NHS
Hull University Teaching Hospitals
NHS Trust

Remarkable people. Extraordinary place.

Annual Report and Accounts 2020/21

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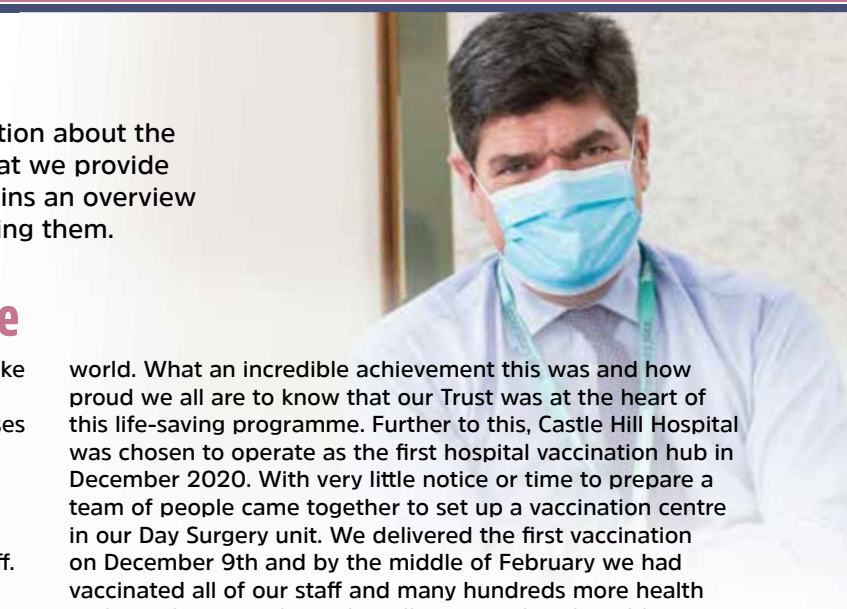
Performance Report

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.



Statement from the Chief Executive

It goes without saying that 2020/2021 has been a year unlike any other we have experienced as an organisation. On the 29th January 2020 our clinicians diagnosed the first UK cases of Covid-19 at Castle Hill Hospital. At the time, although we all harboured a few quiet concerns and anxieties regarding this unknown virus, none of us could have predicted how significant an event this would turn out to be for our nation and, closer to home, our hospitals, our patients and our staff.

Since that day we have seen the number of Covid cases in our hospitals peak at 267 in January 2021. Our intensive care units have, at times, been almost entirely occupied by Covid patients. Over 870 people have, at the time of writing this introduction, died in our hospitals, including three of our colleagues: Adrian Cruttenden, Richard Albufera and Nicola Diles. We also lost one of our team of outstanding volunteers, Ray Dove, to this disease. Each one of these people has left behind families and loved ones and as ever my thoughts remain with them as they contemplate life without someone they loved dearly. The devastating emotional impact of Covid will be felt by thousands of people in the Hull and East Riding of Yorkshire alone. My sincere condolences go to each and every person who has been affected in this way during the past year.

Our staff have felt the impact of the pandemic acutely. Not only have they had to adjust to different ways of working, different roles, different teams and wards, many have had to adapt to caring for patients in full PPE in sweltering conditions. They have held the hands of dying patients when relatives were not allowed to spend the last moments with their family members. This takes its toll on people and words cannot adequately express how grateful we are to everyone who works for this Trust and the admiration we have for them. However, I will say, very simply, thank you to each and every one of our team here at HUTH. They truly are remarkable people.

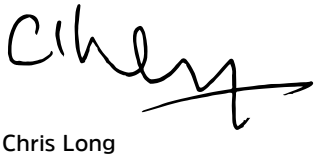
In times of crisis though we often see the best that humanity has to offer. There wouldn't be enough room in this report for me to thank everyone who donated items to our staff, delivered free meals or volunteered to come and support our teams. The generosity of local people and the acts of compassion and kindness were humbling to say the least and this depth of feeling for the NHS, which I genuinely believe is the greatest organisation in the world, helped all of us to find the strength and endurance to get through even the darkest and most challenging days that Covid threw at us.

Innovation has been everywhere. From the establishment of Covid wards and the transition of theatres into additional intensive care capacity to the use of video conferencing for patient consultations and appointments our teams stepped up to ensure this virus would never get the better of us. Nowhere was this seen more than in the establishment of a Covid vaccine trial team which was rapidly bought together thanks to the leadership of our infectious diseases team. They played an integral part in the development of the Oxford AstraZeneca Covid-19 vaccine which is now being delivered to thousands of people across our region, our nation and the world. What an incredible achievement this was and how proud we all are to know that our Trust was at the heart of this life-saving programme. Further to this, Castle Hill Hospital was chosen to operate as the first hospital vaccination hub in December 2020. With very little notice or time to prepare a team of people came together to set up a vaccination centre in our Day Surgery unit. We delivered the first vaccination on December 9th and by the middle of February we had vaccinated all of our staff and many hundreds more health and social care workers, clinically extremely vulnerable individuals and patients over the age of 80. I would like to pay tribute to everyone involved in all these innovations as well as the support staff who made this possible and those who were redeployed to different parts of our hospital when we refocused our efforts to tackling Covid-19.

The shift in direction itself has created a different challenge for us now. In March 2020 we were directed at national level to cancel all planned surgery and many patient appointments in order to prepare our hospitals for the wave of Covid patients who subsequently were admitted to our beds. As a result we now have a significant backlog of patients waiting to be seen and consequently much longer waiting times for people who need care and treatment. I would like to begin by apologising to anyone who has been affected by this and the position they find themselves in at this time. We are working around the clock to rectify this situation and have long-term recovery plans to reduce those waiting lists. By late summer we aim to return to over 85% of 2019 activity levels for planned surgery and almost 100% of activity for outpatient appointments, and day surgery. This means that our staff are being asked to work even harder than before, and continue to innovate to meet the needs of our population. If anyone can do this they can.

The months ahead present us with a binary challenge: deliver more activity and at the same time look after our workforce. It is our stated intent to ensure our staff are well supported and well cared for as we move into a new world where Covid is ever present but routine and emergency care is also possible. We will not lose sight of the fact that a healthy workforce is vital to our future success in this endeavour. Alongside our activity recovery plans we have a people recovery plan which acknowledges that the wellbeing of staff must be central to future decisions and considerations. We owe them a huge debt of gratitude not only for what they have done but for what they will do throughout 2021/2022, and we will work with our managers and teams to enable them to act bravely and compassionately in everything they do.

Thank you to our staff, and thank you to the population we serve for everything you have done to keep us safe and keep our spirits high. I sincerely believe we have a brighter future ahead.



Chris Long
Chief Executive

Purpose and activities of the Trust

1. Introduction

Hull University Teaching Hospitals NHS Trust is a large acute NHS 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 8400 whole time equivalent staff, have an annual income of circa £726 million and we have two main hospital sites: Hull Royal Infirmary and Castle Hill Hospital and some support sites predominantly in Hull. 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 1.05million 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 a Major Trauma Centre. The Trust is a university teaching hospital and a partner in the Hull York Medical School.

In 2020/21 we provided the following services:

- We assessed over 165,000 people who attended our Emergency Department at Hull Royal Infirmary
- We had over 700,000 attendances at our outpatient clinics
- We admitted over 109,000 patients to our wards and over 11,000 patients attended our wards for a planned review following treatment

The Trust is structured in five Health Groups (Medicine, Surgery, Cancer and Clinical Support, Family and Women's Health and Emergency Care) through which our clinical services are delivered. The Health Groups are supported by Corporate Services (Estates, Facilities and Development, Planning, Finance, Human Resources including Education and Development, Quality Governance, Corporate Governance, Information Management and Technology).

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.

The Trust is in the second year of its Trust strategy for 2019-2024, and has continued to work with the following strategic goals:

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

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

As noted above, we have a Trust Strategy (2019-24), which describes our long-term aims as an organisation. Supporting this over-arching strategy, we have some specific strategies, which will help us develop and deliver our aims over the next few years:

- People Strategy 2019-2022
- Estate Strategy 2017-2022
- Digital Strategy 2018-2023
- Research and Innovation Strategy 2018-2023

All of these documents are published on our website.

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 circa 458,000 people (2019). 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. 28% (14,430) of children in Hull live in low income families and the health and wellbeing of children is worse than the England average.

The East Riding of Yorkshire is a predominantly rural area, populated by circa 340,000 people (2019). The geography of the East Riding makes it difficult for some people to access services. The health of people living in the county and their life expectancy is better than the England average. 12.2% (6,370) of children live in low income families and the health and wellbeing of children is better than the England average.

People are living longer, many with multiple and complex needs, and with higher expectations of their health and social care services. Within the next 20 years, the number of people aged 80 years and over in Hull and the East Riding is expected to increase from 33,000 to 55,300. Births are predicted to decline slightly.

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 to 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.

Purpose and activities of the Trust

Partnership and Integrated Services

In 2020-21, the Trust continued to work as a key partner within the Humber Coast and Vale Integrated Care System (ICS). The Trust is a member of and sends representation to the following:

- HCV Partnership Board
- The HCV Acute Provider Collaborative Board
- Cancer Alliance Board (Trust Directors lead two of the four Alliance work programmes)
- The HCV Local Maternity System, (chaired by the Trust Chief Nurse)
- Digital Technology Workstream (with the Trust as the Chair of this Board)
- Estates Workstream
- Workforce Workstream
- Finance Technical Working Group

The Trust is jointly leading a Humber Acute Services Review within the ICS together with Northern Lincolnshire and Goole NHS Foundation Trust and the four Humber Clinical Commissioning Groups

The Trust has identified a risk to its strategic objective 'Partnership and Integration' related to the collective ability of the ICS to shape service reconfiguration in a way that meets the financial, quality and planning objectives as published in Humber Coast and Vale Sustainability and Transformation Plan. Increasingly, national funding allocations are being made through the ICS. The Trust, together with the partner organisations, needs to provide capacity and leadership to the ICS in order to achieve the system-wide goals which impact upon the Trust.

Key issues and risks that could affect the Trust in delivering its objectives

This section of the annual report sets out the background to the issues under the headings of the Trust's refreshed key strategic goals, the risk that they posed and the action taken.

Honest, caring and accountable culture

Overall the Trust has seen an improving performance in the National Staff Survey each year for five years. We perform better than or equal to the national average for eight of the ten key themes in the National Staff Survey. Five themes showed an improvement and three a deterioration since 2019. There is more information contained within the body of the report.

The Trust focussed on the detailed findings of the national staff survey and the quarterly cultural surveys as part of the new People Strategy.

Valued, skilled and sufficient staff

The Trust's financial position was less challenging throughout 2020/21 due to the pandemic and funding available to help Trusts with spiralling Covid expenditure. The Trust continues to balance the need to recruit to vacancies and use agency staff where absolutely necessary to maintain safe, high quality, accessible services. Throughout the year, the Trust Board continued to report against the mandated requirements in relation to nursing and midwifery staff and fill rates for inpatient areas. The Trust reported careful management of nursing staff numbers and fill-rates and as seen in previous years, there was a gradual turnover of nursing staff numbers until an injection of new nursing staff through the September graduating class.

The Trust will recruit from the newly qualifying nurses in September each year; the recruitment process for September 2021 had already commenced prior to year-end.

High Quality Care

The Trust was partly inspected during 2019/20 by the Care Quality Commission. The Care Quality Commission commenced an inspection of the Trust in March 2020 and consisted unannounced inspections to four core services: medicine, surgery, the emergency department and critical care.

The Trust was not inspected during 20-21 but did submit Infection Prevention Control Board Assuarance Frameworks and a return again the Patient First assessment as per CQC requirements.

Due to the COVID-19 pandemic, the CQC and NHS Improvement have suspended the well-led and the use of resources assessments. It is a key aim of the Trust to move its Care Quality Commission rating to 'Good' overall as soon as possible, as the rating impacts on the confidence of patients in the services we deliver and on staff morale.

Against its suite of core patient quality and safety indicators within the Single Operating Framework, against which all hospital Trusts report, the Trust has delivered on 5 out of 7 'caring' standards and 0 out of the 5 'effective' standards although some of the data is not yet available. Further detail on all Single Operating Framework requirements are contained in this annual report. The Trust has reported 3 Never Events this year; 8 were reported last financial year. A full investigation has taken place for each incident. The Trust has implemented more robust measures on its safer surgical checklist training, audit and policy.

Great Clinical Services

The Trust is required to work towards the mandated waiting times within the NHS Constitution, based on trajectories of improvement agreed with its local commissioners.

There has been a negative impact in 2020 due to the pandemic on our waiting lists and ability to achieve the constitutional standards.

The Trust's recovery plans in 2020/21 include some reconfiguration of the medical bed base in order to provide better patient flow in acute medical pathways. The Trust's 18-week and cancer performance is more adversely affected by increases in referrals and increases in volumes of related diagnostics, which are capacity constraints in being able to provide all care within the target responsiveness times.

The Trust recognises that changes are needed to the way in which clinical services are configured, delivered and resourced. In 2018-19 the Trust was successful in its bid for Wave 4 capital investment to improve the urgent and emergency care pathways within the Hull Royal Infirmary through the reconfiguration of accommodation and the procurement of additional diagnostic equipment, including MRI and CT and the Trust was able to bring forward a number of elements of this work in to 2019-20, which are now impacting positively on patient flow in 2020- 21.

Research and Innovation

The Trust has represents the Hull City Region Vaccine Hub and is one of 7 hubs in Yorkshire and Humber. To date the Trust has received £116,000 dedicated Vaccine Task Force funding to support the delivery of covid-19 vaccine trials.

Locally, 494 participants were enrolled into the Oxford trial being led by Dr Patrick Lillie. This means that 1 in every 40 of the participants in the trial globally came from the Hull and East Yorkshire region.

COVID-19 vaccine research will be on-going for a significant period of 2021/22 as follow-up of participants continues. In addition, research to enable licensed vaccines in other populations and cohorts is also on-going with 4 known vaccine trials still being setup nationally. The Trust is currently in discussions with the University of Oxford with a view to supporting further COVID-19 vaccine work from next month

The Trust is working with colleagues from Yorkshire and Humber CRN on a strategic project to help manage misinformation on COVID-19 research, specifically the COVID-19 vaccine, within local communities ensuring that those of Black Asian and Minority Ethnic groups are able to make informed decisions in a safe environment.

Key issues and risks that could affect the Trust in delivering its objectives

The project hopes to link up with the Trust's BAME Network with dedicated funded support to allow the delivery of co-ordinated workshops in Q4 of 2021/22.

The Trust has also participated in the Yorkshire and Humber CRN BAME Network Leads Survey. Our network has provided some insightful feedback informing engagement with communities, fears and concerns and media and social media guidance.

The Trust wishes to lead the establishment of a Humber, Coast and Vale Integrated Care System 'Research Collaborative' initially of the Acute Providers in the patch; Harrogate, HUTH, NLAG and York.

Informal work has begun with a focus of COVID-19 research delivery. A formal framework will be embedded in 2021-22 to try and set the terms of this collaboration and to try and identify areas of work that would lend themselves to the development of a mutually beneficial ICS Research Strategy.

The timing of these discussions fits well with the likelihood of future Y&H Clinical Research Network funding destined (in some shape or form) to be contingent upon demonstrating strong research themes and collaboration in each ICS.

Financial sustainability

The Trust has reported that it has delivered a surplus of £145k as its performance for the 2nd period of 2020/21 reporting. On top of the break-even position for the first period, this means that it has delivered a £145k surplus for the full financial year, 2020/21.

As noted above the Trust has reported a surplus of £145k, which is £6.2m better than plan driven by two income sources, offsetting the expected shortfalls in other income and annual leave accrual.

The reported capital position at month 12 shows gross capital expenditure of £64.97m. The Trust invested £35.4m in capital expenditure in the period. This was funded through a combination of depreciation, charitable donations, public dividend capital and loan funding. This programme reflects a significant investment in replacement infrastructure: in terms of medical equipment, backlog maintenance of our physical estate and essential digital infrastructure works including the continued replacement of the Trusts digital network.

Looking to the immediate future the Covid-19 Pandemic has significantly impacted on the Trust's ability to provide cost effective clinical services with reductions in productivity and capacity becoming more pronounced as the pandemic extends. The Trust will continue to work with system partners to develop services in line with emerging national planning guidance and will operate a financial system that delivers in line with national expectation.

Performance Summary

The year-end performance against the Trust's key 'responsiveness' indicators are included in this annual report. The Trust's position on 'responsive' was adversely affected in 2020/21, following national directives to cancel elective procedures and outpatient clinics in order to create capacity for Covid-19 patients. Previous to March 2020, the Trust was on track to maintain 52-week breaches at two for the year, to maintain its waiting list volume to the required figure, to achieve the 2 week-wait standard for the year and achieve 2 out of 31-day cancer standards.

The Trust met its cancer performance targets for 31 day subsequent drug standard and 31 day subsequent radiotherapy standard.

The year-end performance against the Trust's key 'safe' indicators met the required standards for the following areas:

- Patient safety alerts outstanding
- Mixed sex accommodations breaches
- MRSA Bacteraemia cases
- Stroke - % of patients spending at least 90% of their time on a stroke ward

The year-end performance against the Trust's key 'safe' indicators did not meet the required standards for the following areas:

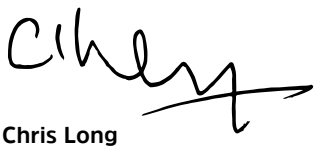
- Venous Thromboembolism (VTE) risk assessment
- Year-end position for emergency caesarean sections
- Never Events
- Stroke - % of patients admitted to a stoke ward within 4 hours of A&E

The year-end performance against the Trust's key 'effective' indicators did not met the required standards. This performance is detailed in the report and has been impacted by the pandemic.

The year-end performance against the Trust's key 'caring' indicators met the required standards for the following areas:

- Mixed Sex Accommodation Breaches

The Friends and Family Test surveys were paused due to the pandemic.



Chris Long
Chief Executive
10 June 2021

Performance Analysis: *Great Staff*

Staff Survey

The 2020 NHS National Staff Survey ran from 21 September to 27 November 2020. This was a full census survey in which 3,387 staff returned a survey, equating to 38% of the workforce. The response rate nationally for acute trusts was 45%.

The Trust has received a full survey report, which is available online at **www.nhsstaffsurveys.com**.

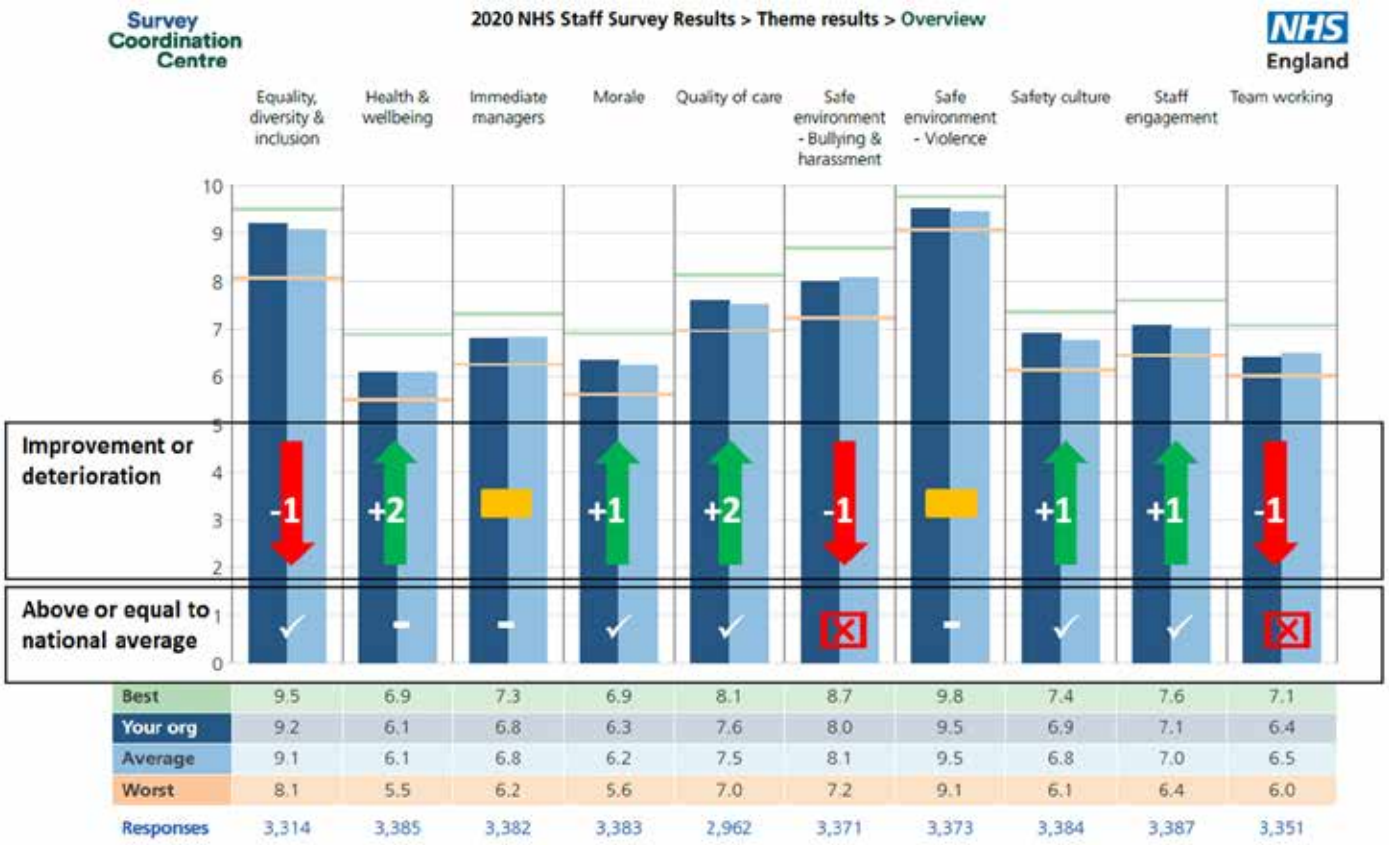
Key Themes

In the previous national staff survey 11 key themes were identified. In the 2020 survey the key theme of Quality of Appraisals has been removed in acknowledgement of the issues most organisations faced during 2020 with running a normal appraisal process. The key themes are as follows:

1. Equality, Diversity and Inclusion
2. Health and Wellbeing
3. Immediate Managers
4. Morale
5. Quality of Care
6. Safe Environment – Bullying
7. Safe Environment – Violence
8. Safety Culture
9. Staff engagement
10. Team working

For each of the key themes organisations receive a score out of ten.

Overall the Trust has seen an improving performance in the National Staff Survey each year for five years. We perform better than or equal to the national average for eight of the ten key themes in the National Staff Survey. Five themes showed an improvement and three a deterioration since 2019. The following image shows the Trust's performance compared with the national average, best score in the NHS and worst score in the NHS for each of the ten key themes.



