	0
Employer Contributions to NHS BSA - Pensions Division	**0**		0
Other pension costs	**19**	19	
Termination benefits	**918**	918	0
Total employee benefits	**289,375**	**269,508**	**19,867**
Employee costs capitalised	**1,629**	1,167	462
Gross Employee Benefits excluding capitalised costs	**287,746**	**268,341**	**19,405**

Employee Benefits - Gross Expenditure 2014-15	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	258,078	241,781	16,297
Social security costs	20,274	19,633	641
Employer Contributions to NHS BSA - Pensions Division	27,904	27,021	883
Other pension costs	15	15	0
Termination benefits	8	8	0
TOTAL - including capitalised costs	306,279	288,458	17,821
Employee costs capitalised	1,084	623	461
Gross Employee Benefits excluding capitalised costs	305,195	287,835	17,360

8.2. Staff Numbers

	2015-16			2014-15
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	**1,058**	959	99	1,034
Administration and estates	**1,513**	1,365	148	1,414
Healthcare assistants and other support staff	**690**	669	21	612
Nursing, midwifery and health visiting staff	**2,845**	2,814	31	2,755
Nursing, midwifery and health visiting learners	**16**	16	0	11
Scientific, therapeutic and technical staff	**1,331**	1,285	46	1,254
Other	**1**	1	0	29
TOTAL	**7,454**	**7,109**	**345**	7,109
Of the above - staff engaged on capital projects	**52**	39	13	24

8.3. Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	56,349	58,556
Total Staff Years	6,996	6,776
Average working Days Lost	8.05	8.64

Total additional pensions liabilities accrued in the year
During the year 13 people retired on the grounds of ill health (2014/15 - 13)
The total of additional pension accruals in respect of ill health retirements is £664k (2014/15 £772k)
Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the accounts.

8. EMPLOYEE BENEFITS AND STAFF NUMBERS

8.4. Exit Packages agreed in 2015-16

Exit package cost band (including any special payment element)	2015-16 *Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	0	0	5	24,115	**5**	**24,115**	0	0
£10,000-£25,000	7	115,191	6	102,399	**13**	**217,590**	0	0
£25,001-£50,000	8	318,488	3	134,279	**11**	**452,767**	0	0
£50,001-£100,000	3	170,738	2	124,874	**5**	**295,612**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	1	120,000
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	1	253,200	**1**	**253,200**	0	0
Total	**18**	**604,417**	**17**	**638,867**	**35**	**1,243,284**	**1**	**120,000**

In 2014/15 there were no exit packages

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda for change handbook. The Trust also ran a mutualy agreed resignation scheeme during the year

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Amounts paid to one employee included contractual payments for termination of employment and a non contractual payment in respect of compensation.

8.5. Exit packages - Other Departures analysis

	2015-16 Agreements	Total value of agreements	2014-15 Agreements	Total value of agreements
	Number	£000s	Number	£000s
Mutually agreed resignations (MARS) contractual costs	16	386	0	0
Contractual payments in lieu of notice	1	133	0	0
Non-contractual payments requiring HMT approval*	1	120	0	0
Total	18		0	0
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

8. EMPLOYEE BENEFITS AND STAFF NUMBERS

8.6. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions
The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

d) Local Pension Scheme (NEST)
During the year the Trust paid £29K (£26K in 2014-15) to the National Employment Savings Trust on behalf of staff that had opted out of the Trust pensions scheme but were automatically enrolled into a workplace pensions scheme as a result of the changes to work place pensions legislation.

9. BETTER PAYMENT PRACTICE CODE

9.1. Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**106,954**	**233,731**	103,508	211,383
Total Non-NHS Trade Invoices Paid Within Target	**93,230**	**200,385**	91,947	180,424
Percentage of NHS Trade Invoices Paid Within Target	**87.17%**	**85.73%**	88.83%	85.35%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,292**	**23,250**	3,515	35,478
Total NHS Trade Invoices Paid Within Target	**1,235**	**5,160**	1,837	19,907
Percentage of NHS Trade Invoices Paid Within Target	**37.52%**	**22.19%**	52.26%	56.11%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

9.2. The Late Payment of Commercial Debts (Interest) Act 1998

We did not pay any interest to our suppliers in respect of overdue invoices in 2015/16 (2014/15 £ 79.93).