Performance Analysis: *Great Staff*

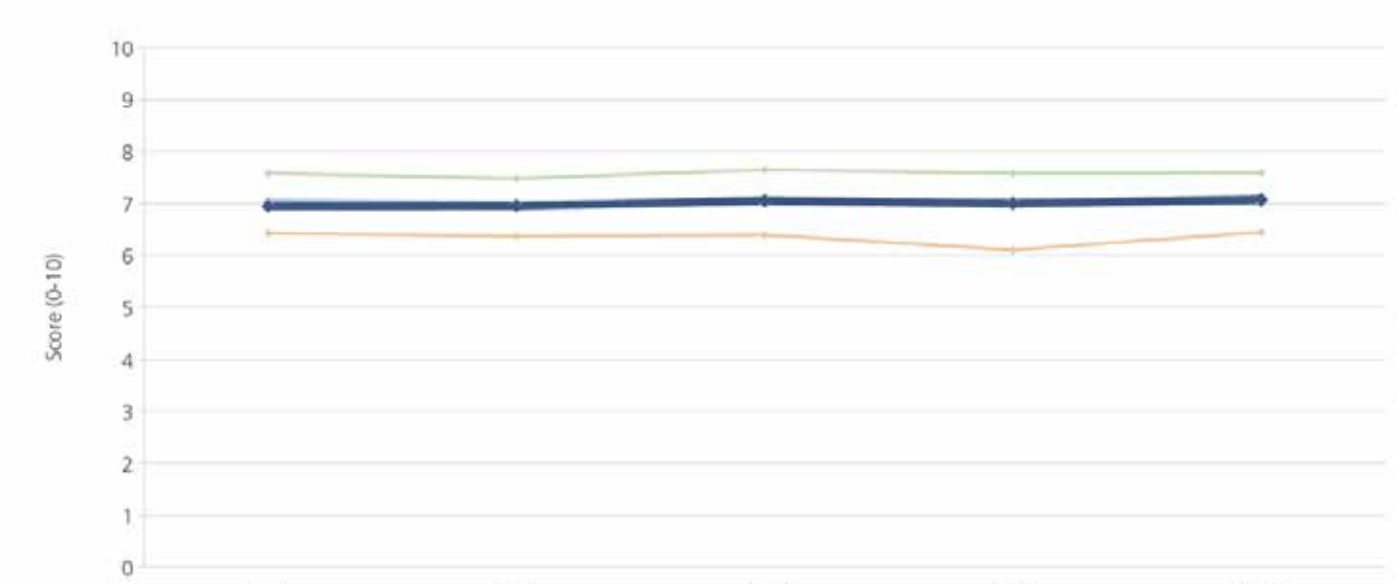
Staff Engagement

Staff engagement has been a key measure for our Trust for over five years with performance measured quarterly. Good staff engagement is linked to better performance, better patient outcomes and is associated with high performing organisations.

The engagement score is based on nine questions in the survey and makes up one of the key themes above. Nationally the Trust performs better than the average for Trusts with a score of 7.1 out of ten.

From May this year it will be a mandatory requirement for all NHS trusts to run a quarterly staff engagement survey. As the Trust has been monitoring engagement quarterly for over five years we have a comprehensive set of data down to ward and department level where ten or more staff complete a survey. This enables managers to understand how their teams are feeling and take action to address any issues they identify.

Our scores against the national average, best score in England and worst score in England over five years show a consistent and improving picture:



	2016	2017	2018	2019	2020
Best	7.6	7.5	7.6	7.6	7.6
Your org	6.9	6.9	7.1	7.0	7.1
Average	7.0	7.0	7.0	7.0	7.0
Worst	6.4	6.4	6.4	6.1	6.4
Responses	3,505	3,450	3,183	3,101	3,387

Actions to take

Discussions are being held now with Health Groups to understand what their approach will be to delivering improvements both in the most challenged areas but also with their most engaged and motivated teams. People Plans are being developed by each Health Group and Directorate which will form a key element in the quarterly performance reviews for those areas. These action plans will be closely monitored and measured by performance in the quarterly staff engagement surveys which will run from May 2021.

To complement this work we are developing a set of key principles for the Executive team and our managers to sign up to, which will set out our approach to delivering our recovery plans with the full engagement of our teams, acknowledging their need to pause and reflect on the year that has gone before us as well as work on their ideas and innovations that will help the organisation to achieve its goals. It is vital that we continue to put our staff first and acknowledge that their health and wellbeing is critical to the delivery of our activity and the care of our patients.

As set out in the Chief Executive's introduction we know that the health and wellbeing of our staff is of paramount importance as we strive to recover our patient activity. We will be constantly reviewing other indicators including staff sickness absence during the year to ensure our teams are well supported and engaged in our priorities for 2021/2022.

Performance Analysis: *Great Staff*

Guardian of Safe Working

The role of the Guardian of Safe working hours is to reassure junior doctors and employers that working conditions are safe for junior doctors and patients. The purpose of exception reporting is to ensure safe working hours are maintained. Junior Doctors are encouraged to exception report when any of the following rules are broken: Difference in hours, unable to take breaks, missed educational or training opportunities or lack of support available during service commitments.

The Guardian of Safe Working Hours reports directly to the Workforce, Education and Culture Committee meeting on a quarterly basis, highlighting the issues the junior doctors are currently facing, any trends identified in exception reporting and information on rota gaps. These reports are also submitted to Health Education England Yorkshire and the Humber for quality assurance.

There is a process in place to identify breaches to the junior doctors contract terms and conditions and fines are issued to the department if these rules are broken.

The Guardian of Safe working is currently working with the Trust to resolve the following issues:

- The Guardian aims to ensure all departments are using the e-roster system fully to ensure safe working hours can be monitored across the Trust.
- Ongoing issues continue with Phlebotomy services and ECG. The Guardian and co-chair of the Junior Doctors Forum are working with the Trust to address these issues.
- The Guardian is also working with the Chief Medical Officer and Director of Workforce and Organisational Development to implement Self-Development time and ensure this is consistent across all departments.
- Building work has started on the Doctors Mess at Castle Hill and this should be completed by the end of the financial year. There is currently a temporary Mess at Hull Royal Infirmary to provide a separate space for junior doctors working COVID / Non-COVID wards. There are plans to re-allocate the Doctors Mess at HRI.

The Junior Doctors Forum is very well attended and trainees issues and concerns are discussed to improve the junior doctors working lives within the Trust. The Guardian had arranged for formal representation of the different specialties and grades of junior doctors on the forum. Extra meetings have been put in place during the Pandemic to provide additional support during difficult times. There are also weekly drop in sessions for trainees jointly with the Director of Medical Education.

Getting it Right First Time (GIRFT)

Project support for GIRFT delivery within the Trust transferred from the HIP team to the CMO office In the middle of the last year. The programme support is overseen by the Chief Medical Officer and delivered by one of our Associate Chief Medical Officers along with a Project Support Manager to ensure good governance and optimise speciality programmes in line with the trusts values, goals and objectives

Performance Analysis: *Great Staff*

Workforce Equality

In line with the Public Sector Equality Duty, the Trust is required to annually report on how large the pay gap is between their male and female employees via the Gender Pay Gap Report; the differences between the experience and treatment of White and BAME staff via the Workforce Race Equality Standard; and the differences between workplace experiences between Disabled and Non-Disabled staff via the Workforce Disability Equality Standard.

The Trust is using the gender pay gap figures, contained within the Gender Pay Gap report which covers the period 1 April 2019 to 31 March 2020, to help understand the underlying causes for it's gender pay gap and to identify suitable steps to minimize it.

Some elements of the Trust's gender pay gap have a historical/national context which will take a period of time to resolve.

The Trust gender pay gap data for the period including 31 March 2020, which shows the difference in average pay between men and women in the workforce, reflects that the Trust has a majority of men in higher-paid roles, predominantly medical staff.

The mean and median hourly pay gap percentages across the health sector and bonus pay gap are significantly affected by the presence of the Medical Consultant body – due to both their high base wage and the historical differences in bonuses awarded under the Clinical Excellence Awards scheme.

Any national changes, including the recommendations contained within the 'Mend the Gap; The Independent Review into Gender Pay Gaps in Medicine in England', will be pivotal in helping reduce the Trust's gender pay gap.

A summary of this can be found in this report, with full details available on the Trust's website.

The Workforce Race Equality Standard (WRES) report covering the period 1 April 2019 to March 2020 highlighted that the lived experiences of BAME colleagues within the Trust is different to other groups. However, working in partnership with the BAME Leadership Network, the Trust is committed to addressing this and areas for improvement have been identified. Further details can be found on the Trust's website.

The Workforce Disability Equality Standard (WDES) report covering the period 1 April 2019 to March 2020 has shown some improvement, including the number of staff declaring a disability has increased in comparison to the previous year. The Trust will continue to work towards closing the gap between the experiences of Disabled and non-disabled staff. Further details can be found on the Trust's website.

Trade Union Facility Time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires employers, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time.

The Trust's Trade Union Facility Time Report can be found on the Trust's website.

Modern Slavery Statement

Following the introduction of the Modern Slavery Act in 2015, businesses are required to produce and publish on their website an annual modern statement within six months of the end of the financial year. This should set out the steps they have taken to identify and address their modern slavery risks, not only in their own business but also in supply chains.

The Trust's Modern Slavery Statement can be found on the Trust's website.

Performance Analysis: *Great Staff*

Research and Innovation

Over the last 12 months, healthcare organisations across the world have continued to turn to research for answers in the fight against the COVID-19 pandemic. Our Trust is no exception.

Our focus has centred on the delivery of the National Institute for Health Research (NIHR) Urgent Public Health research portfolio in response to the Government's co-ordinated COVID-19 action plan: (1) Contain (2) Delay (3) Research (4) Mitigate.

The NIHR 'Urgent Public Health Research' agenda was rapidly established to address numerous pressing questions such as: "Who is susceptible, and why?", "What are the mechanisms of severe / critical disease?", "What are the sites and dynamics of virus replication?", "How can early cases be identified and triaged?", "Use and validation of innovative diagnostic tests?" and "What treatments work?".

The UK is a leading nation for the delivery of clinical trials. Our Trust response to the COVID-19 pandemic has demonstrated our capabilities to deliver clinical research at pace and scale and we enrolled over 2,500 participants across 27 COVID-19 studies since April 2020.

Strategically, all NHS R&D Offices were asked to prioritise NIHR Urgent Public Health research and the national priority COVID-19 trials (including vaccine work) as well as longer-term research in areas such as rehabilitation post-hospitalisation and recovery strategies for patients.

Hull University Teaching Hospitals NHS Trust has successfully managed an intensive portfolio of COVID-19 research as well as ensuring studies that provide access to potentially life preserving or life-extending treatment, not otherwise available to the patient, can continue with appropriate safeguards.

The deployment of a strategy supporting interventional Urgent Public Health research that offered therapeutic options for all pathways and severity of COVID-19 disease ensured the following achievements:

- Recruiting over 3,300 participants into research studies (over 2,500 participants to COVID-19 research) in 2020-21.
- Opening 27 COVID-19 studies (86 open and recruiting portfolio studies overall)
- 494 participants enrolled into the Oxford/AstraZeneca COVID-19 vaccine Trial (accounting for 1 in every 45 participants globally in the initial trial).
- 200 recruits to the RECOVERY study (NIHR Platform study) rapidly identifying therapeutic treatments for hospitalised patients (including the use of Dexamethasone).
- Being one of the first trial sites in the UK to be able to offer the drug Remdesivir to those admitted to hospital with both severe and moderate COVID-19 disease.
- Recruiting 25% of the global recruits to the Synairgen commercial COVID-19 study offering another therapy for our severely ill patients.
- Recruiting the first global participant to the sister Synairgen commercial COVID-19 study.
- One of the top recruiters nationally to the SIREN study investigating the nature of antibody protection against COVID-19
- Top recruiter nationally in the CLARITY-IBD study looking at the development of antibodies to SARS-CoV-2 in UK patients with Crohn's and Colitis.
- The significant contribution to the collection of large cohort data to better understand the nature and impact of the disease (PRIEST and ISARIC studies).
- Assisting projects to help manage misinformation on COVID-19 research, specifically the COVID-19 vaccine, within local communities ensuring that those of Black Asian and Minority Ethnic groups are able to make informed decisions in a safe environment.
- Leading work focussed on the management of acute diseases in shielding groups (i.e. IBD: PREPARE-IBD, PROTECT ASUC) and surgical outcomes studies for impacts (i.e. Vascular: COVER study).
- Undertaking studies looking at the post-hospital rehabilitation of COVID-19 patients (PHOSP-COVID and COVID-19 Tele-Rehab studies).
- 83% of non-COVID-19 activity issued continuing Capability and Capacity as part of the NIHR 'Restart' initiative allowing recruitment to studies where the research protocol includes an urgent treatment or intervention without which patients could come to harm.
- Achieving the NIHR Clinical Research Target of at least 80% of COVID-19 commercial research recruiting on time and to target (RTT).
- Using opportunities for collaborative working with local stakeholders within Humber Coast and Vale ICS (Humber Foundation Trust support for vaccine study delivery, CHCP for PHOSP-COVID study).

Performance Analysis: *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, NHS England/Improvement has a number of mandated indicators which cover patient safety, infection control, clinical effectiveness, maternity, patient experience and NHS Constitution standards.

A number of performance standards in March 2020 were significantly affected by Covid-19, this continued in to 2020/2021. The Trust have agreed recovery plans and trajectories to recover delivery of performance standards.

Quality Accounts 2020/21

Each year the Trust publishes its Quality Accounts. These contain the details of the quality and safety priorities for 2020/21 and how we performed against them. The Quality Accounts are published on NHS Choices webpage and also on the Trust's website. The Quality Accounts are published by 30 June and this Annual Report should be read in conjunction with the Quality Accounts.

Patient Safety

Domain	Indicator	Standard	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020/21
Safe	Occurrence of any Never Event	0	2	0	0	0	0	0	0	0	0	1	0	not yet published	3
	Potential under-reporting of patient safety incidents (reported 6 months)	reduction	not yet published						not yet published						not yet published
	VTE Risk Assessment	95%			86.90%			85.00%			84.30%			not yet published	85.40%
	Patient Safety Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MRSA Bacteraemias	0	0	0	0	0	0	0	0	0	0	0	0	not yet published	0
	Clostridium Difficile	<=80 (20/21)	4	5	4	2	5	2	5	2	5	3	3	not yet published	40
	Emergency C-section rate	<=12.1%	14.93%	22.59%	15.11%	17.48%	14.21%	17.82%	19.48%	20.89%	20.21%	20.15%	13.88%	17.74%	17.87%
	Stroke - % of patients spending at least 90% of their time on a Stroke Ward	≥80%	82.80%	75.00%	87.10%	87.30%	83.90%	89.30%	89.40%	79.70%	85.40%	80.90%	84.10%	80.70%	84.00%
	Stroke - % of patients admitted to a Stroke Ward within 4 hours via A&E	≥90%	85.70%	90.50%	86.70%	78.40%	80.00%	87.30%	77.80%	66.10%	77.80%	74.60%	85.40%	68.10%	79.40%
	Stroke - TIA Service: % of high risk patients treated within 24 hours	≥75%	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue
	Stroke - TIA Service: % of low-moderate risk patients receiving specialist assessment and brain scan within 7 days	≥95%	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue	data collection issue

The Trust has reported three Never Events this year; 8 were reported last financial year. A full investigation has taken place for each incident. The Trust has implemented more robust measures on its safer surgical checklist training, audit and policy.

The Trust was below the threshold for clostridium difficile cases and further information on infection prevention and control is given below. The Trust has maintained its position in responding to patient safety alerts throughout the year, except for March 2021, there was one Covid-19 related alert reported. The Trust achieved to meet one of the stroke measures. The third and fourth measures are unable to be reported for 2020/21 due to technical difficulties. This has now been resolved and reporting will resume April 2021.

Areas where further improvements are required: The Trust continues to work on its compliance with Venous Thromboembolism Episode (VTE – a blood clot) risk assessments and acknowledges that compliance needs to reach the required standard in this area. The Trust is also reviewing its emergency Caesarean Section rate – the Trust has set a stretch target to below 12.1% against a national standard to be below 15%.

MRSA: please see infection prevention and control section on next page.

Performance Analysis: *Great Care*

Infection Prevention & Control Arrangements

Greta Johnson is the Trust **Director of Infection Prevention and Control (DIPC)/ Lead Nurse** and was responsible for leading and managing the Trust's Infection Prevention and Control (IPC) plan during 2020-21. Beverley Geary, Chief Nursing Officer, had executive responsibility for infection prevention and control during 2020-21. During 2020-21 the role of **Infection Control Doctor** was facilitated by Dr Debbie Wearmouth, Consultant Microbiologist. During 2020-21, the Trust was successful in recruiting an additional Infectious Diseases Consultant and a Consultant Microbiologist along with a trainee Consultant Clinical Scientist in Medical Microbiology. The **DIPC/Lead Nurse for the Department of Infection** is responsible for the infection prevention & control team and Infectious Diseases specialist nurse teams.

During April 2020, the DIPC and CNO restructured the meetings held to discuss all matters related to infection prevention & control. The previous **Infection Reduction Committee (IRC)** which met monthly was replaced with the Strategic Infection Reduction Committee, capitalising on the Command structure put in place to manage the Trust's COVID-19 response, under the chairpersonship of the DIPC. This meeting met bi-monthly initially and towards the end of the financial year increased to meeting monthly. The SIRC is a performance management and assurance committee, responsible for holding the Health Groups and Directorates to account for their performance in preventing and managing healthcare associated infections/ infectious diseases, and providing information and assurance to the Trust Board that all issues relating to infection prevention and control governance are being managed safely and effectively. The Committee is a forum for the Health Groups to demonstrate their compliance with Trust and national policies and procedures, and to share good practice. Attendance by the senior HG representatives has been good, and most meetings are quorate.

The **Infection Prevention and Control Committee (IPCC)** met bimonthly and was replaced by the Operational Infection Reduction Committee (OIRC), meeting monthly. During 2020-21 this committee was chaired by the Senior Infection Prevention & Control Nurses or the DIPC. The Committee is a forum for the Health Groups to demonstrate their compliance with Trust and national policies and procedures, and to share good practice. Attendance by the senior HG representatives has been good, and most meetings are quorate. The OIRC is an expert advisory body, with the core role of providing advice to the Trust Board and Health Groups on issues pertaining to infection management (including the structure and governance of the infection prevention and control team). The Committee has representation from each Health Group, from the IPC team, from the Department of Infection, from Occupational Health, from the Estates & Facilities Directorate, from the Sterilisation and Decontamination Unit, and from Pharmacy. It reports to the SIRC. The OIRC has responsibility for guiding Infection Prevention and Control activity within the Trust, interpreting external guidance and instruction, and providing the Chief Executive with relevant information and advice. It also advises the Trust on its statutory requirements in relation to Infection Prevention and Control and the decontamination of medical and surgical equipment.

4. Other Relevant Committees

The Trust has specific committees responsible for decontamination and for water safety. These committees have representation on the Operational Infection Reduction Committee (OIRC), and report to SIRC. There have been previous concerns about frequency of meetings but attendance was impacted during 2020-21 by the pandemic. The chair of the Water Safety Committee, which is a mandatory institution, saw an improvement in attendance by Health Groups and Fresenius Renal Unit. The Water Safety Committee has also benefitted from the continuation of input from an Authorising Engineer for water safety. Water safety issues are also reviewed regularly by both the SIRC and OIRC.

The Trust's designated Board level **Decontamination Lead** (as required by the Health and Social Care Act) is the Director of Estates, Facilities & Development supported by the Surgical Health Group Medical & Nursing Directors.

5. The Wider Infection Prevention Team

In addition to the core clinical IPC team (DIPC, Infection Control Doctor, IPC nurses, etc.) an increasing number of other clinicians are being recruited to support the Trust's efforts.

The Infection Prevention and Control Link Practitioners act as a resource for good infection prevention practice within their clinical areas. Study days, which are facilitated by the Infection Prevention and Control Team (IPCT), are normally held twice a year to disseminate new information and guidance but due to the COVID-19 pandemic this was not possible. However, during 2020-21 Link Practitioners continued to be supported by the IPCT to be proactive in implementing guidance both existing and new within their workplace.

Access to infection prevention and control information can also be obtained from the Trust Pattie page and via the Trust's global email address Ask Infection, facilitated by the Infectious Diseases consultants in the first instance, with support available from the IPC team as required. During 2020-21, a global IPC team email address was available for staff to access and email the team with queries, concerns and/or requests for advice or assistance.

Performance Analysis: *Great Care*

Infection Prevention & Control Arrangements

6. Surveillance of Healthcare Associated Infection

Public Health England Fingertips data

PHE produce regularly-updated information on a variety of IPC parameters, benchmarking NHS Trusts against other organisations in England (https://fingertips.phe.org.uk/profile/amr-local-indicators/data). The huge amount of information available can be grouped in various ways: the appendices contain spine plots of the performance of the Trust against all other acute NHS trusts in England in overall performance on all HAI targets (Appendix 1), in antimicrobial prescribing data (Appendix 2), in antimicrobial resistance data (Appendix 3) and in other IPC measured initiatives (Appendix 4). This information represents 2018-19 data (depending on availability of information) against the NHS initiative targets, HUTH has performed at or better than the benchmark in all cases. For the wider range of HAI targets the Trust generally falls between the 25th and 75th centile, but was a significant negative outlier for hospital onset Meticillin Sensitive Staphylococcus Aureus (MSSA) blood stream infections (BSI) during 2019-20 but in spite of the COVID-19 pandemic, numbers during 2020-21 remained static. Performance remained good for the antimicrobial prescribing targets: the Trust was better than the benchmark value in all criteria, and remained a significant (positive) outlier in some areas.

i Meticillin resistant Staphylococcus aureus (MRSA) bloodstream infection (BSI)

The Trust had achieved a year on year reduction in cases of MRSA BSI since reporting 102 cases in 2005-6 when mandatory surveillance was introduced. Up until 2013 NHS trusts were set progressively decreasing maximum thresholds for MRSA BSI by the Department of Health & Social Care.

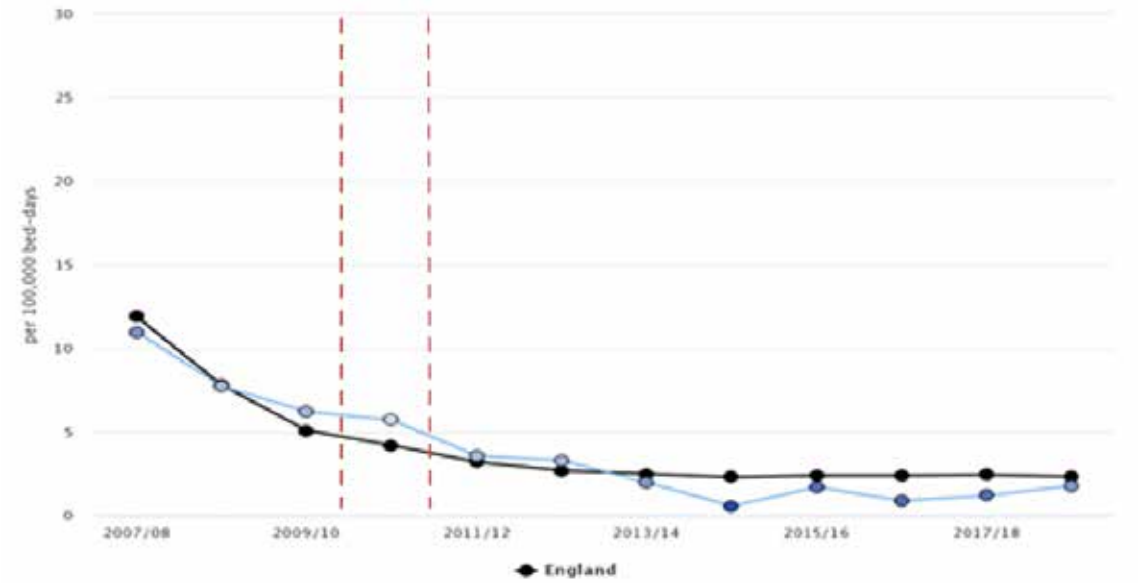


Figure 1. MRSA BSI rates in England 2007-2019 in comparison with Hull University Teaching Hospitals NHS Trust (red lines indicate introduction of universal screening)

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Infection Prevention & Control Arrangements

From 2013-14 the Department of Health & Social Care moved away from a fixed numerical target in favour of a policy of 'zero tolerance of avoidable infection'. It was accepted, that there would continue to be small numbers of infections seen, and that the national aim was to reach an 'irreducible minimum'. National figures support this contention (Figure 1). The numbers of total and Trust-attributed MRSA BSI diagnosed in the Trust for the last 6 years are shown in Table 1.

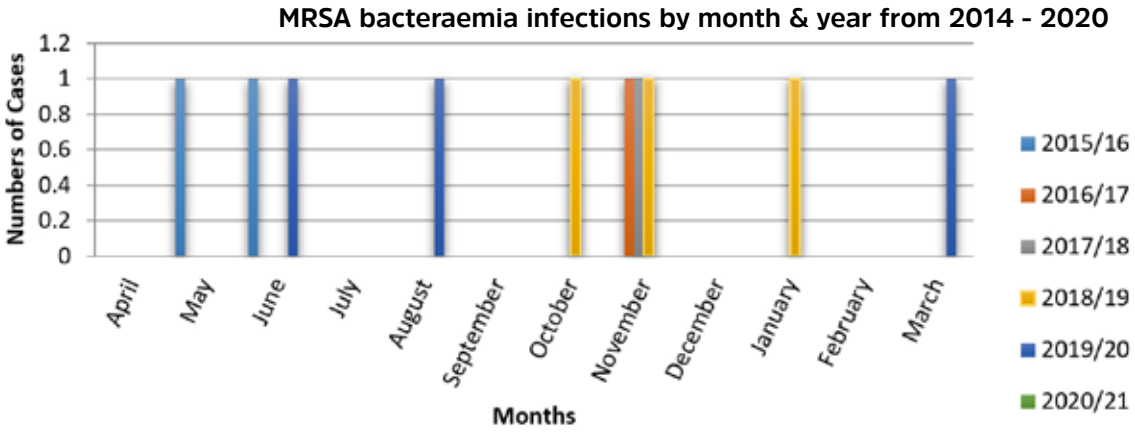

Table 1. MRSA bloodstream infection diagnosed in HUTHT 2015-20

During 2020-21, one Community apportioned case was reported in June 2021 and investigated by both the Trust and Commissioning Team with no lapses in practice identified with regards the care the patient received whilst admitted to the Trust.

There was no other MRSA BSI reported during 2020-21, inclusive of hospital onset cases; a significant improvement for the Trust and especially in context with regards the COVID-19 pandemic.

Among other measures to try to reduce the number of MRSA BSI, the Department of Health in 2010 mandated that all patients admitted to hospital in England must be screened for MRSA skin colonisation. This has proved difficult to implement in practice, and the efficacy of such universal screening (as opposed to testing patients at higher risk) has always been debated. In 2014 the DH Expert Advisory Group on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) reviewed the available evidence, and recommended that all Trusts move from a policy of universal screening to one of selective screening of high risk patients. The Trust developed a proforma to assist clinical areas with identifying which patients, which areas and when HCAI screening will be completed. To date this has not been formally adopted, especially with a continued increase in MRSA bacteraemia cases experienced during 2019-20 and the competing priorities experienced during the COVID-19 pandemic, therefore, the Trust continues to screen all admissions for MRSA on admission. It was hoped that the proforma and preferred option would be launched during 2019-20, however, there were impending changes nationally again with regards to MRSA screening which at the time of writing this report remain outstanding due in part to the COVID-19 pandemic. Opportunities to screen for other HCAI's, including *Clostridioides difficile* and Carbapenemase producing Enterobacteriaceae (CPE) are taken in line with the drafted proforma which the IPCT continue to monitor.

ii Clostridioides difficile Associated Diarrhoea (CDAD)

The Trust has participated in the mandatory surveillance of Clostridioides difficile since 2004. The Trust was a significant outlier with regards hospital acquired C difficile infection during 2011-12 with 105 cases of CDAD attributed to the Trust, against a maximum threshold of 60 set by the Department of Health but following a number of interventions the number of cases in 2012-13 fell to 58, and the Trust has maintained a steady improvement in performance since then (Figure 2). In 2019, the Department of Health and PHE introduced updated CDAD objectives based on using CDAD data from 1 April 2018 to 31 December 2018. The changes to the CDI reporting algorithm for financial year 2019-20 which included the addition of a prior healthcare exposure element for community onset cases, reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission has continued during 2020-21. Therefore, for 2020-21 cases reported were assigned as follows:

- hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission (HOHA)
- community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (COHA)
- community onset indeterminate association: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks (COIA)

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- community onset community associated: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks (COCA)

Acute provider objectives were not published for 2020-21 because of the COVID-19 pandemic but data was collected utilising these two categories:

- hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission
- community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

In 2020-2021 there were 47 HOHA and 14 COHA cases reported, taking the total of CDAD cases to 58, against a threshold of 80 cases.

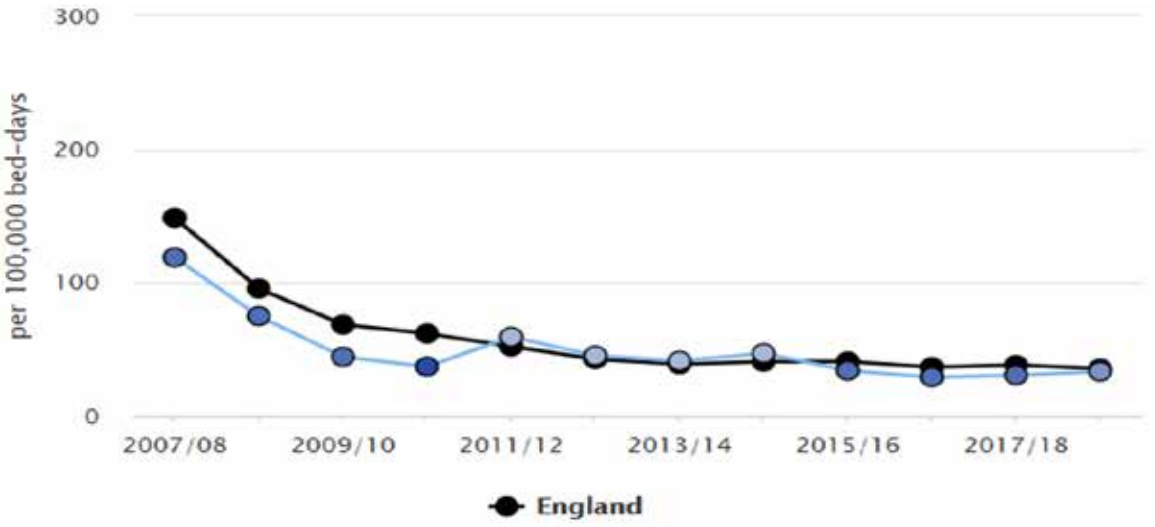

Figure 2. C. difficile rates in England 2007-2019 in comparison with Hull University Teaching Hospitals NHS Trust per 100,000 bed-days (PHE Fingertips)

From 2015-16 there was an opportunity for cases of C difficile for which the commissioners agreed that there had been no lapses of care (and the infection was therefore unavoidable) would be highlighted and removed from any financial penalty, although still included in the total. The Trust agreed a very strict definition with the commissioners, whereby any deviation from Trust or national guidance (even if not necessarily contributory to the development of infection) was classed as a lapse of care. Meetings with the Commissioners to review CDAD cases were postponed due to COVID-19 but opportunity to discuss HCAIs including hospital onset CDAD cases where lapses in practice occurred continued through other outbreak meetings set up to discuss COVID-19 activity.

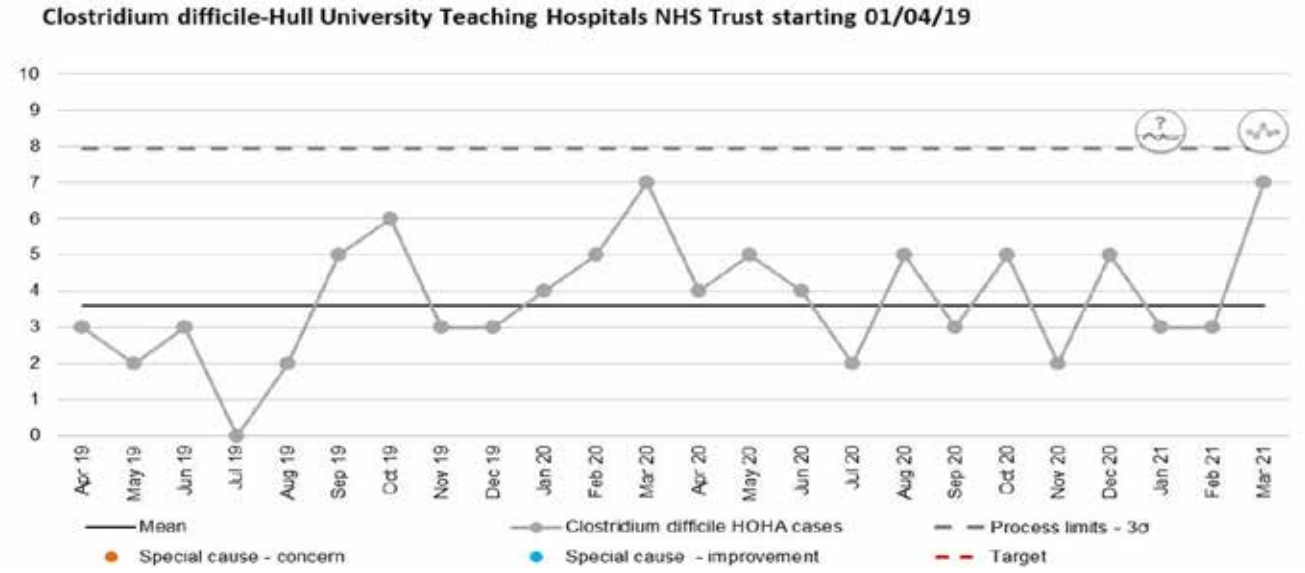

Table 2. Hospital onset Clostridioides difficile infections diagnosed in HUTHT 2019-21

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Infection Prevention & Control Arrangements

All cases of *C difficile* infection are subject to a Root Cause Analysis (RCA). The RCA process is led by the senior clinicians (medical and nursing) involved with the care of the patient, and supported by the IPC team. Summary outcomes are presented to the IRC. In most cases there were no significant failures of care apparent that had led to the development of CDAD. One key identified issue for improvement related to antimicrobial stewardship and adhering to the Trust antimicrobial prescribing guidance.

Of note is a slight increase overall of three HOHA cases at year end early indications suggest the use of high risk antibiotics such as Cephalosporin's and Quinolones used to treat patients with COVID-19 at the start of the first wave has clearly impacted on acquisition of CDAD. Another aspect is reduced 'in reach' by the Infectious Diseases team to wards and departments, especially at the peaks of the pandemic in the Trust, providing advice on prudent antimicrobial prescribing. Active review of cases is facilitated by the IPCT.

Meticillin sensitive Staphylococcus aureus (MSSA) BSI

National data show that the general reduction in MRSA BSI has not been mirrored by a fall in MSSA bloodstream infection. This is of concern as the two organisms have similar epidemiology and pathogenesis. The Department of Health therefore introduced mandatory surveillance of MSSA bacteraemia from January 2011.

Benchmarking for MSSA infections is less developed than for MRSA, and the balance between healthcare-associated and other infection less clear. Root cause analysis of MSSA BSI cases are completed and reported via the OIRC. There have been year to year fluctuations, but during 2020-21 HUTH reported the same rate of infection as experienced during 2019-20 it however, remains the one major HAI indicator for which we are significantly worse than the national benchmark.

From a national perspective, rates of Meticillin-Sensitive Staphylococcus aureus (MSSA) bacteraemia continued to increase moderately from 2011-12 when the PHE HCAI surveillance was introduced. Since the mandatory reporting of MSSA bacteraemia began in January 2011 there has been a general trend of increasing counts and incidence rates of cases. The count of all reported cases of MSSA bacteraemia increased by 34.0% from 2,199 to 2,947 between January to March 2011 and October to December 2020. This was accompanied by a 23.7% increase in incidence rate from 16.8 to 20.8 per 100,000 population. These increases are primarily driven by the increase in community-onset cases. Between January 2011 and October to December 2020, the count and the incidence rate of community-onset cases increased by 40.4% and 29.6% respectively from 1,464 to 2,055 cases and from 11.2 to 14.5 cases per 100,000 population. Over the same period, the count of hospital-onset cases increased by 21.4% from 735 to 892 cases, while the incidence rate increased 41.1% from 8.4 to 11.8 cases per 100,000 bed-days.

Since the beginning of the COVID-19 pandemic there has been a decrease in all reported cases and a contrasting increase in hospital-onset cases. The overall reduction is, in part a result of reduced hospital activity, although the increase nationally in hospital-onset cases is still under investigation. It is worthy to note that the Trust has not seen an increase in MSSA bacteraemia cases, with numbers remaining static at 62 hospital onset cases being reported.

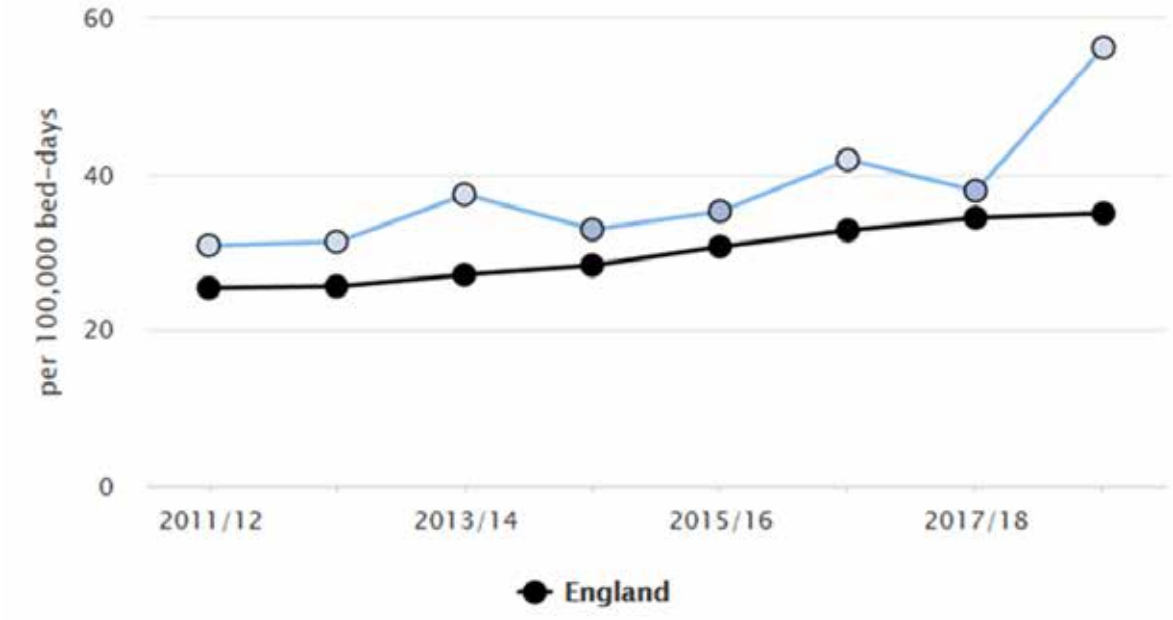

Figure 3. MSSA BSI rates in England 2011 - 2019 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

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Infection Prevention & Control Arrangements

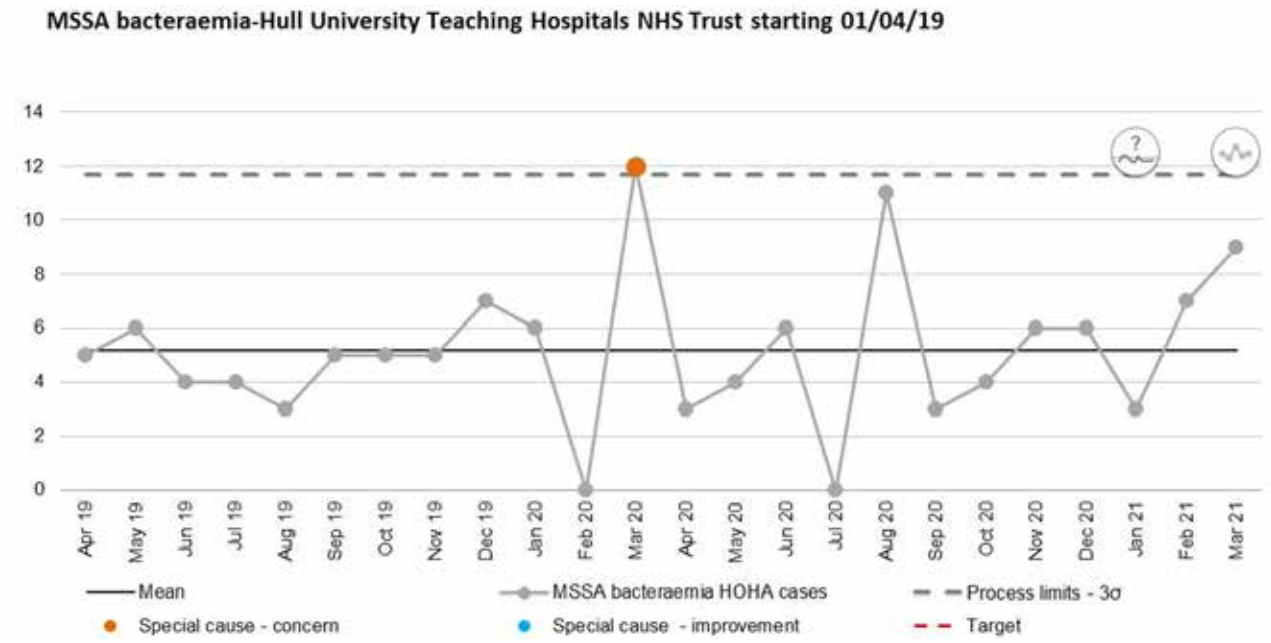

Table 3. MSSA bloodstream infection diagnosed in HUTHT 2019-21

Reasons for the continued relatively high rate of MSSA BSI during 2020-21 are multifactorial and relate to a variety of causes including skin and soft tissue infections, ventilator associated pneumonia, especially in COVID-19 positive patients and ongoing poor intravascular line insertion and care, specifically peripheral vascular devices but thankfully in lesser numbers during 2020-21 yet these should be avoidable. During 2020-21, in spite of the COVID-19 pandemic the Device Task, Challenge & Finish Group continued to meet to understand the systems, processes, products and human factors responsible for increasing the risk of infection and mitigating those risks by making it easier for clinical staff to do the right thing. Other cases associated with intravenous drug use and chronic ulcers are more difficult to address, but further work is needed to investigate why such a high proportion of our overall MSSA BSI cases are hospital-apportioned. During 2020-21, focus has primarily been working alongside the Surgical Health Group to address concerns with regards a number of surgical wards with higher than average MSSA bacteraemia rates. Initial findings suggest a correlation with regards the use of central venous access devices and a lack of robust evidence to support staff competencies. Additional training was being provided along with a Trust wide roll out updated care bundles to improve documentation. In those areas where this has been delivered a marked reduction in MSSA bacteraemia has been noted. Community Apportioned MSSA bacteraemia cases across Hull & East Riding of Yorkshire during 2020-21 have reduced potentially due in part to the reduced footfall of patients accessing treatment and the measures taken to reduce the transmission of COVID-19 in the community.

Escherichia coli bacteraemia

The national incidence rate of all reported E. coli bacteraemia has increased each year since the initiation of the mandatory surveillance of E. coli bacteraemia in July 2011 to the start of the COVID-19 pandemic in April to June 2020. This was primarily driven by the increase in the rate of community-onset cases. Since the start of the pandemic, the total cases and rates and community-onset cases and rates have fallen but are still higher than the start of the period. In contrast, the incidence rate of hospital-onset cases has remained relatively stable within the same period.

Between July to September 2011 and October to December 2020, the count of cases and the incidence rate of all reported cases of E. coli bacteraemia increased by 12.1% from 8,275 cases to 9,275 and from 61.8 to 65.4 cases per 100,000 population. Similarly, over the same period, the count of community-onset cases increased by 19.1% from 6,279 to 7,479, while the incidence rate increased by 12.4% from 46.9 cases per 100,000 population to 52.7.

Between July to September 2011 and October to December 2020, the count of hospital-onset cases decreased by 10.0% from 1,996 to 1,796. In contrast, there has been an increase in the incidence rate of hospital-onset cases of 0.5% between July to September 2011 and October to December 2020 from 23.6 per 100,000 bed-days to 23.7. This contrast between the change in counts and rates of hospital-onset infections can, in part be explained through the reduction of hospital activity as a result of COVID-19 pandemic.

When comparing the most recent quarter (October to December 2020) to the same period in the previous year (October to December 2019) there is a 13.2% decrease in the count of all reported cases from 10,685 to 9,275, while the incidence rate also decreased by 13.2% from 75.3 per 100,000 population to 65.4. Community-onset E. coli bacteraemia cases

decreased by 13.9% from 8,690 to 7,479, with the community-onset incidence rate decreasing by the same percentage (13.9% from 61.3 per 100,000 population to 52.7.

Furthermore, hospital onset E. coli bacteraemia cases decreased by 10.0% from 1,995 to 1,796. However, incidence rate increased by 5.4% from 22.5 to 23.7 per 100,000 bed-days. It is important that these figures be interpreted with caution. Since the start of the COVID-19 global pandemic, the total count and rate of E. coli bacteraemia cases declined due to reduced hospital activity but the rate of hospital-onset case has increased compared to the previous year.

In previous years, there is a strong seasonality to the incidence of all-reported E. coli bacteraemia cases, with the highest rates observed between July to September of each year. Care is required in interpreting 2020 to 2021 as we have seen a reduction in cases and hospital activity.

The Department of Health had announced a formal intention to reduce the incidence of E coli bacteraemia by 50% by 2020; this was subsequently reviewed and updated on the 24th January 2019 on the Department of Health publication of 'Tackling antimicrobial resistance 2019–2024. The UK's five-year national action plan'. This publication acknowledged the complexity of reducing gram negative bloodstream infections but reiterated the need to continue work to halve healthcare associated Gram negative BSIs, adopting a systematic approach to preventing infections and delivering a 25% reduction by 2021-2022 with the full 50% by 2023-2024

The majority of E coli BSI diagnosed in HUTH are the cause of admission rather than being hospital-acquired (usually related to urine or gall bladder infections), and are therefore considered as 'non-attributable' to the Trust. However a proportion of E coli bloodstream infections continue to be acquired in hospital, associated with urinary catheters, wound infections, vascular devices, and ventilator-associated pneumonia. Even for the 'community-attributable' bacteraemia the situation is not as straightforward as it may seem, as infections developing in the community may be related to a previous admission to hospital. Although surveillance of cases is reported, it is difficult to determine which infections were potentially avoidable without robust investigation. Each hospital apportioned case is subject to a review by the IPCT and if identified lapses in practice are identified then a root cause analysis ((RCA) is completed.