10. INVESTMENT REVENUE

Investment income consists of bank interest on short term deposits of surplus funds. During the year £54,691 was earned (2014/15 £ 62,035)

11. OTHER GAINS AND LOSSES

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**0**	28
Gain (Loss) on disposal of assets held for sale	**78**	0
Change in fair value of investment property	**8,222**	0
Total	**8,300**	28

12. FINANCE COSTS

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	**875**	728
Interest on obligations under finance leases	**5**	4
Interest on obligations under PFI contracts	**4,003**	4,136
Total interest expense	**4,883**	4,868
Provisions - unwinding of discount	**16**	24
Total	**4,899**	4,892

13. PROPERTY, PLANT AND EQUIPMENT

13.1. Property, plant and equipment

2015-16	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2015	10,279	233,794	8,225	65,489	502	11,641	8,993	**338,923**
Adjustment to opening balance		1,899					(8,993)	**(7,094)**
Additions of Assets Under Construction			2,915	3,898	0	0	0	**6,813**
Additions Purchased	0	0	0	4,217	50	808	0	**5,075**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	446	0	0	0	**446**
Reclassifications		5,487	(5,487)		0			**0**
Disposals other than for sale	(32)	0	0	(1,959)	(115)	(403)	0	**(2,509)**
Recalassification as investment	(149)							**(149)**
Upward revaluation/positive indexation	1,620	(17,890)	0	0	0	0	0	**(16,270)**
Impairment/reversals charged to operating expenses		(6,487)	0	(213)	0	0		**(6,700)**
At 31 March 2016	**11,718**	**216,803**	**5,653**	**71,878**	**437**	**12,046**	**0**	**318,535**
Depreciation								
At 1 April 2015	0	0	0	35,883	380	7,289	422	**43,974**
Adjustment to opening balance		422					(422)	
Disposals other than for sale	0		0	(1,959)	(115)	(403)		**(2,477)**
Charged During the Year	0	3,815	0	6,222	46	1,060		**11,143**
At 31 March 2016	**0**	**4,237**	**0**	**40,146**	**311**	**7,946**	**0**	**52,640**
Net Book Value at 31 March 2016	**11,718**	**212,566**	**5,653**	**31,732**	**126**	**4,100**	**0**	**265,895**
Asset financing:								
Owned - Purchased	11,718	151,119	5,653	29,432	126	4,100	0	**202,148**
Owned - Donated	0	6,476	0	2,300	0	0	0	**8,776**
Held on finance lease	0	1,717	0	0	0	0	0	**1,717**
On-SOFP PFI contracts	0	53,254	0	0	0	0	0	**53,254**
Total at 31 March 2016	**11,718**	**212,566**	**5,653**	**31,732**	**126**	**4,100**	**0**	**265,895**
Revaluation Reserve Balance for Property, Plant & Equipment								
At 1 April 2015	4,737	22,277	0	2,433	0	0	0	**29,447**
Revaluation of land and buildings	1,620	(17,890)						**(16,270)**
At 31 March 2016	**6,357**	**4,387**	**0**	**2,433**	**0**	**0**	**0**	**13,177**

All additions to assets under construction were in respect of buildings.

13.2. Property, plant and equipment prior-year

2014-15	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2014	10,279	218,136	10,516	65,175	616	11,337	8,476	**324,535**
Additions of Assets Under Construction	0	0	13,884	0	0	0	0	**13,884**
Additions Purchased	0	0	0	3,988	0	563	0	**4,551**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	1,111	0	0	0	**1,111**
Reclassifications	0	15,658	(16,175)	0	0	0	517	**0**
Disposals other than for sale	0	0	0	(4,967)	(114)	(259)	0	**(5,340)**
Revaluation	0	0	0	182	0	0	0	**182**
At 31 March 2015	**10,279**	**233,794**	**8,225**	**65,489**	**502**	**11,641**	**8,993**	**338,923**
Depreciation								
At 1 April 2014	0	0	0	35,762	466	6,402	0	**42,630**
Disposals other than for sale	0	0	0	(4,962)	(114)	(259)	0	**(5,335)**
Reversal of Impairments charged to operating expenses	0	0	0	(321)	0	0	0	**(321)**
Charged During the Year	0	7,094	0	5,404	28	1,146	422	**14,094**
At 31 March 2015	**0**	**7,094**	**0**	**35,883**	**380**	**7,289**	**422**	**51,068**
Net Book Value at 31 March 2015	**10,279**	**226,700**	**8,225**	**29,606**	**122**	**4,352**	**8,571**	**287,855**
Asset financing:								
Owned - Purchased	10,279	177,896	8,225	27,548	122	4,352	8,534	**236,956**
Owned - Donated	0	4,695	0	2,058	0	0	37	**6,790**
Held on finance lease	0	2,296	0	0	0	0	0	**2,296**
On-SOFP PFI contracts	0	41,813	0	0	0	0	0	**41,813**
Total at 31 March 2015	**10,279**	**226,700**	**8,225**	**29,606**	**122**	**4,352**	**8,571**	**287,855**