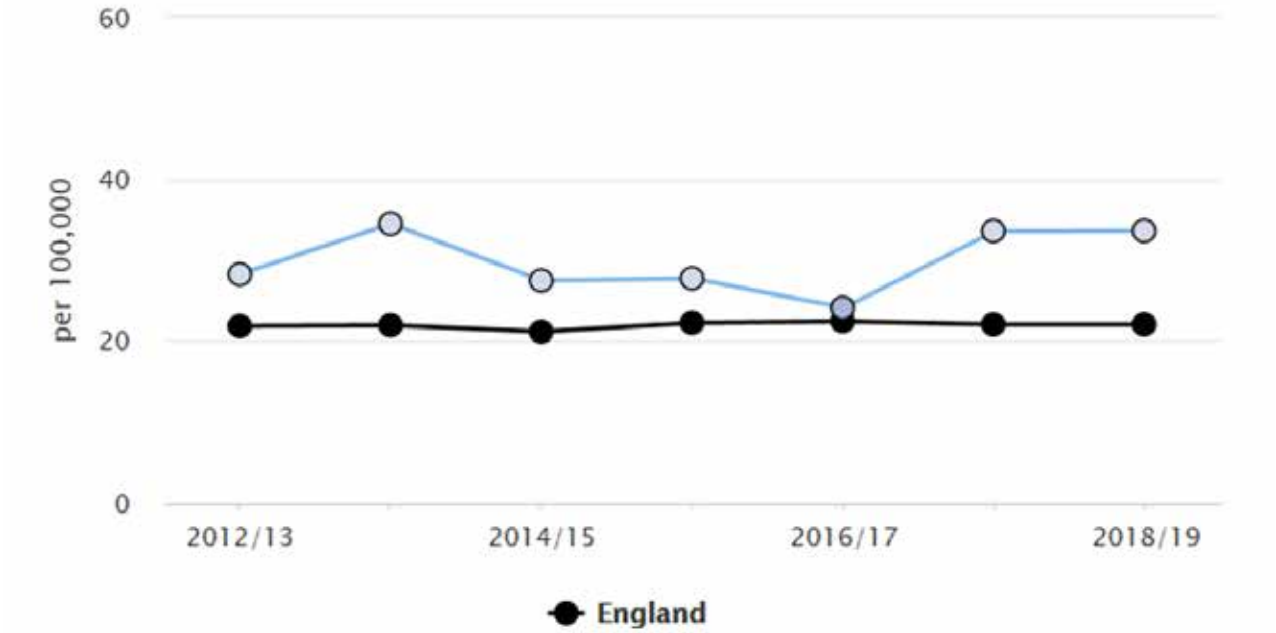

Figure 4. E.coli BSI rates in England 2012 - 2019 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

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Infection Prevention & Control Arrangements

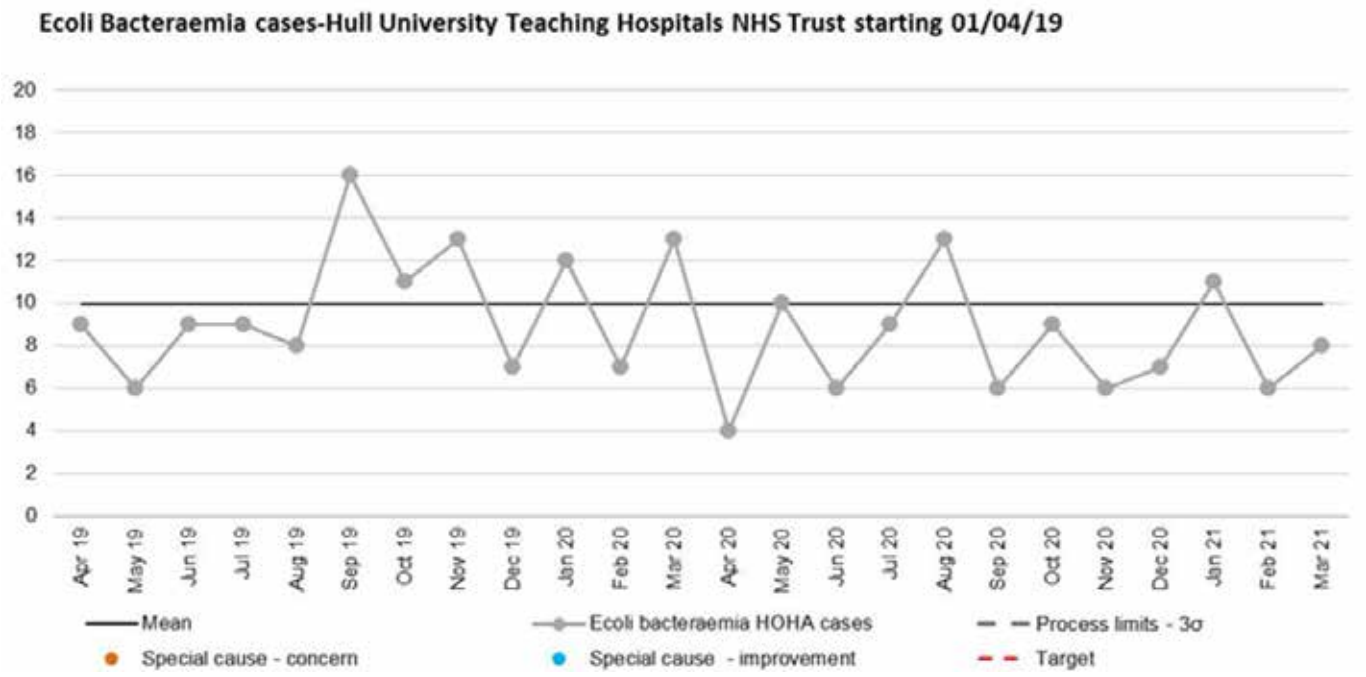

Table 4. E. coli bloodstream infection diagnosed in HUTHT 2019-21

Klebsiella and Pseudomonas Aeruginosa bacteraemia

For the operational period 1st April 2019 to 31st March 2020, PHE and NHS England required NHS Trusts to continue to report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa. This is to support the government initiative to reduce Gram-negative bloodstream infections by delivering a 25% reduction by the financial year 2021-2022 with the full 50% by 2023-2024, inclusive of E.coli, Klebsiella and Pseudomonas Aeruginosa bacteraemia. Klebsiella and Pseudomonas Aeruginosa bacteraemia demonstrate similar risk factors as those found with E.coli bacteraemia, with both reported for cases of respiratory and urinary tract infections.

Klebsiella bacteraemia

Between April to June 2017 and October to December 2020, there was a 23.7% increase in the count of all nationally reported Klebsiella spp. bacteraemia cases from 2,348 to 2,905 and a 20.9% increase in the incidence rate from 16.9 to 20.5 cases per 100,000 population respectively. The count of community-onset cases also increased by 11.8% from 1,678 to 1,876 cases, while the incidence rate increased by 9.3% from 12.1 to 13.2 cases per 100,000 population respectively. Over the same period, the count and the incidence rate of hospital-onset cases increased by 53.6% from 670 to 1,029 cases and by 75.0% from 7.8 to 13.6 cases per 100,000 bed-days respectively. The sharp rise in hospital-onset counts and rates is a recent development and is currently under investigation by PHE and NHSI.

Comparing the most recent quarter (October to December 2020) to the same period in the previous year (October to December 2019) shows a 1.5% decrease in the count of all reported cases from 2,950 to 2,905, with the same decrease in rate from 20.8 to 20.5 per 100,000 population. Hospital-onset Klebsiella spp. cases have increased sharply by 19.1% from 864 to 1,029 corresponding incidence rate increased by 39.5% from 9.7 to 13.6 per 100,000 bed-days. Community-onset Klebsiella spp. cases decreased 10.1% from 2,086 to 1,876, with rates decreasing by the same percentage (10.1% reduction from 14.7 to 13.2 per 100,000 population).

During October to December 2020, 72.1% (2,095/2,905) of all reported Klebsiella spp. bacteraemia were caused by Klebsiella pneumoniae, a decrease from 74.1% in the same quarter in the previous year (October to December 2019). Over the same period, the percentage of cases caused by Klebsiella oxytoca increased to 17.2% (499/2,905) in October to December 2020 from 15.9% in the same quarter in the previous year (October to December 2019).

There is evidence of seasonality to the incidence of all-reported Klebsiella spp. bacteraemia cases, with the highest rates observed in July to September of each year. Due to this seasonality, trends of Klebsiella spp. and the limited data points available the results need to be interpreted with caution.

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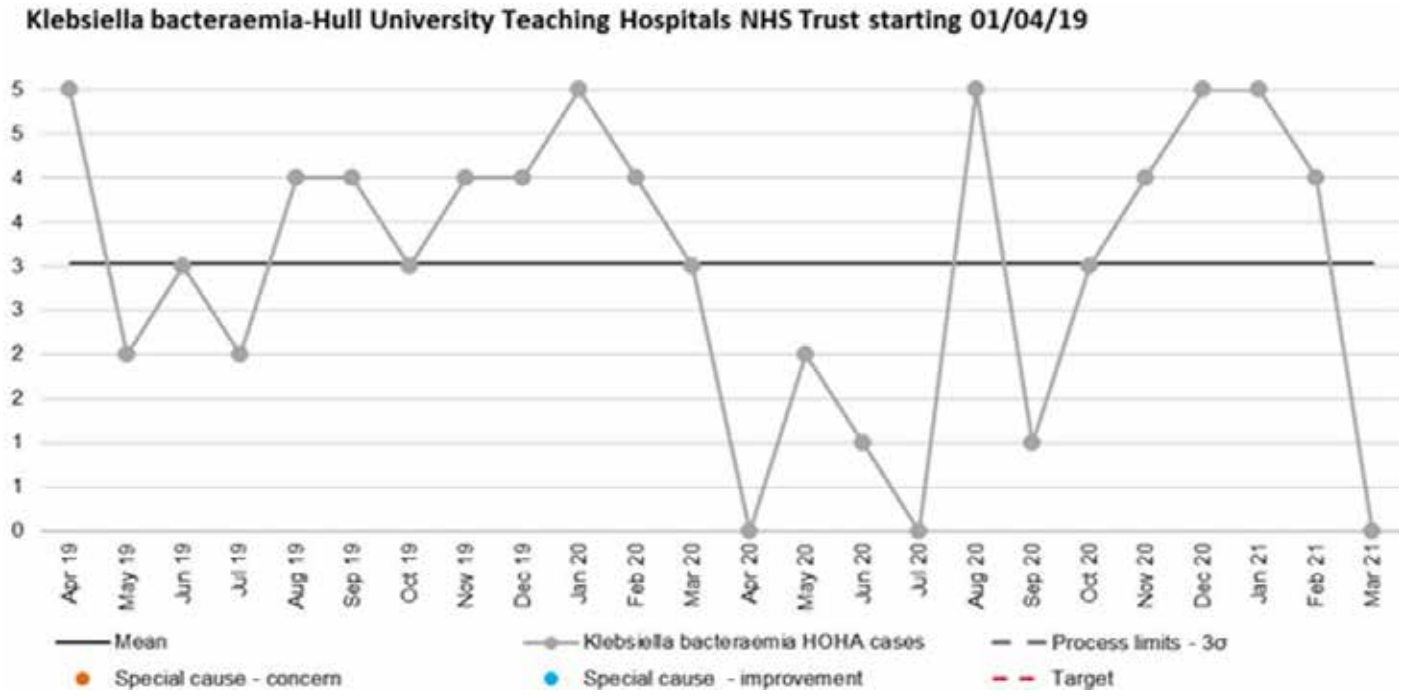
Pseudomonas aeruginosa bacteraemia

Between April to June 2017 and October to December 2020, there was a 10.2% increase in the count of all nationally reported P. aeruginosa bacteraemia cases from 1,012 to 1,115 and a 7.7% increase in the incidence rate from 7.3 to 7.9 cases per 100,000 population respectively. The count and the incidence rate of community-onset cases also increased by 5.2% from 638 to 671 cases and by 2.8% from 4.6 to 4.7 cases per 100,000 population respectively. Over the same period, the count and the incidence rate of hospital-onset cases increased by 18.7% from 374 to 444 cases and by 35.3% from 4.3 to 5.9 cases per 100,000 bed-days respectively.

Comparing the most recent quarter (October to December 2020) to the same period in the previous year (October to December 2019) shows a 0.5% increase in the count of all nationally reported cases from 1,110 to 1,115, while the incidence rate increased 0.5% from 7.8 to 7.9. Hospital-onset P. aeruginosa case counts, like those for Klebsiella spp., increased sharply (7.5%) from 413 to 444, which corresponds to an increase in the incidence rate increase of 25.9% from 4.6 to 5.9 per 100,000 bed-days. Similarly to Klebsiella spp., the underlying causes for these increases other than changes resulting from the pandemic response, are currently unknown. Community-onset P. aeruginosa cases decreased 3.7% from 697 to 671 per 100,000 population, while the community-onset incidence rate decreased 3.7% from 4.9 to 4.7 per 100,000 population.

There is evidence of seasonality to the incidence of all-reported P. aeruginosa bacteraemia cases, with the highest rates observed in July to September of each year. Due to this seasonality, trends of P. aeruginosa and the limited data points available the results need to be interpreted with caution.

Tables 5&6. Klebsiella and Pseudomonas aeruginosa bloodstream infections diagnosed in HUTHT 2019-2021



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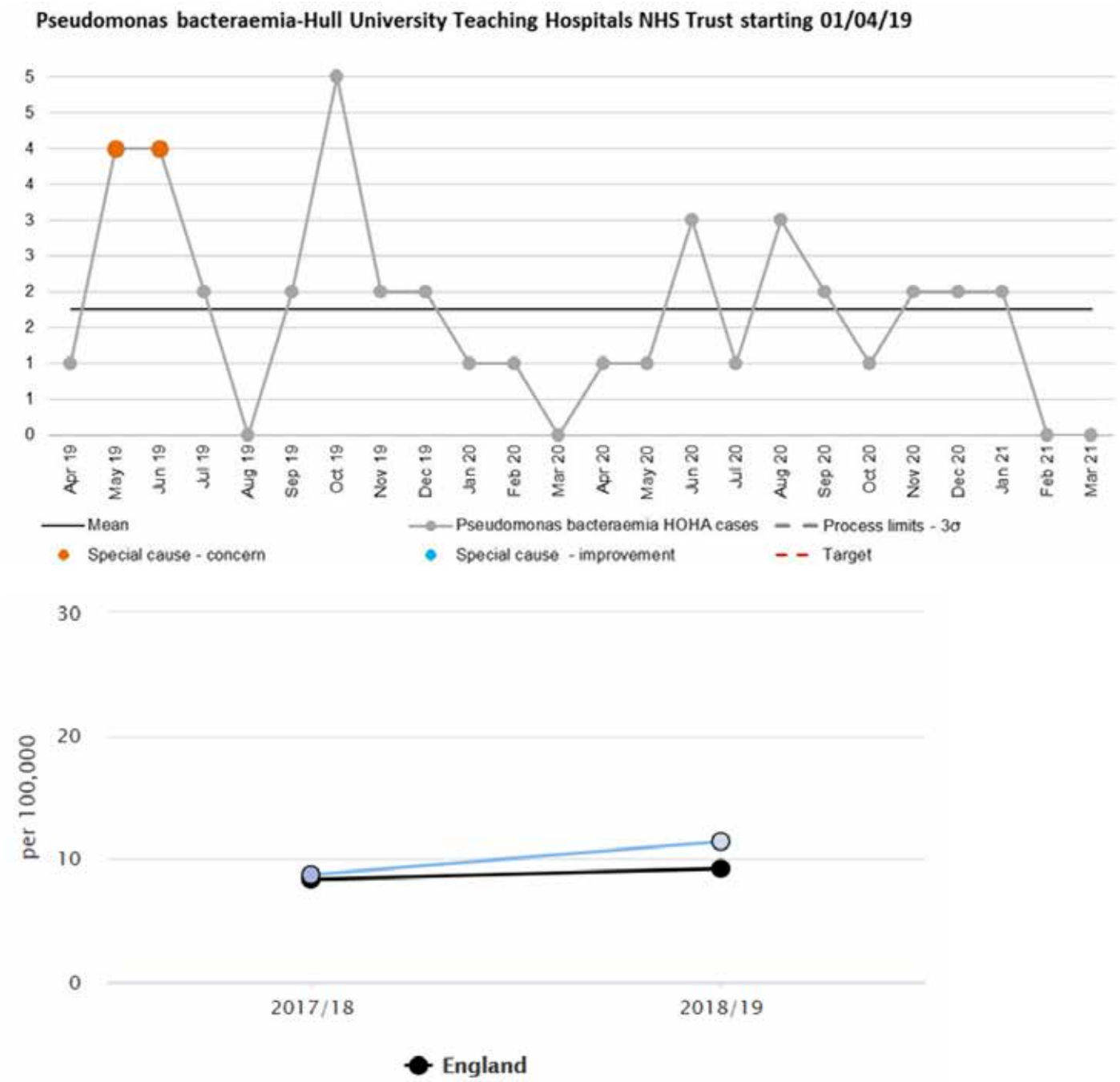

Figure 4. Klebsiella BSI rates in England 2017 - 2019 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

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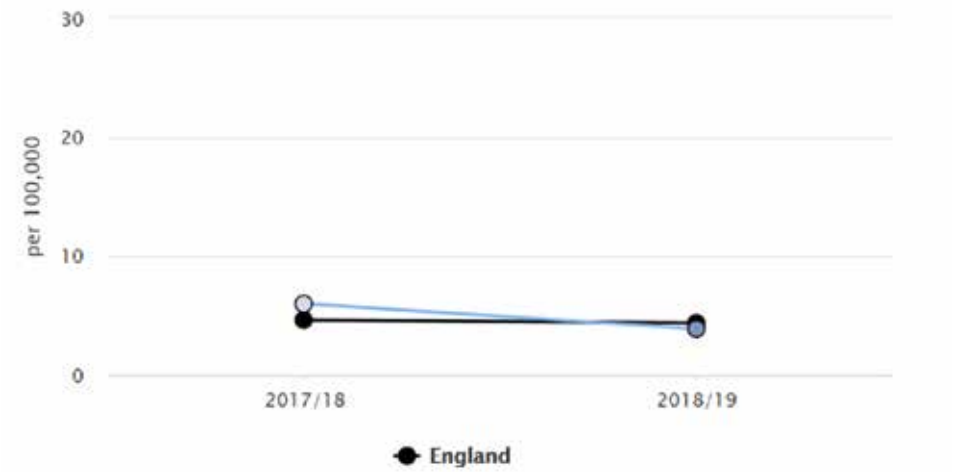

Figure 5. Pseudomonas aeruginosa BSI rates in England 2017 - 2019 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

Surgical Site Surveillance

The Trust continues to participate in both mandatory and voluntary surveillance of surgical site infection: in 2020/21 this included orthopaedic surveillance (hip replacements) and was commenced during October to December 2020; in addition, from January 2020 to March 2020 because of previous concerns raised regarding perceived increase in wound infections amongst fractured neck of femur patients, repair of neck of femur fracture surveillance was once again undertaken, providing the opportunity to compare year on year figures.

With regards hip replacement surveillance, the IPCT commenced surveillance on the 1st October 2020 but because of increasing numbers of COVID-19 cases during November 2021, all elective hip replacement surgery was postponed resulting in a significant reduction in identified surveillance cases. IPCT sought advice from PHE Surgical Site Infection Surveillance team with regards continuation of this surveillance period and it was decided to postpone the surveillance and reschedule for 2021-22.

With regards repair of neck of femur fracture surveillance completed during January – March 2021, eighty eight repair of neck of femur operations were surveyed, 1 patient was reported to have a superficial wound infection providing the percentage of surgical site infections (SSIs) at the Trust at 1.1%, in line with the national hospital SSI rate. These figures remain static from the same surveillance period for January to March 2020. At the time of drafting the report, the surveillance is awaiting sign off and ratification by the PHE Surgical Site Surveillance Service (SSISS).

8. Outbreaks and Resistant Organisms

The Trust's policy on outbreaks and incidents of infection was updated during 2020-21 to reflect the challenges of COVID-19 and has been followed by the IPC team and respective Health Groups. Incident and Outbreak Control Group meetings have been held where necessary to support clinical areas in determining whether an incident or outbreak is occurring, ensuring patient safety and preventing onward transmission. The majority of outbreaks during 2020-21 have related to COVID-19 and is covered in this report in a separate section.

Diarrhoea & Vomiting/ Norovirus

During 2020-21, no incidences and/or outbreaks of Norovirus were reported. This was not an isolated event but experienced by other Trusts and community settings such as care homes. Due in part to the restrictions imposed to tackle the COVID-19 pandemic and the reduction of movement of patients, staff and visitors, coupled with improved compliance with IPC measures such as hand hygiene.

During 2020-21, outbreaks of diarrhoea & vomiting (D&V), mainly affecting medical elderly wards were reported. In the majority of cases, only bays were affected and following applied control measures and sampling, closure was short-lived. In March 2021, ward H8 was closed to admissions for 11 days due to an outbreak of diarrhoea and vomiting which was protracted and affected a number of patients some of whom became symptomatic within 24 hours of admission. No causative organisms were detected in spite of numerous faecal samples submitted to Microbiology and the likely cause was believed to be condition/ medication related requiring further investigation by the medical team responsible for the affected patient's care.

In accordance with national guidance hospital outbreaks of D&V/ Norovirus were managed with partial restrictions but some complete ward closures were necessary.

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Carbapenemase producing Enterobacteriaceae (CPE)

Infections with multi-drug resistant Gram negative bacteria are becoming increasingly common in Britain, and there have been a number of healthcare associated outbreaks (including some in other acute trusts in Yorkshire). During 2020-21 Hull University Teaching Hospitals NHS Trust continued to experience imported infected and/or colonized patients, all of whom brought the organism in from elsewhere albeit at lower numbers due to restrictions of patient movement imposed by the COVID-19 pandemic. The Trust continues to identify and respond as per the updated national toolkit 'Framework of actions to contain carbapenemase-producing Enterobacterales' (updated September 2020) on the prevention and management of CPE and during 2020-21 met the requirements of the toolkit e.g. identifying, screening and managing at risk patients and those with active infection. During 2020-21 in response to admissions and transfers of patients with CPE and a concern regarding the propensity for CPE to survive in healthcare environments, reactive cleaning of ward/department areas using Hydrogen Peroxide Vapours (HPV) was conducted where patients had been nursed and/or treated. This was invariably needed out of normal working hours and conducted by an external company who specialise in HPV decontamination. This represents a cost burden to the Trust in the long term with HPV decontamination out of hours costing the Trust approximately £25,000.00 excluding VAT for 2020-21.

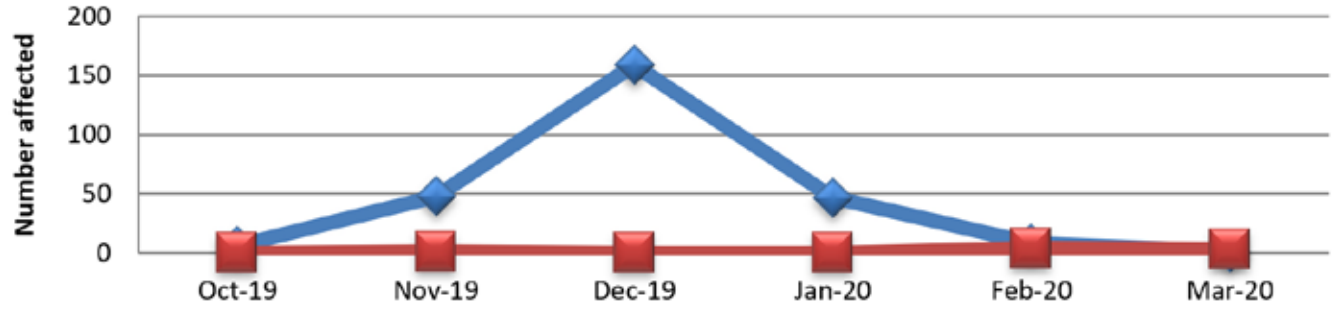
Influenza

Although cases of Influenza were reported during March 2020 there were no further cases reported during 2020-21, albeit only three cases reported during November & December 2020 representing paediatric patients but these were determined as vaccine related and not clinical cases of Influenza.

The influenza vaccination campaign for 2020-21 commenced on the 25th September 2020 and at year end, 87% of Trust staff involved in providing direct patient care had taken up the influenza vaccine a marked increase from previous campaigns.

During 2020-21, the Microbiology laboratory continued to use molecular testing (Biofire film array multiplex PCR system). This provided rapid respiratory panel testing including influenza, enabling prudent management and treatment of respiratory viral infections and improving patient flow. During 2020-21, this included COVID-19 as standard. Patients were proactively screened for influenza, along with COVID-19, during admission and/or treatment when presenting with flu-like symptoms which is to be commended and encouraged, ensuring patient and staff safety. The following two graphs show the distribution of Influenza strains for FY 19-20 and 20-21.

Influenza Activity 2019/20 at Hull University Teaching Hospitals NHS Trust



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Flu A	6	48	159	47	8	1
Flu B	0	1	0	0	4	3

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Influenza Activity 2020/21
at Hull University Teaching Hospitals NHS Trust

	Oct-20	Nov-20	Dec-20	01/01/202021	Feb-21	Mar-21
Flu A	0	0	0	0	0	0
Flu B	0	0	0	0	0	0

Table 9. Represents influenza activity at the Trust since October 2020 until the end of March 2021

In previous annual reports national Influenza data provided by PHE has been included but due to the COVID-19 pandemic and a marked reduction of cases reported, the last weekly report received by the Trust was published on 1st October 2020 and at the time of drafting the Annual DIPC report 2020-21 the PHE Annual Influenza Report remains outstanding.

COVID-19

During 2020-21, COVID-19 remained the largest challenge for the organisation. The first UK patients with Coronavirus Disease (COVID-19) to were admitted to Castle Hill Hospital on the 30th January 2020. The first COVID-19 related death reported at the Trust occurred on the 19th March 2021.

The Trust adopted a Command Structure to manage the pandemic and the subsequent Trust COVID-19 Surge Plan. The pandemic can be separated into 3 waves. The first wave of the pandemic continued until June 2020 with a peak of 112 patients on the 1st April 2021. Outbreaks of COVID-19 infection were identified in small numbers during this period mainly on the HRI site, compounded by asymptomatic carriage in both patients and staff and a lack of understanding of the transmissibility of the virus.

A second wave was identified at the beginning of October 2021 with a peak of cases identified by the 17th November 2021 totalling 183 patients and a further peak or arguable wave reported in January 2021 with the largest peak of 267 patients.

During these subsequent waves a number of Trust outbreaks occurred both on the HRI and CHH site. A definition of a hospital onset case was published in May 2020 and using these definitions 512 patients tested positive for COVID-19 infection 8 or more days into their inpatient stay, 358 8-14 days (probable) and 154 15 days or more (definitely). Unfortunately, a quarter of these patients (132) died within 30 days of testing positive and during this period the Trust was an outlier with regards hospital onset cases of COVID-19 when compared to other Trusts.

The causes of outbreaks have been previously outlined in a separate report to the Trust Board but the learning from these will provide the focus of attention for the Trust during the coming financial year(s).

9. Isolation Facilities

There have been, for many years, concerns about the Trust's isolation facilities. Like many other NHS trusts with older estate there is a general shortage of single rooms suitable for isolating patients with potentially contagious conditions. This is a long-standing issue, and there is no simple solution.

The opening of ward C7 has had a positive impact on patient management, particularly those patients with difficult to treat infections and infectious diseases requiring specialist isolation facilities, particularly pertinent in light of COVID-19. It also means that we can manage several patients at once with conditions requiring long term isolation, for example multidrug resistant tuberculosis.

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There remain concerns about the organisation's ability to isolate children, especially those with airborne infections. Although plans are discussed and implemented to minimise the risk of infections, especially during winter with risk assessments and liaison with IPCT - there have been, and will continue to be, cases of hospital transmitted influenza and respiratory syncytial virus (RSV) until more suitable facilities for isolating children with these infections are provided. Cases of childhood respiratory viruses were significantly reduced during 2020/21 due in part to the measures implemented to mitigate the concerns with regards COVID-19 such as facemasks, social distancing and the importance of prudent hand hygiene. Consequently, paediatric services with reduced surgical elective activity were able to manage any admissions with respiratory infections effectively across the paediatric bed base. During 2020-21, with IPC input and involvement, multi-disciplinary meetings have been held and work has commenced on a new paediatric inpatient, high dependency unit and outpatient facility. Improved isolation capacity and smaller bedded areas e.g. 2 bedded bays will enable prudent management of paediatric patients and minimise the risk associated with the transmission of infections.

The Neonatal Intensive Care Unit, a tertiary level 3 unit, has had a number of incidents and outbreaks the last 6 years with the environment cited as being a contributory factor and significant work has been undertaken on the unit to mitigate risks. The 'blue room' although reduced by one cot space requires further work to reconfigure the space following a recommendation from the Department of Infection for this to be addressed as soon as is practicable. The COVID-19 pandemic paused any imminent plans and although the reconfiguration has been approved, additional allocated funding is pending at the time of writing this report.

During 2020-21, the COVID-19 pandemic provided the opportunity to review the Trust's existing bed capacity and with it the ability to isolate patients effectively in collaboration with the Estates team and the IPCT. A ward block was constructed including wards H36, H37 & H38 for nursing COVID-19 positive patients, with H36 provided with 18 cubicles of which 6 had lobbied areas with negative pressure ventilation and H37 constructed and configured to nurse level 2 respiratory patients.

The COVID-19 pandemic highlighted the need for compliant isolation facilities in ICU settings on both hospital sites and to this end in January 2021 work commenced on building a fully compliant ICU on the HRI site, in collaboration with clinical teams and involvement of the IPCT, with expected completion by September 2021.

10. Antimicrobial Stewardship

Increasing emphasis is being placed nationally on the importance of antimicrobial stewardship as part of infection prevention and control plan. This is useful in reducing the development of C difficile infection, but is even more important in limiting the emergence of bacterial resistance. The Trust has for many years had a good record in antimicrobial stewardship.

The World Health Organisation created the Access, Watch and Reserve antibiotic categories to assist antimicrobial stewardship and to reduce antimicrobial resistance. The three AWaRe categories divide antibiotics as follows:

- Reserve – antibiotics that need to be reserved due to antimicrobial resistance
- Watch – second-line agents
- Access – key antibiotics which are narrow spectrum and used as first-line treatment options.

During 2020-21 the assigned CQUINS – with regards antimicrobial resistance and the use of antifungals and appropriate antibiotic prescribing for UTI in adults aged 16+ were paused because of the focused attention on the COVID-19 pandemic. Although the CQUINs were paused the Trust continued to monitor Carbapenem usage throughout 2020-21 and the proportion of ACCESS agents.

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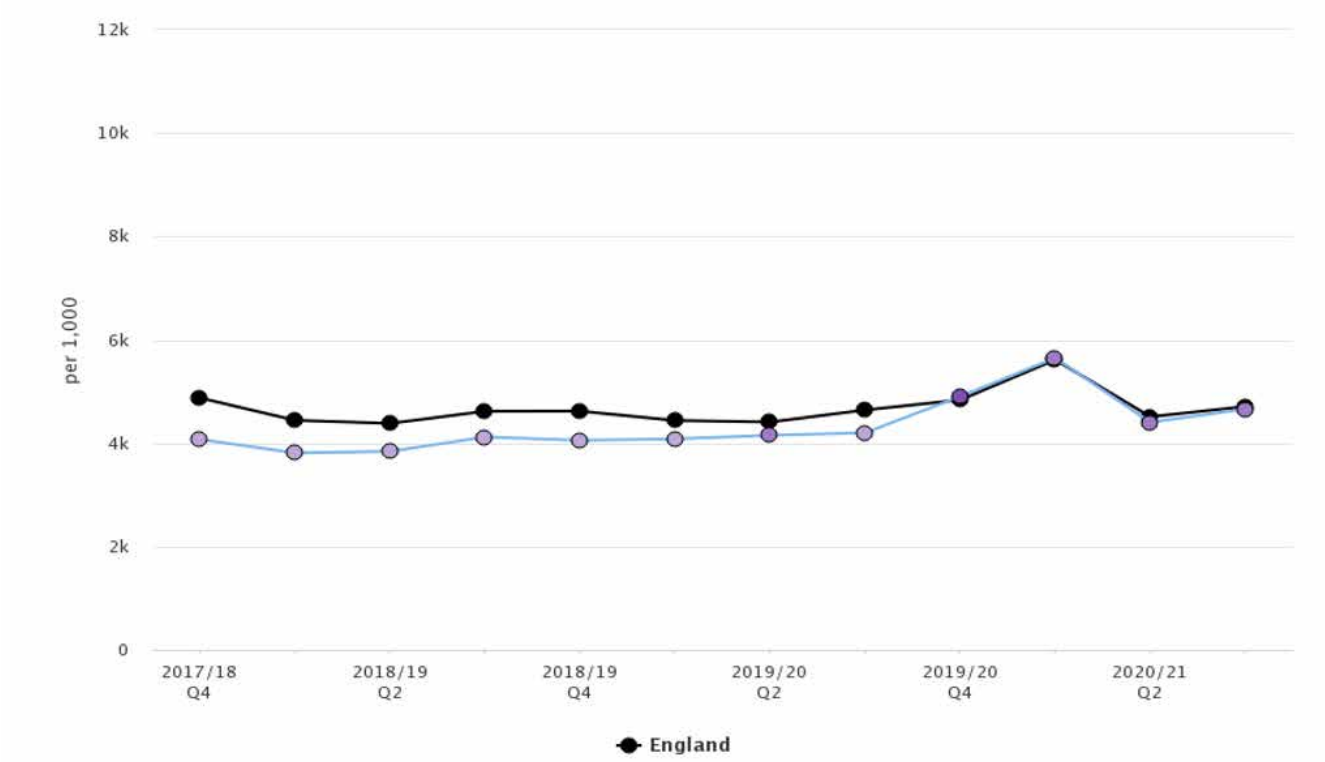
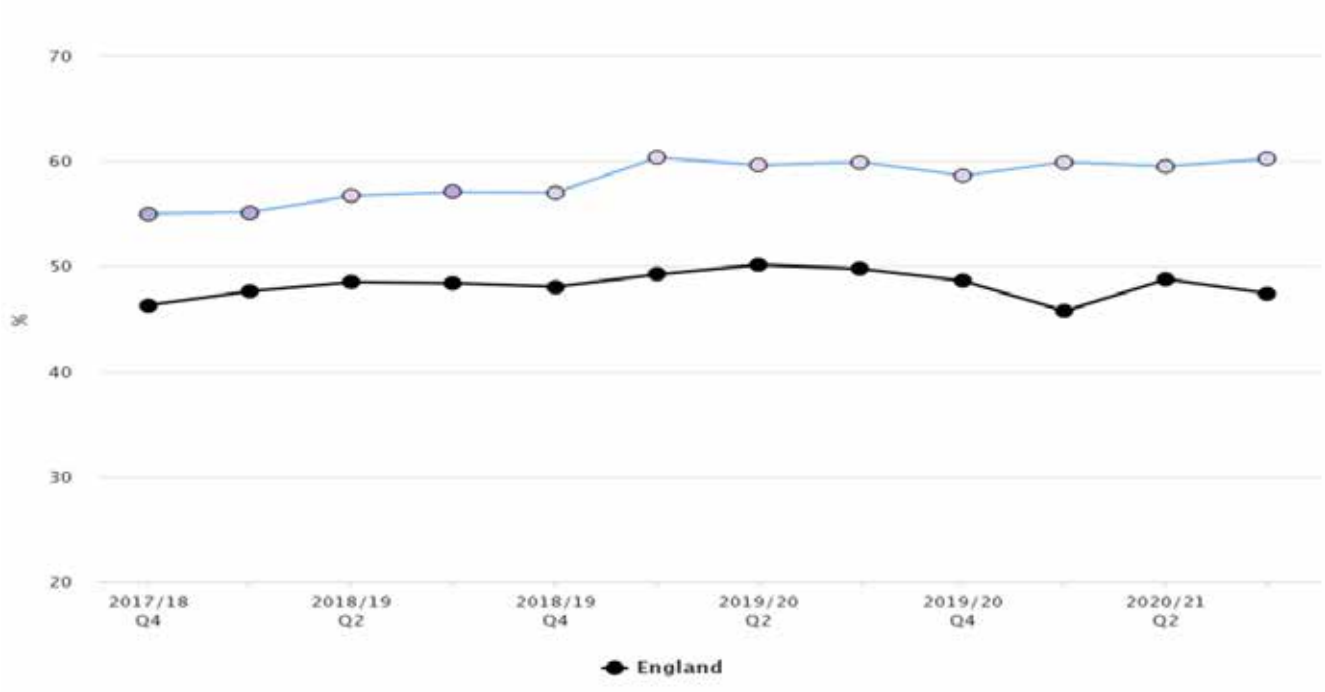
Infection Prevention & Control Arrangements



Total antibiotic prescribing DDDs per 1000 admissions; by quarter and trust



Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index; by quarter and acute trust

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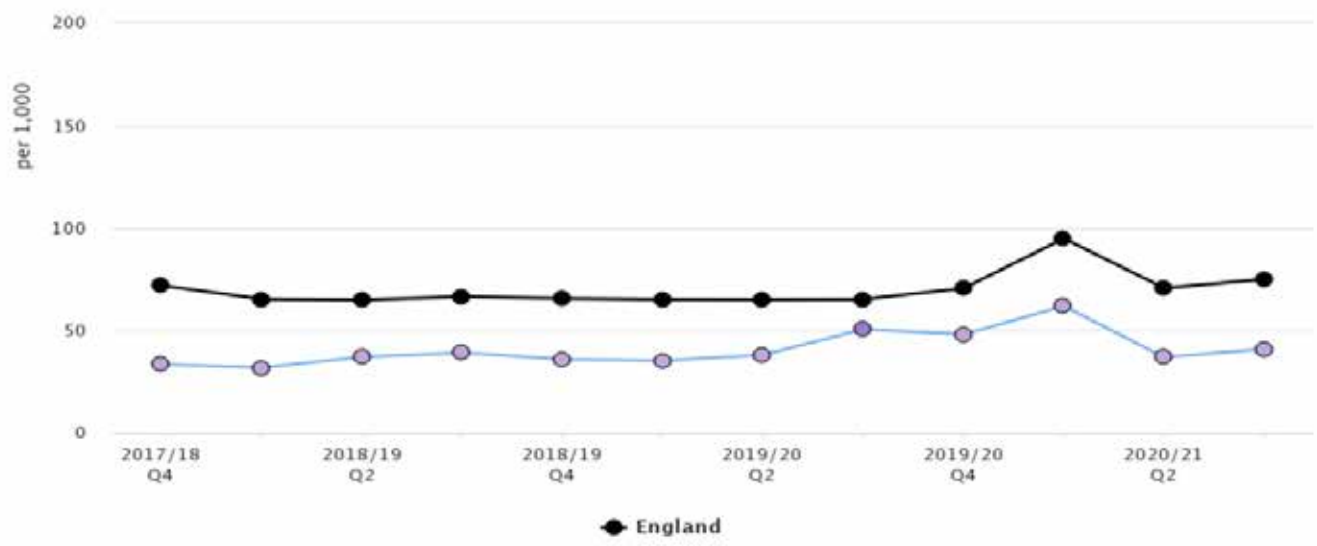

Carbapenem prescribing DDDs per 1000 admissions; by quarter and acute trust

The Antibiotic Control Advisory Team (ACAT continues to work on improving antibiotic usage within the Trust. Advice on the use of antibiotics is included in consultants' mandatory training day and junior doctor's induction. In addition to an innovative antibiotic formulary (promoting less use of broad spectrum agents) ACAT has produced guidelines on empiric antibiotic prescribing, antibiotic 'streamlining', and surgical antibiotic prophylaxis. All this guidance is available both in hard copy and on Pattie. The Antibiotic Pattie page has been reviewed and improved so that each speciality has their own section and they are currently being updated. Closer links with the specialities concerned is integral to the development of the updates which will hopefully encourage guideline adherence. During 2020-21, in spite of the challenges faced by the COVID-19 pandemic ACAT continued to meet, less frequently and in some cases virtually.

On the Pattie homepage there is a direct link to the Antibiotic page and it is accessible on mobile devices via Pattie links.

The Empiric Guidance has been further updated during 2020-21 with the addition of new charts to accompany the 'blue adult' including the 'green child', 'orange neonate' and 'purple pregnant women' available on the wards. The focus is moving to intranet and mobile device access rather than hard copies with the exception of the new posters. ACAT meets regularly to review antibiotic usage, and reports to IRC. ACAT and pharmacy have altered the reports that are reviewed at IRC and ACAT, tabling the updated reports towards the end of the financial year, these include quarterly Health Group reports looking at antibiotic consumption, I&D reporting, antibiotic related incident reporting via DATIX and bi-annual speciality reports.

During 2020-21 electronic prescribing and medicines administration (EPMA) continued across the Clinical Support Health Group. There were continued issues regarding the documentation of indication and duration on the electronic system affecting the overall Trust position when audited by Pharmacy teams. This was addressed by training, prompts and escalation by the respective consultants, along with changes to the EPMA interface with improvement noted.

Along with conventional antimicrobial stewardship, the benefit of an outpatient parenteral antimicrobial therapy (OPAT) service to manage the delivery of intravenous and complex oral antibiotics to patients who are medically stable, within an outpatient setting eliminates the need to either admit or keep in hospital patients whose only reason to stay in hospital is to receive IV / complex oral antibiotic therapy. All OPAT patients continue to have their medical condition and therapy closely supervised by a multidisciplinary team with a proven record that this service contributes to reducing a patient's length of stay in hospital, promotes early discharges and improves patient experiences. It improves quality of life for patients and reduces the risk of hospital-acquired infection. Feedback from OPAT patients is overwhelmingly positive, citing the benefits of receiving treatment as an outpatient, the ability to return to work, and the care, support and expertise of the OPAT team. Throughout the COVID19 pandemic the OPAT service provided an invaluable means of discharging numerous patients out of hospital safely while still maintaining their treatment. Challenges existed with regards the delivery of the service and the need to maintain social distancing requirements alongside the planned reconfiguration of facilities within the Queens Centre with plans to expand the service into community settings.

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11. Sepsis

The Trust Sepsis service consists of 1PA of Infectious Diseases consultant time as the clinical lead for the service and 2 Sepsis specialist nurses. An innovative wrap around review service for patients with Sepsis was designed and due to be introduced in February 2020. Unfortunately the introduction of this had to be postponed due to the pandemic and the impact of a shielding member of the nursing team on the service and the inability of doing any meaningful face to face patient contact, compounded by the consultant lead and other specialist nurse supporting wards managing patients with COVID-19. It is hoped this will be introduced during 2021-20, the team anticipate a further improvement in the care and patient experience for patients with Sepsis once this is introduced.

The Sepsis team previously ran a full teaching programme but this was converted to virtual Big Blue Button training and although there was a brief commencement of face to face training this was short-lived.

11. Decontamination

The Trust Decontamination Committee convened and chaired by the Surgical Health Group covers decontamination in Sterile Services, Endoscopy, decontamination of medical devices and patient equipment and environmental cleaning. The Committee would normally meet quarterly but due to the impact of the COVID-19 pandemic this was paused. The Trust endoscopy users, sterile services department and theatre report into this group and during 2020-21, escalation of concerns has been via the IPCT and the Surgical Health Group. This committee reports to the OIRC.

Central Sterile Services Department (CSSD) continues to meet the requirements of disinfection, assembly, packing, moist heat and gas plasma sterilisation of theatre trays and procedure packs and supplementary instruments in accordance with ISO 13485:2003 and ISO 9001:2008. For moist heat and gas plasma sterilisation of theatre trays, procedure packs and supplementary instruments in accordance with Medical Devices Directive 93/42/EEC Annex V, Article 12 (Sterility Aspects Only). Activity in CSSD was significantly reduced because of the impact of the COVID-19 pandemic and the cancellation of elective surgery, unless for life limiting conditions such as cancer. Many staff employed via CSSD were redeployed to other areas of the Trust to provide additional support to clinical staff across the Trust.

During 2020-21 embedded support for CSSD, theatres and endoscopy by the Infection Prevention and Control team, in respect to surgical instrumentation, cleaning and disinfection and advice on quarantining instruments and scopes has continued.

12. Water Safety

The Water Safety Group (WSG) continues to work to raise awareness of water safety issues throughout the Trust and continues to take steps to improve arrangements for water safety and governance. The Water Safety Group was convened during 2020-21 in spite of the COVID-19 pandemic but pressures resulted in a reduced frequency of meetings. During 2020-21 attendance at the WSG from respective Health Groups was noted, better and continued clinical representation is needed to effectively assess and respond to risks to patient safety and translate the work of the WSG to the clinical environment. Attendance of an appointed authorising engineer for water safety continued during 2020-21 provided assurance to Estates, Health Groups and the IPCT of the adopted systems/ processes but also the challenge to change and improve practice.

Flushing on both Trust sites is now firmly established, with improved compliance now seen. The Estates department utilise a software database to record flushing. This improved the ease with which clinical staff recorded flushing in real time. The system creates compliance reports but will also escalate non-compliance through a pre-determined electronic cascade system. The system continues to be embedded by the Estates Department and respective Health Groups and is reliant on contemporaneous contact details of key team members, in some cases wards and departments use both the electronic system and paper records to record flushing compliance.

Any positive water samples culturing both Legionella and/ or Pseudomonas are reported by Public Health England to both the Estates team and key members of the Infection Prevention and Control Team with prompt action to reduce risks to patients, including escalation and control of infection incident meetings.

During 2020-21, two incident meetings were held to discuss an increase in water samples culturing Legionella resulting in wards being closed to admissions and remedial actions taken by the Estates team. The COVID-19 pandemic resulted in reduced or reconfigured activity on some wards and in some cases closure of wards, thereby increasing the risk of reduced use and irregular flushing of water outlets. Prudent communication to the Estates team by Health Groups, especially when wards were closed to admissions was vital to maintain prudent flushing regimes. During 2020-21, following a review of the Trust's Water Safety Plan the Estates team commenced a consistent and comprehensive regime of water testing especially in augmented care areas and areas managing immunocompromised patients.

13. Cleaning Services

Hull University Teaching Hospitals NHS Trust has a responsibility to provide and maintain a clean and appropriate environment for healthcare. With a higher profile on improving cleanliness in hospitals this is now a key element of how each hospitals performance is judged and it is assessed in a number of ways which feature in the Care Quality Commission's (CQC) Essential Standards of Quality and Safety.

During 2020-21, Outsourced Client Solutions (OCS) has been responsible for providing cleaning services for Hull University Teaching Hospitals NHS Trust. The COVID-19 pandemic has brought challenges with regards cleaning services, especially during surges of infection. Enhanced

cleaning with additional hours needed and an increased staffing resource over and above the existing Trust contract has been required, in addition an increase of post-infection (Amber) cleans have been required along with specialist cleans involving Hydrogen Peroxide Vapours (HPV). Changes to the working patterns of the Cleaning Action Team were required during 2020-21 to address the need for both in and out of hours responsive cleaning.

During the financial year the IPCT attended operational meetings to share information with regards risk and/or issues related to COVID-19, HCAIs and outbreaks but also to acquire assurance that hospital cleanliness remained a priority.

An Estates & Facilities COVID-19 Command structure was set up during 2020-21 to capture actions, concerns and areas requiring improvement and/or further investment e.g. time or additional staffing. Liaison with the DIPC and IPCT was escalated via the COVID-19 Command structure.

During 2020-21, the dedicated monitoring of standards of cleanliness has been impacted by the COVID-19 pandemic, with designated COVID-19 wards limiting footfall onto the wards and departments. Ad hoc monitoring by Domestic Supervisors, who at times have been operational supporting staff in cleaning to the standards expected has taken place. Formal monitoring from Facilities was resumed briefly during the summer. Additional monitoring via audit completed by the IPCT, Senior Matrons and dedicated CENSUS audits during 2020-21 continued to ensure the contract is being delivered to the required standards, Trust expectations and in line with changes to standards of cleanliness due to COVID-19 e.g. enhanced cleaning of high touch points/ bathrooms and toilets.

14. Place Inspections

The annual Patient Led Assessment of the Environment (PLACE) inspection of the Trust did not take place during 2020-21 due to the COVID-19 pandemic but work has continued to address and/or monitor the issues raised during the 2019-20 inspections.