13. PROPERTY, PLANT AND EQUIPMENT

13.3. (cont). Property, plant and equipment

Assets to the value of £446K were donated to the Trust from it's charity Hull and East Yorkshire Hospitals NHS Trust Charitable fund.

The Trust's Land and Buildings were fully revalued at 1 April 2015 and the valuation was updated at 31 March 2016. The valuation was undertaken by independent valuers Cushman and Wakefield.

The valuation of buildings has been undertaken with reference to the building's current condition and agreed obsolescence and assumed that over its life it will be maintained to its current condition. The valuation has been undertaken on a moderm equivalent asset basis and reflects the current service potential of the Trust. The previous valuation was undertaken by the Valuation Service using a different methodlogy but still reflecting a modern equivalent asset and current service potential.

The impact of the valuation is a general increase in asset lives and this has reduced the level of depreciation by £3.6m in 2015/16 and beyond. It resulted in a net impairment of £22.7m of which £6.5m was charged through revenue and £16.2m through reserves.

The value of land has increased by £1.7m.

Digital Mammography equpment to the value of £213k was impaired during the year.

The total gross book value of equipment with a nil net value is £9.811m (£9.269m)

14. INTANGIBLE NON-CURRENT ASSETS

14.1. Intangible non-current assets

2015-16	Intangible Assets
Cost	**£000's**
At 1 April 2015	**5,087**
Additions Purchased	505
Disposals other than by sale	(88)
At 31 March 2016	**5,504**
Amortisation	**2,906**
At 1 April 2015	523
	3,341
Net book value at 31 March 2016	**2,163**

14.2. Intangible non-current assets prior year

2014-15	Licenses and Trademarks	Development Expenditure - Internally Generated	Total
			£000's
Cost			
At 1 April 2014	45	5,079	**5,124**
Additions - internally generated	0	445	445
Disposals other than by sale	0	(437)	(437)
At 31 March 2015	45	5,087	**5,132**
Amortisation			
At 1 April 2014	45	2,577	**2,622**
Disposals other than by sale	0	(437)	(437)
Charged during the year	0	766	766
At 31 March 2015	45	2,906	**2,951**
Net book value at 31 March 2015	**0**	**2,181**	2,181

14.3. Intangible non-current assets

Intangible assets comprise of software licences and internally generated developments. Intangible non current assets are carried at depreciated historic cost, as a proxy for fair value.
The useful lives of both classes of intangible assets are finite and detailed in note 1 to the accounts. The revaluation reserve for intangible assets was £33,000 as at 31/03/16 (£33,000 2014-15)

15. ANALYSIS OF IMPAIRMENTS AND REVERSALS RECOGNISED IN 2015-16

	SOCI	SOFP	2015-16 Total	2014-15 Total
	£000s	£000s	£000s	£000s
Property, Plant and Equipment Impairments				
Land impairments	0	(1,620)	(1,620)	0
Building impairments	6,487	17,890	24,377	0
Equipment impairments	213		213	(321)
Building reserves			0	0
Equipment reserves			0	0
Changes in market price	6,700	16,270	22,970	(321)

Total charged to SOCI - Annually Managed Expenditure £3.78m

16. INVESTMENT PROPERTY

	31 March 2016
	£000s
Balance at 1 April 2015	0
Transfers from Non current assets	149
Revaluation to fair value	8,222
Balance at 31 March 2016	**8,371**

The Trust owns agricultural land adjacent to the Castle Hill site. The total value as at 1 April 15 was £159k. During the year planning permission was granted and some restrictions lifted on a proportion of this land and it was revalued to fair value. This land had previously been categorised as a non current asset, during the year it has been re-categorised as investment property. The land has been held for rental to a farmer for the period of its ownership, earning a favourable return on investment. The land has been marketed for sale and offers have been received, the sale is expected to complete in the Summer of 2016

17. COMMITMENTS

17.1. Capital commitments

At 31st March 2016 there are £68k of capital commitments that are not accounted for but to which the Trust is committed at 31 March 2015 £1066k was committed.