15. Audit

An annual programme of audit is agreed as part of the annual IPC/ Fundamental Standards programme. The audit programme is a combination of policy audits and general IPC audits carried out as part of an unannounced visit schedule. Audits of both practice and environment are also undertaken following incidents/outbreaks of infection. Audit results are collated and fed back to the clinical area and action plans are requested as appropriate. During 2020-21 audits were presented to the respective Infection Reduction Committees, summarising all of the audit activity and high level findings. Due to the demands placed on the IPC team with regards COVID-19, peer IPC audits along with other fundamental standard audits were completed by Senior Matrons and/or Practice Development Matrons but with involvement of the IPC team should any concerns and/or evidence of good practice identified, In addition, during 2020-21 additional audits were completed to gain assurance with regards compliance against management of COVID-19 and compliance with regards infection prevention & control measures e.g. COVID-19 Census audits.

At ward/ departmental level, monthly IPC audits are undertaken by the nursing/ clinical team these include 5 moments of hand hygiene audit, auditing 20 moments of hand hygiene opportunities and an IPC ownership audit tool capturing key elements of prudent IPC practice and adherence. During 2020-21, compliance with audit requirements has been affected by relocation of teams and change in service delivery e.g. providing care to COVID-19 positive patients. In these circumstances daily, weekly and monthly audits have been completed by Senior Matrons witH support from the IPCT.

16. Policies

The Trust has a programme for review and revision of core infection prevention and control policies as required by the Health and Social Care Act 2008 Code of Practice (2015). All policies are available to staff on PATTIE and many are also available to the public on the main internet web page. In addition, policies and procedures on COVID-19 were added and updated accordingly during 2020-21 as and when national guidance was published and/or updated with a dedicated COVID-19 PATTIE page.

17. Training and Education

Education and training are essential to the plan to limit healthcare associated infections (HCAI) in the Trust. They form part of every staff job description, and an integral part of the appraisal process.

Infection prevention & control education forms part of the mandatory induction programme for all staff. Additionally infection prevention and control is included in junior doctor orientation and as part of the consultants' mandatory training programme. Staff attendance at mandatory infection control updates is recorded centrally.

The infection prevention and control team conduct ad hoc education sessions to staff groups which have included security, volunteers and Estates staff.

At the start of 2020, COVID-19 provided the opportunity for the IPCT to deliver bespoke training on donning and doffing of personal protective equipment and also to deliver fit test training to staff required to wear FFP3 masks. This continued throughout 2020-21 with training underpinned by visual cues such as posters and guidance available to staff on Pattie and auditing of compliance.

Face to face training was paused to ensure COVID-19 Secure requirements were followed and replaced with the roll out of 'Big Blue' virtual training. ELearning utilised for induction and annual training compliance became the default route for staff rather than the face to face Trust Safety Day. Level 1 IPC ELearning is for all staff with Level 2 IPC ELearning for clinical staff, at the time of writing this report 4084 clinical staff completed level 1 & 2 ELearning during 2020-21.

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Infection Prevention & Control Arrangements

18. Other Achievements in 2020-21

The Trust has always worked in collaboration with commissioners and other partners in reducing avoidable infections. Although some national targets and CQUINs divide healthcare associated infections into 'acute-attributed' and 'community-attributed' these are artificial distinctions. Many infections diagnosed in the community have their origins in hospital, and vice versa. It is therefore essential that a 'whole system' approach is taken to tackling healthcare associated infections. During 2020-21, this has been vital and the COVID-19 pandemic has further enhanced Trust collaboration with NHS Improvement, Public Health England (PHE), Local Authorities and Integrated care systems (ICSs). The Trust continues to meet regularly with partners in a number of forums, and during 2020-21 successful collaboration continued with regards COVID-19, nosocomial case numbers and investigation of HCAIs and notifiable diseases.

19. Other Risks in 2020-21

During 2020-21, the identification of Tuberculosis (TB) in inpatients, resulting in contact tracing of both staff and patients continued. The infection prevention and control team have worked closely with the community TB nursing team, infectious diseases consultants, respiratory consultants and Public Health England to reduce ongoing risks to patients and staff. These incidences have provided the opportunity to reinforce the importance of appropriate isolation of 'at risk' patients, use of appropriate personal protective equipment (PPE) e.g. FFP3 facemasks and also communication of cases and incidents to local commissioners.

During 2020-21, cases of Pseudomonas Aeruginosa colonisation were detected in neonates nursed on the Neonatal Intensive Care Unit found on twice weekly screening. No bacteraemia cases have been detected on the unit since August 2018. Extensive investigation regarding a possible source related to the environment has taken place with no known source found. Measures to improve water safety and mitigate environmental contamination have taken place during 2020-21 although this had been hampered by the COVID-19 pandemic. Prudent communication with Public Health England and local commissioners via incident meetings has taken place as has ongoing screening. All samples are submitted to PHE for variable number tandem repeats (VNTR) profiling to enable links to be identified; no linked cases were identified to date during 2020-21.

An extended pilot of a novel sink drain cleaning product was planned on the unit but delayed due to commercial issues and then supply issues due to the CIVID-19 pandemic. It is hoped this will be resolved and commenced as soon as possible on the unit.

During 2020-21, the IPCT continued to work closely with the cardiac perfusion team to mitigate the risks associated with Mycobacterium chimaera. In 2016, following a worldwide rise in patients developing this infection following cardiac bypass surgery, the Medicines & Healthcare products Regulatory Agency (MHRA) published a medical device alert with regards cardiac perfusion machines and the risks associated with this organism. The issue was compounded in that the majority of cardiac perfusion machines were contaminated during manufacture which was only identified once a rise in cases was noted. Since 2016, the Infectious Diseases team and IPCT have worked alongside the perfusion team and cardiac surgeons to safeguard patients, undertaken water sampling from the machines and acting on positive results, removing affected machines from use, following PHE and manufacturers guidance and if required contact tracing patients, alerting GPs and providing a follow up service to patients. When required incident meetings have been held with the Surgical Health Group and with involvement of PHE.

Although improvements were made to the environment to facilitate safe physical decontamination and cleaning of the perfusion machines, during February & March 2021 three cardiac perfusion machines were found to culture Mycobacteria chimaera and removed from use. Incident meetings were held and patients contact traced who had valve replacement surgery, previously facilitated by the affected machines with no patient harm identified but GPs aware should patients latterly present with health concerns.

At the time of writing the report, additional loan machines are hired to assist with the increase in cardiothoracic surgery and water testing has been undertaken from all remaining machines and from the water supply serving the cardiothoracic theatres. The area has been thorough cleaned and no further issues cases reported.

During 2020-21, the COVID-19 pandemic highlighted the increased need for robust digital systems not only within the Trust but also for the IPCT. This is now brought sharply into focus due to the Pathology merger with York & Scarborough Teaching Hospitals NHS Foundation Trust and the current IT system used by the IPCT not supported following the successful merger with a paper tabled at the Trust Digital Board by the Department of Infection and an associated risk raised.

20. External Inspections

The Trust during 2020-21 at regular intervals were required to provide assurance to the CQC on a number of measures inclusive of IPC in the absence of a formal inspection regime.

Following a marked rise in nosocomial COVID-19 infections, NHSI Head of Infection Prevention and Control - North East and Yorkshire region visited the Trust on the 4th February 2021 for an informal visit. The visit, which exclusively was at the HRI site, involved the Emergency Department, an intensive care unit, and a number of wards. Following the visit, a letter with recommendations inclusive of removing beds to assist with social distancing and improving ventilation was forwarded to the DIPC for consideration

Performance Analysis: *Great Care*

Covid-19 Impact

The year 2020/21 has been a challenging time for the Trust and the staff within. We have experienced three lockdowns through the year due to Covid-19 and this has had an adverse effect with elective activity coming to a standstill, this has impacted on a number of performance measures. The Trust has still strived to maintain quality of patient care.

All emergency, clinically urgent and cancer activity has been maintained throughout the year. A Clinical Harm Review process was agreed in January 2021 for cancer breaches of 104 days and RTT breaches of 52 weeks. All referrals are now triaged on receipt into the organisation.

The following actions have been put in to place throughout the pandemic:

- GP referral triaged as clinically appropriate and declined if not.
- Telephone and video conference appointments were and continue to be put in to place where possible, to restrict the need for patients to leave their home and less footfall in our hospitals.
- The Trust's Emergency Department was reconfigured into Covid-19 and non-Covid-19 areas.
- Media campaigns were implemented to ask that patients do not bring relatives or friends with them when attending the ED Department to reduce the risk of Covid-19 infections and to make use of Minor Injury Units and Urgent Care Centre.
- The Trust's inpatient wards including critical care were fully reconfigured to have Covid-19 screening and Covid-19 positive patient wards, and Covid-19 negative wards.
- Suspension of patient visiting to all patient areas.
- Staff rapidly retrained and redeployed in to key clinical areas to support patient care.
- Clinical prioritisation accommodating those patients still requiring urgent surgery, including cancer-related surgery.
- Personal and Protective Equipment guidelines provided to all staff as new national guidance has been issued throughout the year.
- All patient and staff areas reviewed to maintain social distancing and staff that have been able to work at home have been allocated the equipment and support to do so.
- Staff testing facility was put in to place for those experiencing symptoms.
- Staff vaccination programme rolled out and the uptake levels have been positive.
- Recovery plans and trajectories have been agreed to regain control of performance metrics.
- New ways of working including digital solutions to continue.
- Continue to review and utilise Spire Hull & East Riding capacity under the national independent services contract.

Alongside these actions the Trust has also provided staff with support for those suffering pressure, anxiety, exhaustion and burnout through staff drop in support sessions and online help. Also a new Humber, Coast and Vale wide service has been set up to support our staff and their families, run by a range of mental health professionals and gives our staff who have been working through COVID-19, in whatever role a place to find further support.

Performance Analysis: *Great Care*

Effectiveness

Single Oversight Framework (SOF) indicators 2020/21:

Domain	Indicator	Standard
Effective	HSMR	< 100
	HSMR Weekend	< 100
	SHMI	< 100
	Theatre Utilisation	90%
	30 Day Readmissions	<=7.9%

Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
136.98	111.7	95.92	87.89	93.24	93.16	97.35	111.01	133.4	139.06	not yet published	not yet published
149.18	115.42	80.03	92.73	80.87	114.94	124.09	122.45	125.19	130.61	not yet published	not yet published
150.67	118.34	124.68	114.76	112.59	111.69	112.86	116.11	not yet published	not yet published	not yet published	not yet published
26.90%	37.70%	36.00%	43.20%	50.60%	62.60%	61.40%	66.10%	63.30%	63.30%	66.70%	78.70%
9.6%	9.5%	8.8%	9.3%	10.0%	7.5%	6.7%	7.3%	8.4%	7.5%	8.5%	not yet published

The Trust has in place a Mortality and Morbidity Committee, which is a multi-agency Committee across the Trust's Health Groups and including primary care colleagues. The Committee undertakes more detailed analysis of the factors affecting mortality.

The results of the Learning from Deaths reviews are reviewed at the Mortality and Morbidity Committee. The Committee reviews patients readmitted within 30 days and whether these were avoidable.

Performance Analysis: *Great Care*

Patient experience

Single Oversight Framework (SOF) indicators 2020/21:

Domain	Indicator	Standard	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020/21
Responsive	Diagnostic Waiting Times: 6 Weeks	<=1%	71.30%	72.50%	55.40%	43.60%	38.80%	39.70%	34.20%	34.80%	40.80%	43.80%	39.60%	37.02%	46.59%
	Referral to Treatment Incomplete pathway	92%	57.70%	49.90%	40.50%	35.20%	40.60%	46.00%	49.90%	51.80%	50.40%	50.00%	50.20%	53.38%	
	Referral to Treatment Incomplete 52+ Week Waiters	0	364	909	1,886	3,307	4,399	5,800	6,820	8,022	9,356	10,873	12,085	10,750	
	Proportion of patients not treated within 28 days of last minute cancellation	0	0	2	6	5	2	6	2	1	6	8	5	4	
	A&E Waiting Times	95%	86.57%	80.90%	87.44%	85.40%	85.45%	77.52%	71.90%	66.40%	67.90%	69.10%	75.20%	70.76%	77.88%
	Ambulance turn around - number over 30 mins	0	210	156	196	158	227	279	493	601	396	426	322	454	
	Ambulance turn around - number over 60 mins	0	19	9	10	1	11	33	171	304	199	211	68	185	
	Stranded Patients (21 days)	reduction	72	57	74	82	78	91	100	93	89	101	81	89	
	Two Week Wait Standard	>=93%	93.09%	95.38%	92.30%	87.64%	85.00%	73.80%	81.30%	76.20%	79.40%	84.80%	91.80%	not yet published	84.00%
	Breast Symptom Two Week Wait Standard	>=93%	80.65%	51.16%	43.94%	59.69%	16.05%	9.70%	5.40%	6.60%	5.60%	5.80%	18.10%	not yet published	20.00%
	31 Day Standard	>=96%	97.34%	93.99%	90.95%	88.81%	92.40%	93.40%	91.70%	92.50%	88.60%	88.80%	91.30%	not yet published	91.60%
	31 Day Subsequent Drug Standard	>=98%	100.00%	100.00%	100.00%	100.00%	100.00%	98.40%	100.00%	100.00%	100.00%	98.40%	100.00%	not yet published	99.70%
	31 Day Subsequent Radiotherapy Standard	>=94%	95.45%	97.84%	98.14%	98.62%	100.00%	99.10%	99.30%	99.20%	97.40%	98.20%	97.80%	not yet published	98.30%
	31 Day Subsequent Surgery Standard	>=94%	86.54%	91.94%	81.08%	81.43%	88.24%	85.10%	80.00%	95.60%	65.60%	75.00%	73.70%	not yet published	82.00%
	Cancer: 62 Day Standard	>=85%	70.82%	56.41%	70.56%	68.87%	71.32%	61.20%	62.20%	69.90%	55.60%	58.40%	56.50%	not yet published	61.50%
	Cancer: 62 Day Screening Standard	>=90%	59.38%	40.00%	0.00%	16.67%	0.00%	66.70%	88.90%	71.80%	51.40%	45.50%	54.00%	not yet published	58.30%
	Cancer 104 Day Waits	0	37	65	189	153	159	103	86	84	83	86	85	65	
	Dementia: >=75 years Emergency Admission LOS >72 hours - Find	90%	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19
	Dementia: >=75 years Emergency Admission LOS >72 hours - Assess/Investigate	90%	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19
	Dementia: >=75 years Emergency Admission LOS >72 hours - Referral	90%	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19	Paused - COVID-19

The Trust's position on 'responsive' was adversely affected in 2020/21, following national directives to cancel elective procedures and outpatient clinics in order to create capacity for Covid-19 patients. Previous to March 2020, the Trust was on track to maintain 52-week breaches at two for the year, to maintain its waiting list volume to the required figure, to achieve the 2 week-wait standard for the year and achieve 2 out of 31-day cancer standards. Improvements would have been expected to continue in to 2020/21.

Throughout the year, the Trust was not meeting the Emergency Department four-hour or ambulance handover targets. The Trust has not met the diagnostic waiting standard throughout the year and the reasons for this have been subject to detailed analysis and recovery planning. COVID-19 has affected all areas of performance, except cancer services which remained business as usual.

The 18-week referral to treatment (RTT) pathway is reported against the NHS Constitutional Standard of 92% and the Trust's position remained affected by Covid- 19 measures on clinical activity. Recovery plans and trajectories have been agreed in order to mitigate any risk in patient harm due to longer waits for treatment.

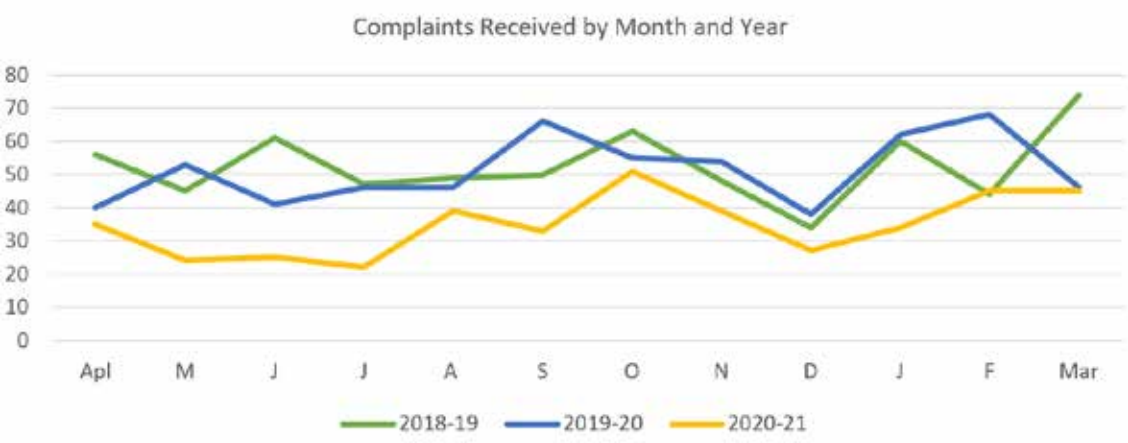
Performance Analysis: *Great Care*

Patient Experience

Single Oversight Framework (SOF) indicators 2020/21:

Domain	Indicator	Standard	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020/21
Caring	Inpatient Scores from Friends and Family Test - % positive	-	100%	98.76%	99.37%	98.82%	98.79%	98.40%	98.83%	99.24%	98.81%	98.86%	99.75%	not yet published	98.93%
	A&E Scores from Friends and Family Test - % positive	-	91.67%	87.48%	87.84%	86.45%	85.36%	83.03%	82.07%	85.45%	85.24%	86.17%	85.98%	not yet published	86.01%
	Maternity Scores from Friends and Family Test - % Positive	-	97.92%	100%	100%	97.04%	100%	100%	100%	90.91%	100%	100%	100%	not yet published	98.93%
	Staff Surveys: FFT recommend the Trust as a place to work	-			68.5%			68.3%			62.7%			not yet published	66.50%
	Staff Surveys: FFT recommend the Trust as a place for care/treatment	-			81.6%			82.3%			70.3%			not yet published	78.10%
	Written Closed Complaints Rate	Reduction	69	45	31	30	27	31	28	41	42	26	35	not yet published	405
	Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Complaints



This graph sets out comparative complaints data from 2018-19 to date. During the period 1 April 2020 to 31 March 2021, the Surgery Health Group (HG) received 104 complaints (24.8%), Medicine HG 133 (31.8%), Family and Women's HG 82 (19.6%), Emergency HG 52 (12.4%) and Cancer and Clinical Support HG 39 (9.3%) complaints. Eight complaints were received for non-HG areas. A monthly breakdown of complaints received is shown on the graph below, compared with the previous two years. The decrease in March 2020 through to December 2020 is as a result of Covid-19 when a reduced number of complaints were received. The number of complaints received increased in January and is now similar to previous years.

Complaints are not always reflective of activity in the month received and can often be about episodes of care several months, or even years previously.

During 2020/21, 447 formal complaints were closed. The Trust aims to close complaints within 40 working days and 65.7% of complaints were closed within this timescale during this period, which is below the Trust's target of 85%. The Patient Experience team are working closely with the Health Groups to improve the closure of complaints in a timely manner. Treatment, not satisfied with plan remains the highest (82), with outcome of treatment (68) outcome of surgery (35), diagnosis incorrect (30) and discharge inappropriate (21) being the top 5 sub-subjects within complaints.

47 complaints were not investigated for varying reasons including; the complainant had requested that it not be progressed, consent not received, the complaint was escalated for a serious incident investigation, or de-escalated to PALS. 120 complaints were not upheld, 248 partly upheld and 78 upheld and 1 passed to another organisation.

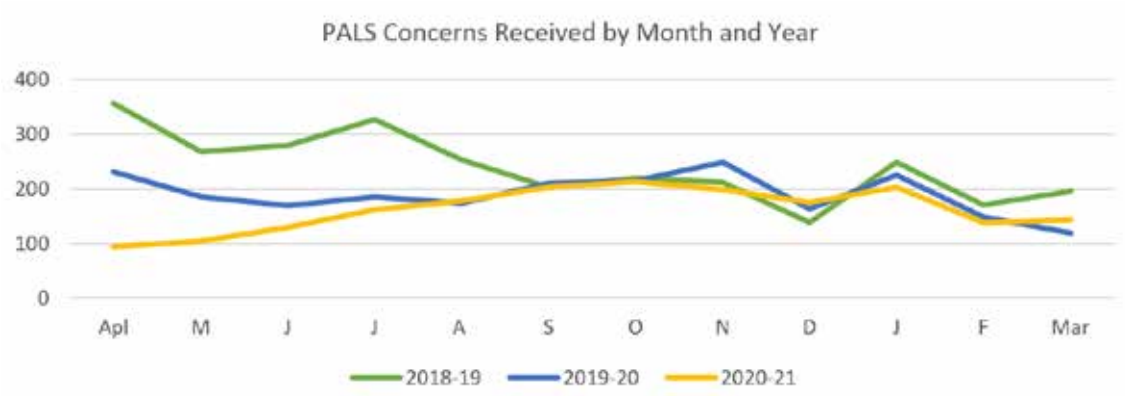
Complaints closed within 40 working days 2020/21 (whole Trust):

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
57.9%	88.8%	67.7%	80%	75%	71%	71%	66%	62%	46%	68.5%	66%

Performance Analysis: *Great Care*

Patient Experience

Patient Advice and Liaison Service



PALS by Type	2018/19	2019/20	2020/21
Comments and suggestions	15	21	25
Compliments	150	142	185
Concerns	2253	1813	1567
General Advice	467	296	169
Totals:	2885	2273	1946

The total number of concerns, compliments, comments and general advice contacts received by the PALS team for April 2020 – March 2021 was 1946, a decrease of 14.5% from the previous financial year (2278) and a 32.3% reduction pre-pandemic when compared to 2018-19 (2877). Due to staffing issues as the pandemic progressed, the decision was made that requests for general advice that did not provide any learning or contribute to a theme would not be recorded so that the team were able to focus on supporting contacts to the service who had more urgent concerns. The Patient Experience team have, during the last few weeks of 2020/21, seen a significant increase in the number of PALS enquiries and this is expected to continue.

The PALS team work closely with all Health Groups to close concerns within 5 working days although this has not always been possible during the pandemic period due to Trust staff not being available or limited resources within the team. The PALS service will be reviewed in line with the NHS Complaint Standard Framework to ensure it complies with the PHSO recommendations.

Top 3 areas of concerns raised were:

- Not satisfied with the treatment plan (173)
- Waiting time for an outpatient appointment, including follow-up appointment (135)
- Unprofessional or inappropriate behaviour by staff (97)

Parliamentary and Health Service Ombudsman

Should the complainant remain dissatisfied with the response received from the Trust into the complaint raised, they can ask the Parliamentary and Health Service Ombudsman to independently review their complaint.