18. INTRA-GOVERNMENT AND OTHER BALANCES

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000s	£000s	£000s	£000s
Balances with Other Central Government Bodies	9	0	5,438	0
Balances with Local Authorities	569	0	450	0
Balances with NHS bodies outside the Departmental Group	0	0	254	0
Balances with NHS bodies inside the Departmental Group	9,999	0	13,350	29,404
Balances with Bodies External to Government	10,517	2,385	33,899	53,987
At 31 March 2016	**21,094**	**2,385**	**53,391**	**83,391**
prior period:				
Balances with Other Central Government Bodies	1,955	664	9,170	0
Balances with Local Authorities	708	0	450	0
Balances with NHS bodies outside the Departmental Group	27	0	65	0
Balances with NHS bodies inside the Departmental Group	9,507	0	7,687	16,987
Balances with Public Corporations and Trading Funds	0	0	2	0
Balances with Bodies External to Government	9,452	1,819	29,158	55,869
At 31 March 2015	**21,649**	**2,483**	**46,532**	**72,856**

19. INVENTORIES

	Drugs	Consumables	Total
	£000s	£000s	£000s
Balance at 1 April 2015	**3,330**	**7,435**	**10,765**
Additions	60,893	68,031	**128,924**
Inventories recognised as an expense in the period	(60,402)	(66,895)	**(127,297)**
Balance at 31 March 2016	**3,821**	**8,571**	**12,392**

20. TRADE AND OTHER RECEIVABLES

20.1. Trade and other receivables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS receivables - revenue	**5,812**	6,832	**0**	0
NHS prepayments and accrued income	**3,524**	2,701	**0**	0
Non-NHS receivables - revenue	**3,548**	4,691	**0**	0
Non-NHS prepayments and accrued income	**4,488**	3,640	**0**	0
PDC Dividend prepaid to DH	**314**	0	**0**	0
Provision for the impairment of receivables	**(1,257)**	(781)	**(525)**	(988)
VAT	**1,549**	1,291	**0**	664
Other receivables	**3,153**	3,275	**2,910**	2,807
Total	**21,131**	21,649	**2,385**	2,483
Total current and non current	**23,516**	24,132		

There are no pre-paid pension contributions included in the values above.

The great majority of trade is with Clinical Commissioning Groups as commissioners for NHS patient care services . As these are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary. NHS receivables include £3.2m as an estimate of amounts due from Primary Care Trusts for incomplete treatments as at 31 March.
In determining this amount we have used date from our patient information systems, the average cost of treatments, and current trends in activity levels.

20.2. Receivables past their due date but not impaired

	31 March 2016 £000s	31 March 2015 £000s
By up to three months	**1,354**	2,811
By three to six months	**273**	645
By more than six months	**1,092**	1,172
Total	**2,719**	4,628

20.3. Provision for impairment of receivables

	2015-16 £000s	2014-15 £000s
Balance at 1 April 2015	**(1,769)**	(1,706)
Amount written off during the year	**314**	84
(Increase)/decrease in receivables impaired	**(327)**	(147)
Balance at 31 March 2016	**(1,782)**	(1,769)

21. CASH AND CASH EQUIVALENTS

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**4,504**	6,991
Net change in year	**(1,812)**	(2,487)
Closing balance	**2,692**	4,504
Made up of		
Cash with Government Banking Service	**2,679**	4,489
Cash in hand	**13**	15
Cash and cash equivalents as in statement of financial position	**2,692**	4,504
Bank overdraft - Commercial banks	**(5)**	(819)
Cash and cash equivalents as in statement of cash flows	**2,687**	3,685

22. TRADE AND OTHER PAYABLES

	31 March 2016 £000s	31 March 2015 £000s
NHS payables - revenue	**10,212**	6,126
NHS payables - capital	**0**	0
NHS accruals and deferred income	**2,963**	364
Non-NHS payables - revenue	**9,021**	9,065
Non-NHS payables - capital	**4,386**	4,097
Non-NHS accruals and deferred income	**13,658**	13,508
Social security costs	**3,028**	3,410
PDC Dividend payable to DH	**0**	2
Accrued Interest on DH Loans	**62**	**0**
VAT	**0**	0
Tax	**2,410**	1,693
Other	**4,505**	4,148
Total payables	**50,245**	42,413

Included in the above foigures are outstanding pension contribusitons of £4.153m (2015/15 £4.063m)
All payables are current and due within one year.

23. BORROWINGS

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Bank overdraft - commercial banks	**5**	819		
Loans from Department of Health	**1,260**	1,260	**29,404**	16,987
PFI liabilities:				
Main liability	**1,826**	1,983	**51,853**	53,679
Finance lease liabilities	**55**	57	**2,134**	2,190
Total	**3,146**	**4,119**	**83,391**	**72,856**
Total Borrowings (current and non-current)	**86,537**	**76,975**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	1,260	3,146	**4,406**
1 - 2 Years	1,260	2,947	**4,207**
2 - 5 Years	17,457	23,231	**40,688**
Over 5 Years	10,687	57,213	**67,900**
TOTAL	**30,664**	**86,537**	**117,201**

24. DEFERRED INCOME

	Current	
	31 March 2016 £000s	31 March 2015 £000s
Opening balance at 1 April 2015	**3,285**	1,379
Deferred revenue addition	**824**	3,285
Transfer of deferred revenue	**0**	(1,379)
Deferred Income at 31 March 2016	**4,109**	3,285

All deferred income is current.

25. FINANCE LEASE OBLIGATIONS AS LESSEE

The Trust has only one finance lease, and also accounts for its 3 PFI facilities as finance leases.

The Daisy charity have constructed a PET CT facility on the Castle Hill site, the facility became operational from Aprl 2014. the Trust is being charged a market rent by the Daisy charity until 2034 after which ownership of the building passes to the Trust. The Trust's obligations in respect of the PET facility and PFI buldings are set out below.

Amounts payable under finance leases (Buildings)	**Minimum lease**		**Present value of**	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Within one year	**55**	57	**55**	57
Between one and five years	**223**	232	**223**	232
After five years	**1,911**	1,958	**1,911**	1,958
Minimum Lease Payments / Present value of minimum lease payments	**2,189**	2,247	**2,189**	2,247
Included in:				
Current borrowings			**55**	57
Non-current borrowings			**2,134**	2,190
			2,189	2,247

26. PROVISIONS

		Comprising:		
	Total	**Early Departure Costs**	**Legal Claims**	**Other**
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**1,599**	301	819	479
Arising during the year	**185**	11	174	0
Utilised during the year	**(781)**	(74)	(228)	(479)
Reversed unused	**(64)**	(24)	(40)	0
Unwinding of discount	**16**	3	13	0
Balance at 31 March 2016	**955**	**217**	**738**	**0**
Expected Timing of Cash Flows:				
No Later than One Year	**233**	64	169	
Later than One Year and not later than Five Years	**506**	129	377	
Later than Five Years	**216**	24	192	

27. CONTINGENCIES

	31 March 2016 £000s	31 March 2015 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(147)**	(217)
Other - Permanent Injury Benefits	**(597)**	(644)
Net value of contingent liabilities	**(744)**	(861)

There were no contingent assets in either 2015-16 or 2014-15.

28. PFI - ADDITIONAL INFORMATION

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI

	2015-16 £000s	2014-15 £000s
Total charge to operating expenses in year - Off SoFP PFI	**81**	81
Service element of on SOFP PFI charged to operating expenses in year	**1,839**	1,689
Total	**1,920**	1,770
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**2,016**	1,851
Later than One Year, No Later than Five Years	**8,454**	8,918
Later than Five Years	**34,338**	35,804
Total	**44,808**	46,573

Contingent rent recognised as an expense was £1.839m (2014/15 £1.744m). There are no restrictive clauses within the PFI or lease agreements.

Imputed "finance lease" obligations for on SOFP PFI contracts due

	2015-16 £000s	2014-15 £000s
No Later than One Year	**5,693**	5,986
Later than One Year, No Later than Five Years	**21,424**	21,832
Later than Five Years	**72,390**	77,674
Subtotal	**99,507**	105,492
Less: Interest Element	**(45,828)**	(49,831)
Total	**53,679**	55,661

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	2015-16 £000s	2014-15 £000s
No Later than One Year	**1,826**	1,983
Later than One Year, No Later than Five Years	**7,238**	7,131
Later than Five Years	**44,615**	46,547
Total	**53,679**	55,661

The Trust has three on SOFP PFI schemes

Under IFRIC 12, the following PFI schemes are treated as an asset of the Trust, and the substance of the contract is that the trust has a finance lease. Payments under the contracts comprise two elements - imputed finance lease charges and service charges. Details of the imputed finance lease charges are shown in the previous table. For all of these schemes the Trust gains ownership of the buildings once the contract ends.