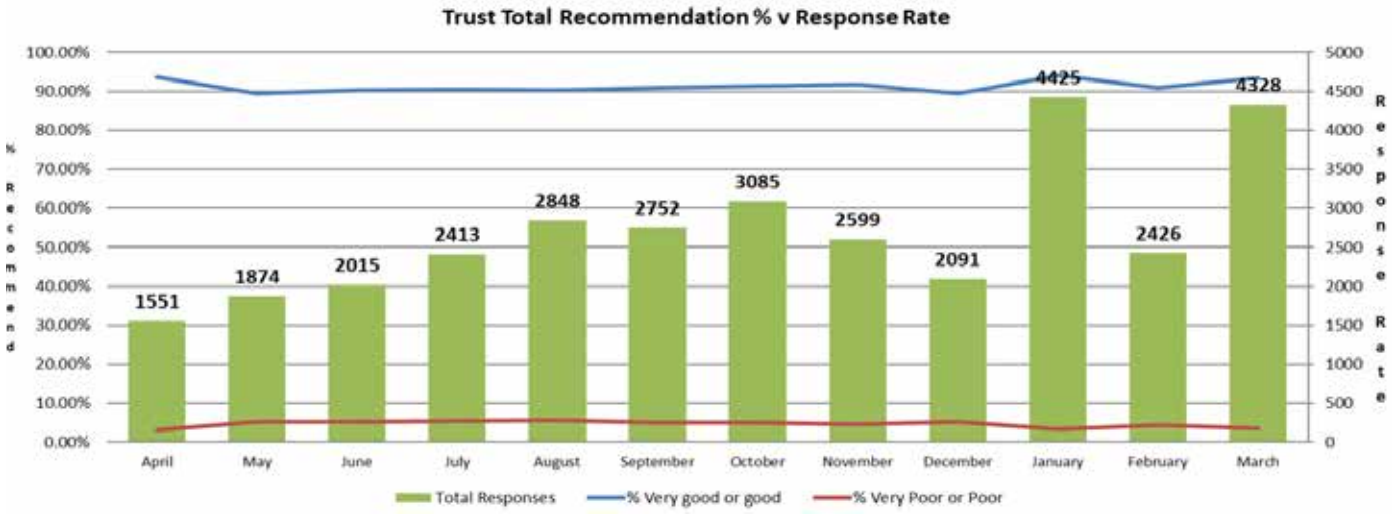
The recommendations from the PHSO on upheld or partly upheld complaints gives an opportunity for the Trust to identify learning and improve the care or service provided. Each Health Group takes responsibility for their own actions and is held accountable through the PEEC. The Parliamentary and Health Service Ombudsman paused the acceptance of new cases and the progress of open cases on 26 March 2020 until 1 July 2020 due to the pandemic.

During 2020/21 there were three complaints referred to the PHSO, of which, two were not upheld and one were partially upheld. The partly upheld complaint resulted in the following actions following recommendations received from the PHSO; discussion of consent process of risks at the specialty governance meeting; a review of the implant used and changes to practice/service considered. Further patient information is now available for the specific procedure with greater emphasis on potential complications.

Performance Analysis: *Great Care*

Patient Experience

Friends and Family Test (FFT)



The Trust has received **712,183** pieces of individual feedback since October 2012 from patients, with **32,407** pieces in the last 12 months. This is supporting the learning of lessons and making improvements to patient services.

Patient results are classified as Very good, Good, Neither good nor poor, Poor, Very poor or Don't know.

- **91.55%** of patients have said that they would be likely to recommend HUTH if they needed to receive care in the future.
- **4.60%** of patients have said that they would be unlikely to recommend HUTH.

Volunteer Services

Where available, 7 days a week, to help in any way that they could, a pool of 95 volunteers supported staff and patients throughout the pandemic to the end of March 2021. This consisted of 55 adult volunteers and 40 Young Health Champions. During this time, the volunteers dedicated 4,756 hours.

In March 2021, the new Ward Voluntary Communicators role was introduced to support staff and a total of 20 volunteers are now involved covering the telephones on wards across the Trust. More volunteers are being recruited to this role and the feedback from the wards so far is very positive; it has been well received and has made a positive difference to patients, relatives and staff. Currently the Voluntary Services team are in the process of setting up iPads with IT, which will be used for video calls to patient's relatives and will be supported by volunteers.

The Trust is supporting 222 Young Health Champions aged sixteen and upwards across all of our hospital sites. Through the Young Health Champions volunteering programme, the Trust is offering volunteering opportunities to young people, some of whom have a learning disability, experience social difficulties, or are otherwise struggling to find employment.

Hull University Teaching Hospitals NHS Trust secured a successful bid from the Pears Foundation in November 2019. The Foundation has agreed to grant £79,520 towards the development of young volunteer opportunities. This will be allocated over a 2-year period.

The first year of the Pears funding was £39,691.00 and had been utilised to recruit two new members of staff; one of the staff came into the department from volunteering to successfully secure an apprenticeship. The apprentice went on to gain full time employment with the Trust as a Healthcare Assistant, which demonstrated that Youth Volunteering opens many career opportunities.

Some of the funding has been used to purchase the Young Health Champions Voluntary Services uniform and will help create a voluntary service hub for young people between the ages of 16 to 25 years. The Trust has now secured the second part of their payment of £39,829.28. Due to the Covid 19 pandemic, plans for the hub has been put on hold, however it is aimed that this will recommence later in 2021. The hub will be available to all young adults in the Trust for pastoral care, as well as a place to meet new people and find out more about what the NHS has to offer.

Performance Analysis: *Sustainability*

Introduction

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. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, the Trust has the following sustainability mission statement located in our sustainable healthcare strategy:

Sustainability in Healthcare is changing, not only do we have a responsibility as a provider organisation but as part of the wider NHS we have a huge part to play in the delivery of the nation's sustainability goals.

The NHS touches the lives and impacts the carbon foot print of almost every individual in the country. Consequently, we are reviewing how services are delivered now and in the future.

The Trust continues to support an NHS that is working to reduce carbon emissions, minimising waste and pollution, making the best use of scarce resources. We need to build resilience to the effects of a changing climate and nurturing our communities. Working towards vertical integration of healthcare services, in partnership with our contractors and suppliers to ensure they to embrace our ethos.

Reporting on our performance is paramount to inform and educate us on the areas where our focus should be. It also provides us an opportunity to increase awareness in services that may not realise the contributions they can make. The Trust has been recognised nationally and was honoured to receive a certificate for 'Excellence in sustainability reporting' awarded by the Sustainable Development Unit (SDU), NHS Improvement and the Health Finance Managers Association (HFMA).

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. The Trust recognises the new targets set by the NHS for a net zero healthcare service by 2040 and is actively implementing systems and processed to be agreed in the new financial year.

Policies

In order to embed sustainability within our business it is important to explain where sustainability features within our process and procedures.
An update to our Sustainable Healthcare strategy is required because it has not been approved by the board in the last 12 months. The Trust will develop a new green plan document in line with NHS guidance in the new financial year.

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.

Our organisation evaluates the environmental and socio-economic opportunities during our procurement process, requesting and reviewing details from suppliers for environmental and carbon management systems, including external certifications and strategies, as part of the decision-making process.

Adaptation

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of 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.

Green space and biodiversity

Currently the organisation does not have a formal approach to unlock the opportunity and benefits of natural capital within a healthcare environment in supporting the health and wellbeing of patient, staff and the community and to protect biodiversity.

Over the past 12 months there has been a significant change in the drive for carbon reduction and the responsibility of Healthcare to play its part. This has been seen both nationally and within HUTH as the commitment to achieve net zero. Following publication of the NHS document Delivering a 'Net Zero' National Health Service, HUTH has worked to implement the goals and aspirations of the document and to this end has started a number of pieces of work to launch in the new financial year.
Looking back over this year has seen a number of success in moving the Trust towards its long term net zero aspirations. Early in the year the Trust declared a climate emergency stating its intent to reduce carbon emissions.
In quarter two the trust installed two new Combined Heat and Power (CHP) plants. These plants burn gas to deliver heat and electricity to the Trust. The largest was to replace an aging plant at HRI the second a much smaller engine to supply our Sterile Services Unit. Though the Trust acknowledges the increased usage of fossil fuels to power these plants they are part of a long term strategy being developed to move to net zero and the financial savings delivered by these plant will help to support the Trust.
Longer term we will look to change the fuel sources or look for ways to replace the technology.

Performance Analysis: *Sustainability*

The Trust was successful in securing a grant of £12.6M from Business Environment Industry and Strategy at the end of Quarter 3. The bid for grant funding included, replacement of lighting to LEDs, upgrades to the insulation of numerous buildings, improvements to the building management system, increased metering, efficient air compressors and a large number of heat pumps to remove and supplement existing gas fired boilers. The bid also included the installation of a large 4MW solar PV installation subject to planning permission.

A number of these works started during quarter 4 including the lighting and insulation works, however much of work and the benefits will be seen in the next financial year.

Energy

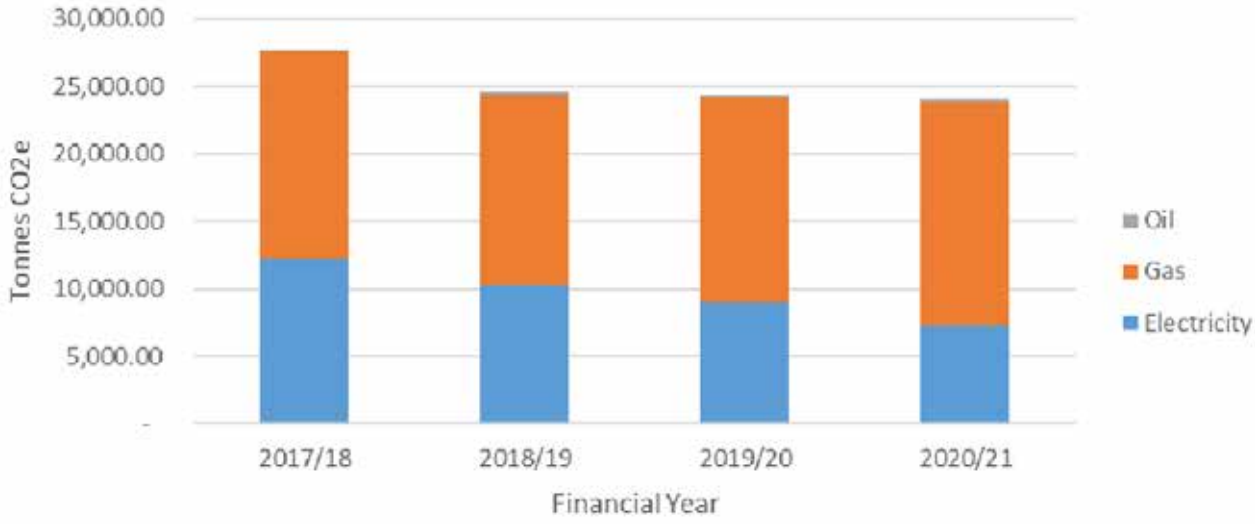
Energy Consumption

		2017/18	2018/19	2019/20	2020/21
Electricity	Use (kWh)	27,497,952	29,045,520	28,530,717	25,137,847
Gas	Use (kWh)	72,563,655	67,254,657	72,996,079	79,769,461
Oil	Use (kWh)	258,110	633,914	657,859	689,436
Total kWh		**100,319,717**	**96,934,091**	**102,184,655**	**105,596,744**
Total Energy Spend	Cost (£)	4,925,625	5,540,173	5,687,804	5,627,062

The Trust has spent £5,627,062 on energy in 2020/21, a decrease £60,742 in spite of an increase to the unit costs of both electricity and gas from market forces. This decrease was achieved by the installation of a new larger Combined Heat and Power (CHP) plant on the Hull Royal Infirmary site. CHP plants burn gas to generate heat and electricity to be used on the Trust sites.
The original CHP plant was 700kWe in size and was over 10 years old and was regularly having failures, the new CHP is 1.5 MWe, twice the site of the original plant and able to meet a much larger proportion of the HRI site requirements.

As can be seen from the figures the larger CHP has resulted in an increase in the amount of gas consumed but a significant reduction in the amount of electricity consumed.

Carbon Emissions from Energy CO2e



This year we have reduced our emissions to 24,037 tonnes. Though only a small reduction from last year it has been achieved both from the installation of demand reduction technologies, the CHP installation and the reduction in the carbon emissions of the grid supplied power used.

Energy Team

During 2017/18 the Energy Team became the first team within the Estates, Facilities and Development Directorate to achieve ISO9001 certification. The team continues to retain this standard and demonstrates the ability of the Trust to consistently provide products and services that meet customer and regulatory requirements.

Performance Analysis: *Sustainability*

Water

Water

		2017/18	2018/19	2019/20	2020/21
Mains	m3	303,304	316,929	348,674	309,451
Waste water	m3	242,643	252,366	278,939	247,561
Water & Sewage Spend	Cost (£)	655,861	656,471	750,431	714,883

The water consumption at the Trust has reduced in the last year. The number of leaks have continued to reduce due to ongoing investment in the replacement of aging water mains on the Castle Hill Hospital site. Cost has risen however this is due to the cost of the utility increasing. To support the reduction in water use the Trust has installed some air powered flush toilets to trial, initial feedback has been positive.

Waste

The Trust produced a combined total 2,532 tonnes of waste during the 2020/21 period. This year's report sees an increased breakdown in the types of waste the Trust produces enabling greater visibility.
There has been a reduction in the volume of waste sent to recycling due to an overall reduction in waste generated by the Trust in non-healthcare areas. This is believed to be due to the impact of covid 19 as the volume of healthcare waste has remained constant.

The amount of healthcare waste being disposed of remains largely unchanged. Over the last twelve months the Trust has worked to educate staff into the correct segregation of healthcare waste resulting in more waste being directed away from incineration into alternative and offensive waste streams.

A key part of this education has been carried out by the waste monitoring team which was formed at the end of the 2019/20 financial year. While the team have played an important role over the last year supporting staff with the requirements of waste disposal during the pandemic. They have worked to educate and advise staff on the correct disposal routes, this integration has resulted in a culture shift in the way waste is disposed of. This has been a significant contribution to reducing the clinical waste cost in 20/21 by £200,000 and ensuring correct segregation.

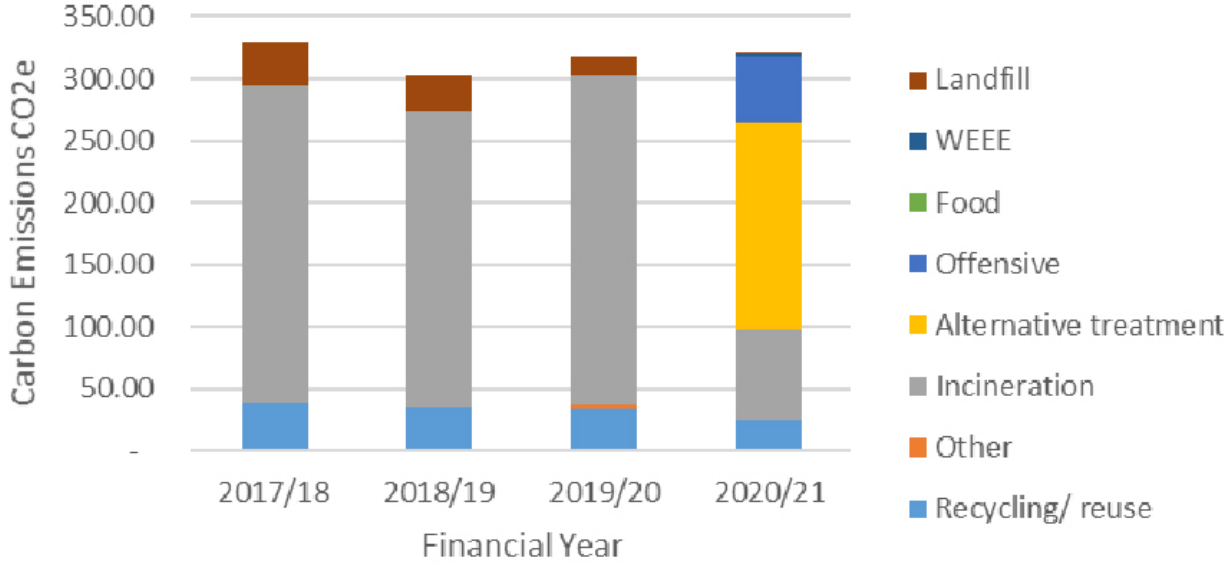
The carbon emissions from waste have increased slightly from 318 to 321 tonnes, due to the greater visibility of waste streams it has enabled more accuracy in calculating the emissions produced. Our emissions have increased primarily as we are now segregating more offensive waste, while in this past this would have been incinerated it now goes to landfill increasing the emissions though significantly reducing costs and demand on the limited UK incineration capacity. We will continue to explore alternative usage and disposal routes of all waste streams to reduce their carbon impact.

		2017/18	2018/19	2019/20	2020/21
Recycling/ reuse	(tonnes)	1,745.00	1,641.00	1,615.00	1,254.00
Other	(tonnes)	11.00	27.00	127.00	
Incineration	(tonnes)	1,165.00	1,078.00	1,208.00	304.00
Alternative treatment	(tonnes)				694.00
Offensive	(tonnes)				221.00
Food	(tonnes)				20.00
WEEE	(tonnes)				32.00
Landfill	(tonnes)	102.00	87.00	45.00	7.00
Total Waste	(tonnes)	3,023.00	2,833.00	2,995.00	2,532.00

Performance Analysis: *Sustainability*

Water

Carbon Emissions from waste CO2e



Anaesthetic Gases

This is the first year that we have publically reported emissions from anaesthetic gases. As an acute Trust we are the largest contributors to anaesthetic gas use within the NHS. Use of these gases is important for the care we provide to our patients but there are opportunities to manage its use to ensure we use it as effectively as possible and for look techniques and technologies that allow us to reduce the environmental impact while not compromising patient care.

As the table below shows we have reduced the use of the most environmentally damaging of the anaesthetic gases, desflurane over the last two years by switching to other gases were possible. We will continue to look at how we can further reduce its use within the organisation. Overall we have seen a reduction in the use of all anaesthetic gases over the last financial year due to the impact of Covid 19.

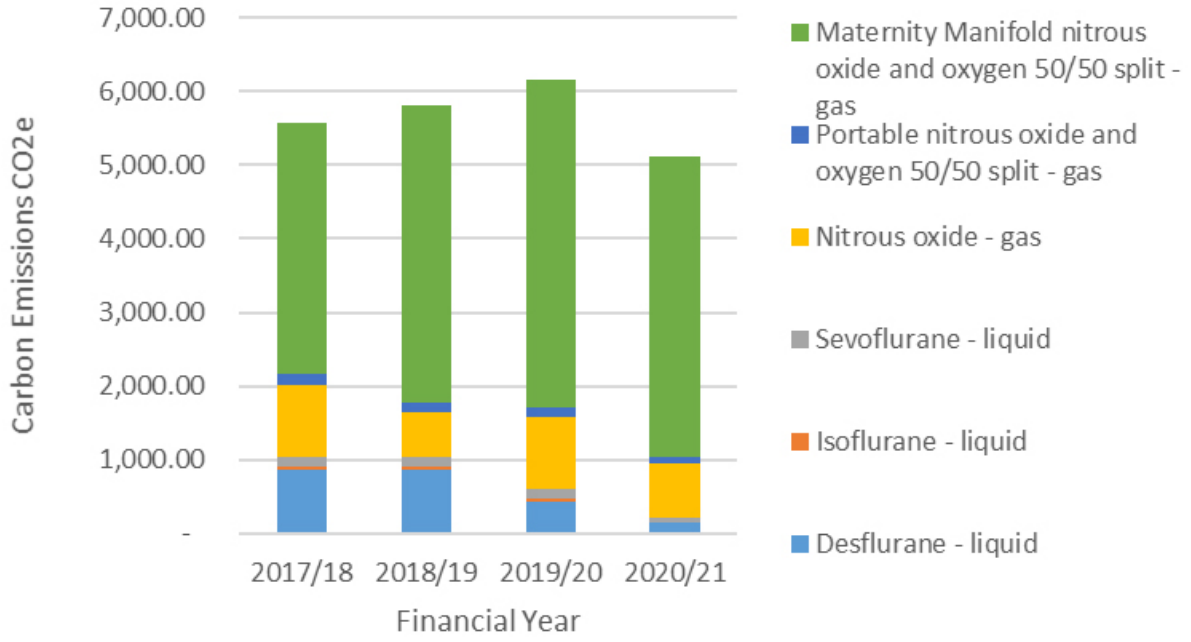
This reduction in usage in all gases has seen a reduction in carbon emissions from anaesthetic gases of over 1,000 tonnes when compared to 2019/20.

Anaesthetic Gases Volume

		2017/18	2018/19	2019/20	2020/21
Desflurane - liquid	litres	234	232	112	39
Isoflurane - liquid	litres	46	57	72	11
Sevoflurane - liquid	litres	620	644	701	322
Nitrous oxide - gas	litres	1,764,000	1,103,400	1,735,200	1,312,200
Portable nitrous oxide and oxygen 50/50 split - gas	litres	569,000	460,600	492,800	331,100
Maternity Manifold nitrous oxide and oxygen 50/50 split - gas	litres	12,225,000	14,535,000	15,960,000	14,640,000

Performance Analysis: *Sustainability*

Carbon Emissions from Anaesthetic gases CO2e



Care Quality Commission

Quality Accounts 2020/21

Each year the Trust publishes its Quality Accounts. These contain the details of the quality and safety priorities for 2020/21 and how we performed against them. The Quality Accounts are published on NHS Choices webpage and also on the Trust's website. The Quality Accounts are published by 30 June and this Annual Report should be read in conjunction with the Quality Accounts.

Care Quality Commission Inspection

The Trust was not inspected during 2020/21 by the Care Quality Commission. The Care Quality Commission undertook an inspection of the Trust's core services in March 2020 but due to Covid-19, was not able to complete the scheduled Use of Resource of Well-led assessments. The report from the unannounced core service inspections was published in June 2020. The Trust's overall rating remains as 'Requires Improvement' due to the non-completion of the Trust well-led inspection. Although the overall rating for the Trust did not change, there were a number of improved ratings for the core services and domains across HRI and CHH. These are detailed in the following rating tables.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Requires improvement Jun 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services
Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hull Royal Infirmary	Requires improvement → ← 2020	Good → ← 2020	Good → ← 2020	Requires improvement → ← 2020	Requires improvement ↓ 2020	Requires improvemen → ← 2020
Castle Hill Hospital	Good ↑ 2020	Good → ← 2020	Good → ← 2020	Good → ← 2020	Good → ← 2020	Good → ← 2020
Overall trust	Requires improvement → ← 2020	Good → ← 2020	Good → ← 2020	Requires improvement → ← 2020	Good → ← 2020	Requires improvemen → ← 2020

Care Quality Commission

Ratings for Castle Hill Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020
Surgery	Good ↑ 2020	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good ↑ 2020
Critical care	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Requires improvement →← 2020	Good ↑ 2020
End of life care	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Outpatients	Good Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018
Overall*	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020

Ratings for Hull Royal Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↓ 2020	Good →← 2020	Good →← 2020	Requires improvement →← 2020	Requires improvement ↓ 2020	Requires improvement ↓ 2020
Medical care (including older people's care)	Requires improvement →← 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020
Surgery	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020
Critical care	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Requires improvement →← 2020	Good ↑ 2020
Maternity	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Services for children and young people	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
End of life care	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Outpatients	Good Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018
Overall*	Requires improvement →← 2020	Good →← 2020	Good →← 2020	Requires improvement →← 2020	Requires improvement ↓ 2020	Requires improvement →← 2020

Care Quality Commission

The CQC found areas of improvement including 11 areas of legal requirements. This translated into 8 must do actions in urgent and emergency services, 1 must do in medical care and 2 in critical care. The Trust was also issued with a number of minor breaches which resulted in should do actions for medical care, surgery and critical care. The Trust developed an action plan in response to the 'Must' and 'Should' do actions, which was shared with the CQC. A review against the action plan was undertaken in April 2021 and although some actions have been delayed due to COVID-19, good progress has been made with a number of 'Must' and 'Should' do actions delivered. A full updated was shared with the CQC in April 2021. Progress against the action plan is monitored through the Governance Structure and via the Trust and CQC routine Engagement Meetings.

Emergency Preparedness

Emergency Preparedness, Resilience and Response Annual Assurance Process 2020/21

In 2019/20, the Trust's self-assessment was that overall we were 'partially compliant' with the NHS Core EPRR standards. Of the 64 standards applicable to Acute Trusts, the Trust was fully compliant with 50 standards, partially compliant with 13 standards and non-compliant with 1 standard. An action plan was developed to address the areas of partial and non-compliance during the remainder of 2019/20 and 2020/21. There will be a further assessment process in 2021.