Urology and Outpatients - Castle Hill Hospital Site
The PFI partner provides the Trust with hospital accommodation for Urology and Outpatient Services at the Castle Hill site. The contract began in Febtruary 2001 and is due to end in February 2032.

Accommodation for Maternity Services - Hull Royal Infirmary site
The PFI partner provides the Trust with hospital accommodation for Maternity Services at the Hull Royal Infirmary site. The contract for the provision of accommodation began in March 2003 and will end in March 2033.

Queens Centre for Oncology and Haematology - Castle Hill Hospital site
The PFI partner provides the Trust with hospital accommodation for Oncology and Haematology services at the Castle Hill site. Work commenced in April 2006, and the building became operational in August 2008, The contract began in June 2006 and will end in June 2037.

29. IMPACT OF IFRS TREATMENT - CURRENT YEAR

The information below is required by the Department of Heath for budget reconciliation purposes	**Expenditure £000s**	Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SOFP under IFRIC12 (e.g PFI)		
Depreciation charges	760	1,321
Interest Expense	4,008	5,868
Impairment charge - AME	(11,623)	0
Other Expenditure	3,679	1,689
Revenue Receivable from subleasing		
Impact on PDC dividend payable	(257)	(421)
Total IFRS Expenditure (IFRIC12)	**(3,433)**	**8,457**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	(10,352)	(9,247)
Net IFRS change (IFRIC12)	**6,919**	**(790)**
Capital Consequences of IFRS : PFI and other items under IFRIC12		
Capital expenditure 2015-16	**627**	650
UK GAAP capital expenditure 2015-16 (Reversionary Interest)	**1,104**	882

	2015-16 Income/ Expenditure IFRIC 12 YTD **£000s**	**2015-16** Income/ Expenditure ESA 10 YTD **£000s**	**2014-15** Income/ Expenditure IFRIC 12 YTD	**2014-15** Income/ Expenditure ESA 10 YTD
Revenue costs of IFRS12 compared with ESA10				
Depreciation charges	**760**		1,321	
Interest Expense	**4,008**		5,868	
Impairment charge - AME	**(11,623)**			
Other Expenditure		8,513		9,247
Service Charge	**1,839**	1,839	1,689	
Contingent Rent	**1,840**			
Impact on PDC Dividend Payable	**(257)**		(421)	
Total Revenue Cost under IFRIC12 vs ESA10	**(3,433)**	**10,352**	**8,457**	**9,247**
Revenue Receivable from subleasing	**0**	**0**	**0**	**0**
Net Revenue Cost/(income) under IDRIC12 vs ESA10	**(3,433)**	**10,352**	**8,457**	**9,247**

30. FINANCIAL INSTRUMENTS

30.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS 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. The NHS 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 the NHS Trust in undertaking its activities.

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

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

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by Trust Development Agency. 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. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with primary care Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

30.2. Financial Assets

	Total
	£000s
Embedded derivatives	**0**
Receivables - NHS	**9,446**
Receivables - non-NHS	**14,143**
Cash at bank and in hand	**2,687**
Other financial assets	**0**
Total at 31 March 2016	**26,276**

30.3. Financial Liabilities

	Total
	£000s
Embedded derivatives	**0**
NHS payables	**12,461**
Non-NHS payables	**37,894**
Other borrowings	**30,669**
PFI & finance lease obligations	**55,868**
Other financial liabilities	**0**
Total at 31 March 2016	**136,892**
Embedded derivatives	0
NHS payables	6,490
Non-NHS payables	35,923
Other borrowings	21,313
PFI & finance lease obligations	55,662
Other financial liabilities	0
Total at 31 March 2015	119,388

*** Note all entries relate to the "other" column**

31. EVENTS AFTER THE END OF THE REPORTING PERIOD

No events have taken place after the reporting period which would have a material impact on the accounts.

32. RELATED PARTY TRANSACTIONS

Hull and East Yorkshire Hospitals NHS Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Hull and East Yorkshire Hospitals NHS Trust.

Professor Trevor Sheldon, non-executive member of the Trust Board, is the Dean of Hull York Medical School.

The Trust has an investment in ordinary shares in Vertual Ltd, a company registered in the United Kingdom. The Trust holds 15% of the company's shares, valued at £208,000. This has not been included in the accounts. The company's main activity is the sale of hardware and software used to train Radiotherapists. The Project Director, Mr D Haire sits on the board. There has been no trading with this company in the year.

The Trust also has an investment in Medipex Ltd, a company registered in the United Kingdom. The company's main activity is to assist the NHS in exploiting intellectual and industrial property rights. It is a company limited by guarantee and the Trust's liability under that guarantee is £100.

The Department of Health is regarded as a related party. During the year Hull and East Yorkshire Hospitals NHS 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:

Calderdale and Huddersfield NHS Foundation Trust
Care Quality Commission
Doncaster CCG
East Riding of Yorkshire CCG
Hambleton, Richmondshire and Whitby CCG Health Education England
Hull CCG
Humber NHS Foundation Trust
Leeds West CCG Lincolnshire East CCG Lincolnshire West CCG NHS Blood & Transplant NHS Litigation Authority NHS Property Services
North East Lincolnshire CCG North Lincolnshire CCG
North Tees and Hartlepool NHS Foundation Trust Northern Lincolnshire and Goole NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust Scarborough and Ryedale CCG
Sheffield CCG
Sheffield Teaching Hospitals NHS Foundation Trust
Vale Of York CCG Wakefield CCG
York Hospitals NHS Foundation Trust

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies.

The Trust has also received revenue and capital payments during the year from a number of charitable funds. Some of the Trustees of these funds also sit on the Trust Board. The amount included within the 2015/2016 is £907,990 (2014/2015 £1,659,665) of revenue contributions, and £82,746 (2014/2015 £46,628) of capital contributions.

33. LOSSES AND SPECIAL PAYMENTS

The total number of losses cases in 2015-16 and their total value was as follows:

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	9,947	13
Special payments	95,431	46
Total losses and special payments	105,378	59

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	87,321	76
Special payments	62536	54
Total losses and special payments	149,857	130

There were no individual cases over £300,000

34. FINANCIAL PERFORMANCE TARGETS

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

34.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
Turnover	366,964	416,169	444,890	469,995	480,633	499,538	497,132	506,703	526,559	**526,253**
Retained surplus/(deficit) for the year	165	6,755	5,020	(49,542)	(1,628)	17,336	(4,947)	1,567	3,860	**(11,995)**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	0									
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0								
Adjustments for impairments			0	0	5,678	(13,268)	9,762	4,150	(321)	**3,780**
Adjustments for impact of policy change re donated/government grants assets						169	209	226	(613)	**201**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				14,851	651	641	396	0	0	**0**
Absorption accounting adjustment							0	0	0	**0**
Other agreed adjustments	0	0	0	42,292	0	0	**0**	0	0	**0**
Break-even in-year position	**165**	**6,755**	**5,020**	**7,601**	**4,701**	**4,878**	**5,420**	**5,943**	**2,926**	**(8,014)**
Break-even cumulative position	**(8,595)**	**(1,840)**	**3,180**	**10,781**	**15,482**	**20,360**	**25,780**	**31,723**	**34,649**	**26,635**

- Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, Hull and East Yorkshire Hospitals NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	0.04	1.62	1.13	1.62	0.98	0.98	1.09	1.17	0.56	**-1.53**
Break-even cumulative position as a percentage of turnover	-2.34	-0.44	0.71	2.29	3.22	4.08	5.19	6.26	6.58	**5.05**

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

34.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

34.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15
External financing limit (EFL)	**11,446**	(1,054)
Cash flow financing	**11,850**	27
Other capital receipts	**(446)**	(1,111)
External financing requirement	**11,404**	(1,084)
Under/(over) spend against EFL	**42**	30

34. FINANCIAL PERFORMANCE TARGETS

34.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**12,835**	19,991
Less: book value of assets disposed of	**(32)**	(2)
Less: capital grants	**0**	2
Less: donations towards the acquisition of non-current assets	**(446)**	(1,111)
Charge against the capital resource limit	**12,357**	18,880
Capital resource limit	**12,440**	18,883
(Over)/underspend against the capital resource limit	**83**	3

35. THIRD PARTY ASSETS

There was no cash held on behalf of patients or other third parties at 31 March 2016 2014/15 £734).