Compliance with EPRR Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
2019/20	64	50	13	1
Position at 31 October 2020	64	60	4	0

Work is ongoing to address the four areas of partial compliance with the NHS core EPRR standards and to ensure that the Trust retains its fully compliant status with all other standards. A programme of education and training was established in 2020/21 and continues in 2021/22, together with the ongoing review of the Major Incident Plan and associated documentation.

Covid-19 preparation and response

The Trust put in place a full surge plan, which was published to all staff on 7 April 2020 and made available to the public and the media at the same time. This has been revisited and updated periodically during the year in response to the peaks and troughs of the Covid-19 pandemic. The Trust stood up a full incident command structure in early March 2020 to respond to national requirements on all NHS Trusts: all non-urgent elective activity was stood down by the end of March 2020, all outpatient appointment activity was reviewed, maintained or postponed, with telephone and video conference appointments put in place where possible.

The Trust's inpatient wards including critical care were fully reconfigured to have Covid-19 screening and Covid-19 positive patient wards, and Covid-19 negative wards. In addition, the Trust's Emergency Department was reconfigured into Covid-19 and non-Covid-19 areas. Patient visiting was suspended on 25 March 2020 apart from exceptional circumstances. Staff were rapidly retrained and redeployed in to key clinical areas in anticipation of a surge of Covid-19 patients, as well as putting in place a clinical prioritisation process to accommodate those patients still requiring urgent surgery, including cancer-related surgery. This was all commenced in March 2020 and completed by mid-April 2020. The Trust built upon its existing infection prevention and control practices around cohorting patients, adapting its Personal and Protective Equipment guidelines to all staff as new national guidance was issued, and reviewing all patient areas, such as waiting rooms, to maintain social distancing. The Trust's figures are shared nationally each day with Public Health England and monitors patient and staff testing rates. The Trust is a full partner of the Local Resilience Forum, which is ensuring all NHS Trusts have all appropriate measures in place and support each other, such as mutual aid on PPE and staff testing capacity.

Eliminating Mixed-Sex Accommodation (EMSA)

Declaration of Compliance 2020-21

Hull University Teaching Hospitals NHS Trust is able to confirm that mixed sex accommodation has been virtually eliminated in all of its hospitals.

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Hull University Teaching Hospitals NHS Trust is committed to providing every patient with same gender accommodation to help safeguard their privacy and dignity when they are often at their most vulnerable.

The Trust is able to confirm that mixed gender accommodation has been virtually eliminated in the Trust. Apart from a few exceptions for clinically justifiable reasons, patients who are admitted to any of our hospitals will only share the room where they sleep with people of the same gender. In addition, same gender toilets and bathing facilities will be as close to their bed area as possible.

Wards within the Trust are grouped according to their clinical specialties. This allows patients with similar conditions to be cared for in one area with staff that are experienced in this type of care.
This means that men and women may be on the same ward but will not share sleeping, bathing or toilet facilities.

There are some exceptions to this. Sharing with people of the opposite gender will happen sometimes. This will only happen by exception and will be based on clinical need in areas such as intensive/critical care units, emergency care areas and some high observation bays. In these instances, every effort will be made to rectify the situation as soon as is reasonably practicable and staff will take extra care to ensure that the privacy and dignity of patients and service users is maintained.

How well are we doing in meeting these standards?
The Trust has made physical changes to many inpatient accommodation areas to provide privacy screening/ partitioning and additional toilet and bathing facilities. Toilet and bathroom signage has also been improved and this work continues. New ward accommodation that has been built in the last 12 months has maintained single-sex standards.

The Trust is required to report any breaches of the Eliminating Mixed Sex Accommodation (EMSA) standards to its commissioners. The Trust can be subject to a financial penalty of £250 for each of these breaches. In 2020/21, there were no breaches of these standards.

The Trust has not received any contacts through its Patient Advice and Liaison Service (PALS) or any formal complaints relating to mixed sex accommodation concerns during 2020/21.

Information for Patients and Service Users

'Same gender-accommodation' means:

- The **room where your bed is** will only have patients of the same gender as you, and;
- Your **toilet and bathroom** will be just for your gender, and will be close to your bed area

It is possible that there will be both male and female patients on the ward but, apart from a few exceptions for clinically-justifiable reasons such as in intensive care or high dependency areas, they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom, but you will not have to walk through sleeping areas that are designated for people of the opposite gender to you.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital (e.g. on your way to X-ray or the operating theatre).

Also, it is most likely that visitors of the opposite gender will come into the room where your bed is, and this may include patients visiting one other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed space/area.

If you need help to use the toilet or take a bath that requires special equipment to help secure your care and safety (e.g. you need a hoist or special bath), then you may be taken to a "unisex" bathroom used by both men and women, but a member of staff will be with you, and other patients will not be in the bathroom at the same time as you.

The NHS and Hull University Teaching Hospitals NHS Trust will not turn patients away just because a "right-gender" bed is not immediately available for them. The patient's clinical need(s) will always take precedence.

What do I do if I think I am in mixed sex accommodation?
If you think you are in mixed accommodation and shouldn't be then please speak with the nurse in charge of the ward or area. This will be taken extremely seriously by staff and action will be taken to explain the reasons behind this and assurance will be provided that you will be moved to a same gender area/bay as soon as is reasonably practicable.

The Trust also wants to know about your experiences. Please contact the Patient Advice and Liaison Service (PALS) on telephone **01482 623065** or via email at: **pals.hey@hey.nhs.uk** if you have any comments or concerns about single gender accommodation. Thank you.

Signed:

Terry Moran CB
Chairman

Chris Long
Chief Executive

10 June 2021

Great Future

Despite the many unforeseen challenges presented by the Covid 19 pandemic, 2020 -21 proved to be another really positive year for the HUTH Improvement Programme (HIP). Without hesitation, every member of the team offered to flex into services and operations where our skills could provide additional support and our team was responsible for writing the Trust Covid 19 Surge plan and took on key roles supporting the various Command meetings.
The team have also offered Coaching and Well-being support to staff across the Trust, as well as to each other. The team itself has expanded this year, to 16 members of staff and in January 2021 welcomed a new Director of Strategy and Planning - Michelle Kemp.
Specific benefits from the various programmes/work undertaken have been:

• OPtimise - Outpatient Programme

Ensuring every contact within any outpatient service is meaningful, adding value to the patient experience and reducing the number of patients waiting for follow up appointments whilst introducing alternative methods to face-to-face activity. This project is currently drawing to a close and successfully delivered its targets which were:-.

- Standardised administration processes that supports a patient through their whole journey – end to end.
- The patient experience will be improved.
- Staff will be clear and confident in their roles and responsibilities
- Efficiency and productivity will increase as rework is eliminated and tasks are completed in the right place, at the right time, by the right person.

• Unplanned Care Delivery Programme

Part of the Hull and East Riding A&E Delivery Board, HUTH has contributed to a number of programmes aimed at improving Urgent and Emergency Care, through close partnership working and by improving our ED 4 hour performance, reducing our delays in the discharge processes and looking at alternative diversionary pathways, thus reducing unnecessary pressures and conveyance to our ED services. The HIP Team have provided full Programme management to support this work achieve its aims.

• Urgent & Emergency Care In Hospital Programme

Focussed on a number of areas within the Trust including, Same Day Emergency Care, Direct Access to ACU, a pilot of the Acute Care Navigation Hub and working with the Discharge to Assess team. The HIP Team have provided full Programme management to support this work achieve its aims.

• EDI Our Voices

As part of a larger programme to deliver our cultural theme of Equality, Inclusion and Diversity, this programme commissioned by our Chief Executive Officer, Chris Long will inform a refresh of the Trust's EDI Strategy and how we will deliver it through a series of engagement exercises based on the lived experience of HUTH staff who have a range of protected characteristics (Equality Act 2020). In addition to this deep engagement exercise, the programme will inform a number of coproduced plans to enable HUTH to become the more inclusive organisation we aspire to be. A series of products and events celebrating our diverse staff and promoting inclusion will be delivered via the programme. Including a multi-cultural cookbook, an exhibition celebrating staff and their contribution to the community and joint initiatives with partners in Higher Institutions of Education.

• Improvement Capability & Capacity

The HIP team continues to develop a programme to increase our improvement capability and capacity informed directly by our Trust Strategy and our People Strategy. Through this programme and the wider strategic programme of cultural change activity, the staff engagement score for the organisation continues to improve. Our HIP Team Pattie pages are constantly being updated with tools and resources for staff to access and learn The Hull Improvement Approach and the team continues to work closely with the Hull York Medical School training our future doctors and with partners in Health Education England. We also continue to train individuals, teams, and support our Leadership Development Programme.

• Twitter '@HUTHImprovement'

This year the HIP Team has established a rapidly expanding Twitter account where we share our improvement work to help frontline services and work collaboratively with other partner HUTH accounts building positive engagement.

Supported by members of the HIP Team, the following staff have been nominated for 2021 National BAME Healthcare Awards:

- Workforce Innovator of the Year – NAMI SAJJA (Senior Organisational Development Practitioner)
- Compassionate & Inclusive Leader – MR ROBERT GODDARD (Consultant Max Fax Surgeon)
- Outstanding Corporate Achievement – AARTHI RAJENDRAN (HASR Transformation Manager)

In 2021 - 22 the improvement programmes that the Trust have prioritised for the Team to run are:

- Cancer Development Group including the Rapid Diagnostic Service
- 4 Improvement Programmes for the Medicine, Surgery, Clinical Support and Family and Women's Health Groups
- Improvement Capability & Capacity
- EDI Our Voices
- Elective Recovery

Accountability Report

Corporate Governance Report

Directors Report

The Chairman of the Trust during 2020/21 was Terry Moran CB, and the Chief Executive was Mr Chris Long.

The Trust Board comprises the Chairman, six voting Non-Executive Directors and five voting 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 Trust Board throughout 2020/21 but they do not have voting rights. These were the Director of Strategy and Planning, the Director of Workforce, the Director of Corporate Affairs and the Director of Quality Governance. The Director of Corporate Affairs left her role 30 September 2020 and the Director of Quality Governance joined the Trust on 1 March 2021.

Four Board members have a clinically-related background. These are the Chief Nurse, the Chief Medical Officer and two Non-Executive Directors.

Terms of Office of Non-Executive Directors

The Non-Executive Directors were appointed to the Board by NHS Improvement. Non-Executive Directors can be appointed for a maximum of 3 terms (up to 9 years). There is one exception: as the Trust is an NHS organisation with a significant teaching commitment, the University of Hull appoints one of the Trust's Non-Executive Directors.

Terms of office – Non-Executive Directors

Name	Position	Current Term Commenced	Term Ends	New Term
Mr T Moran	Chair	01.09.18	31.03.22	
Mr S Hall	Vice Chair/Non-Executive Director	01.10.19	30.09.23	
Mr M Robson	Non-Executive Director	01.04.20	31.03.22	
Mrs T Christmas	Non-Executive Director	01.10.19	30.09.21	
Prof M Veysey	Non-Executive Director	01.04.18	30.09.20	
Prof U Macleod	Non-Executive Director	01.04.20	31.03.21	01.04.21 – 31.03.23
Mr T Curry	Non-Executive Director	01.10.19	30.09.21	
Mrs J Bolus *	Non-Executive Director	01.12.20	30.11.22	
Mrs L Jackson	Associate Non-Executive Director	01.04.20	31.03.22	

* With deep sadness we regret to report Julie died following a short illness on 1st April 2021.

The biographies of the Chairman and the Chief Executive together with other Board members are set out on the following pages.

Accountability Report

Chairman and Non-Executive Directors

Terry Moran CB – Chair

Terry was appointed as Chairman to the Trust on 1 April 2017. Terry retired in March 2013 following a 36-year career in the Civil Service. His most recent appointment was a Second Permanent Secretary at the Department for Work and Pensions.

He joined the civil service in 1977 straight from school as a clerical assistant and spent his first 12 years working in local offices in Yorkshire and London. The remainder of his career saw him move into senior regional and national roles including advising successive governments on policy changes and operations. This included the positions of Chief Operating Officer for the Department of Work and Pensions, Chief Executive of the Pension, Disability and Carers Service, Chief Executive of the Pension Service, Chief Executive of the Disability and Carers Service, Director, Jobcentre Plus, North West Region and Director, Benefits Agency, Yorkshire and Humber Region.

He successfully completed the Advanced Management Programme at Harvard Business School in 2005.

He was previously Chair of Trustees at Together for Short Lives and a Trustee on the national Board of Victim Support, Chair of the Diversity Council from 2005-2008, and a Trustee on the Board of the Social Care Institute for Excellence. He has previous service as an NHS Non-Executive Director, with 18 months' service at Mid Yorkshire Hospitals Trust.

He was appointed a Companion of the Order of the Bath (CB) in the HM The Queen's Birthday Honours List 2007.

Stuart Hall – Non-Executive Director
(and Vice Chair from 1 October 2019)

Stuart was appointed in January 2015. He 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.

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.

Tony Curry – Non-Executive Director

Tony was appointed in April 2019 and has held senior appointments in higher education, financial services and manufacturing and also as a director with Pricewaterhouse Coopers. He has over 40 years' information technology experience working the UK and internationally.
Over the past decade he has had a particular focus on strategy and transformation programmes which exploit the advances in mobile and self-service technologies.

Mike Robson – Non-Executive Director

An experienced Finance Director with over 15 years in the NHS at director level including several periods as Acting Chief Executive, Mike is now working as a self employed Management Consultant specialising in change management and providing expertise and flexible support to organisations particularly in the health, social care and public sectors. Mike is also a Trustee/Non-Executive Director for the Hull Truck Theatre and provides freelance coaching to a small number of individuals. He previously worked in various financial roles in the private sector including 5 years at director level.

Accountability Report

Non-Executive Directors

Una Macleod – Non-Executive Director

Una was appointed in 2020. She is Dean of the Hull York Medical School and during 2020 is Interim Dean of the Faculty of Health Sciences at the University of Hull. She trained in Medicine in Glasgow and then worked as a Senior Lecturer in General Practice and Primary Care and as a GP Principal in the city before joining Hull York Medical School in 2010 as Professor of Primary Care Medicine. She became Dean of Hull York Medical School in 2017 and does GP sessions at James Alexander Family Practice, Bransholme Health Centre in Hull. She is a national leader in the area of cancer and early diagnosis research. Her interests in cancer research and primary care and her passion for reducing health inequalities has led her to receive grants from Cancer Research UK, Yorkshire Cancer Research and the Department of Health Policy Research Unit programme, as well as contributing to policy development.

Julie Bolus – Non-Executive Director

(December 2020 – April 2021)

Julie unfortunately passed away in April 2021 following a short illness. Julie held senior executive nursing roles for over 13 years before her retirement in 2015. She started her nurse training in Yorkshire in 1982 and finished her executive nursing career at NHS England as Director of Nursing and Quality for Derbyshire and Nottinghamshire area team. She was a non-executive director at the National Association of Primary Care and was previously vice-chair at a Local Community Interest company. She was passionate about improving population health, reducing inequalities, and in supporting high quality care. She remained a registered passionate nurse; she was married, had three grown up children and an adored grandson. Julie was well respected by all her peers and will be sadly missed. Our thoughts are with her family and friends.

Linda Jackson – Associate Non-Executive Director

Linda Jackson is from Cleethorpes and studied hotel, catering and institutional management at Grimsby College before graduating with a Diploma in Management from the University of Reading. Her career in facilities management began in London where she secured a position of trainee manager for ISS Facility Services who provide facilities services across the NHS. Linda quickly worked her way up the ranks to hold positions including regional director providing facilities services across NHS organisations in the capital and became board director at the age of 38. In her last 10 years in the private sector she undertook a transformational change role responsible for implementing the company's new business and initiatives nationally within the NHS. Linda is also the Vice-Chair at North Lincolnshire and Goole Hospitals Foundation Trust.

Martin Veysey - Non-Executive Director

(April 2018 – November 2020)

Martin joined as Associate Non-Executive Director in September 2017 and became Non-Executive Director in April 2018. Martin is a Professor of Gastroenterology at the University of Hull and holds an Honorary Consultant Gastroenterologist appointment at York Teaching Hospitals NHS Foundation Trust. He has over 25 years' experience in healthcare and higher education both in the UK and, more recently, in Australia. In February 2017, Martin joined the Hull York Medical School as Programme Director of the MBBS. His research interests include medical education, molecular nutrition and luminal gastrointestinal disease.

Accountability Report

Executive Directors

Chris Long – Chief Executive Officer (CEO)

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 the Trust in 2014, he worked as the Area Director for NHS England's Locality Team in Yorkshire and the Humber.

Lee Bond – Chief Financial Officer and Deputy CEO

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 Director of Finance posts include Sherwood Forest Hospitals NHS FT and Sheffield Children's NHS FT.

Makani Purva – Chief Medical Officer

Dr Makani Purva took up the substantive post of Chief Medical Officer on 1 July 2019; Dr Purva was interim Chief Medical Officer from August 2018. She is a Consultant Anaesthetist at the Trust, specialising in Obstetrics. She is the former Director of Simulation at the Hull Institute of Learning and Simulation. She has a particular interest in supporting innovation, and is assisting with the Trust's international recruitment strategy, as well as taking a lead role in developing the Trust's relationship with the Sri Ramachandra Medical Institute in India.

Beverley Geary – Chief Nurse

Beverley has been a nurse for over 30 years and joined the Trust on 1 March 2019. She has worked in a number of acute providers across the region working predominately in medical specialities. She also has experience in education and mental health. Some of her senior nursing roles have included quality governance and patient experience leads. Most recently Beverley was Chief Nurse and Director of Infection and Control at York Teaching Hospitals NHS Foundation Trust.

Teresa Cope – Chief Operating Officer (April 2018 – November 2020)

Teresa was appointed in April 2018 as a job share with Ellen Ryabov and joined the Trust from Humber NHS Foundation Trust where she had been Chief Operating Officer for the previous 3 years. Teresa has work within the NHS for 25 years and started her career as a Diagnostic Radiographer in 1993 before taking up a number of senior management roles in Acute, Mental Health and Community Services provider organisations. Teresa has also worked in commissioning organisations and was previously Director of Commissioning for Nottingham City CCG and Programme Director for Urgent Care for the South Nottinghamshire system leading system wide Improvement in Urgent and Emergency Care. Teresa obtained her MSc in 2001 and completed a Senior Executive Management programme with Ashridge Business School in 2012.

Ellen Ryabov – Interim Chief Operating Officer (December 2020 to date)

Ellen was appointed in December 2020 and has worked at Board level in various NHS organisations on both a permanent and interim basis for the last 15 years. Having previously worked as Chief Operating Officer with the Trust for 3 years, Ellen returned to the Trust in an interim capacity January 2019, initially as Director of Operations in the Medicine Health Group and now as the Chief Operating Officer. Prior to her time with the Trust Ellen spent 2 years at Sheffield Teaching Hospitals NHS FT, latterly as their Interim Chief Operating Officer. Her previous substantive NHS role was Chief Operating Officer at Heart of England NHS FT, and prior to that she worked in London and the South East. Ellen has worked in the NHS for over 30 years, starting her career as a Finance Trainee in the Scottish Health Service, following which she moved from finance into acute operational management where she has remained throughout her career.

Accountability Report

Executive Directors

Jacqueline Myers – Director of Strategy and Planning (non-voting) (Until 31st December 2020)

Jacqueline was appointed in July 2013 as Director of Strategy and Planning. She was previously Director of Planning at Leeds Teaching Hospitals NHS Trust and prior to this held the posts of Divisional General Manager and the Lead Cancer Manager. She has also held a range of general management and strategic positions at University College London Hospital Foundation Trust and Guys and St Thomas's FT. She is a Trustee of St Leonard's Hospice in York.

Simon Nearney – Director of Workforce and Organisational Development (non-voting)

Simon joined the Trust in September 2012 from his previous post as Director of Human Resources at Leicestershire County Council and took up post as Director of Workforce and Organisational Development in July 2015. 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.

Carla Ramsay – Director of Corporate Affairs (non-voting) (Until 30th September 2020)

Carla was appointed in December 2016. She worked previously as Head of Quality in NHS Yorkshire and Humber Commissioning Support and has held previous Board Secretary roles within NHS Commissioning and in further education. She started her NHS management career at the Trust and has held operational management posts in medicine and surgery previously. She is a Trustee and Honorary Treasurer to two local charities.

Michelle Kemp – Director of Strategy and Planning (non-voting)

Michelle started her career in Queen Alexandra's Royal Army Nursing corps before joining the NHS and working in a number of hospitals throughout the UK in clinical and leadership roles. Since joining the Trust in 2016, Michelle has worked as an Operations Director and Deputy Chief Operating Officer before being seconded to the role of Director of Strategy and Planning in January 2021.

Suzanne Rostron – Director of Quality Governance (non-voting)

Suzanne returned to the Trust in March 2021, having left the Deputy Director role in 2012. When Suzanne initially left she set up her own business and undertook work for the CQC as a specialist adviser for Well Led gaining a wide range of experience from other organisations. More recently Suzanne has specialised in working with challenged organisations to successfully drive improvement. This included the position of Executive Director of Quality Governance at the Isle of Wight NHS Trust and as an Improvement Director with NHSEI.

Accountability Report

Statement of Directors' Responsibilities

Name	Job Title	Key areas of responsibility
Chris Long	Chief Executive	Accountable Officer
Lee Bond	Chief Financial Officer	Financial Management Estates, Facilities and Development Information Management and Technology (IM&T)
Beverley Geary	Chief Nurse	Professional lead for nursing and midwifery Patient Experience Safeguarding
Makani Purva	Chief Medical Officer	Professional lead for medical staff
Teresa Cope/ Ellen Ryabov	Chief Operating Officer	Performance Clinical Service delivery
Jacqueline Myers/ Michelle Kemp	Director of Strategy and Planning	Operational and business planning Trust Strategy Improvement
Simon Nearney	Director of Workforce and Organisational Development	Human Resources (Policy and HR delivery) Learning and Organisational Development Occupational Health Communications and Engagement Employee Service Centre
Carla Ramsay	Director of Corporate Affairs	Trust Secretary Corporate Governance Freedom to Speak Up Guardian
Suzanne Rostron	Director of Quality Governance	Quality Governance Corporate Governance Patient Safety Compliance CQC

Accountability Report

Statement of Non-Executive Directors' roles

Name	Title	Committee Membership	Trust Roles
Terry Moran	Chairman	Remuneration (Chair)	Lead for Emergency Planning Lead for ICS
Stuart Hall	Vice Chair/NED	Remuneration Quality Performance and Finance	Lead for RTT Deputy Lead ICS
Tracey Christmas	NED/Senior Independent Director	Remuneration Audit (Chair) Performance and Finance	Speaking Up/Whistleblowing Champion Transition child/adult lead Safeguarding Champion
Julie Bolus	NED	Remuneration Quality (Chair) Audit	Quality Lead
Tony Curry	NED	Remuneration Performance and Finance Charitable Funds (Chair)	Lead for Digital and IT Scan4Safety Champion
Mike Robson	NED	Remuneration Audit Performance and Finance (Chair) Charitable Funds Committee	GIRFT Champion
Una Macleod	NED	Remuneration Quality Workforce, Education and Culture Committee (Chair)	Lead for Hull University Partnership Champion for End of Life Care
Linda Jackson	Associate NED	Attends: Remuneration Quality	

Trust Board Meetings

The Trust Board met on 10 occasions during 2020/21, including an extraordinary Trust Board meeting in June 2020 to approve the annual report and accounts. A record of attendance is kept for each Board meeting and the table below sets out the attendance of Board members during the year.

Name	14/4	12/5	18/6	14/7	8/9	10/11	8/12	12/1	9/2	9/3	Total
T Moran	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
S Hall	✓	✓	Apols	✓	✓	✓	✓	✓	✓	✓	9/10
T Christmas	✓	✓	✓	✓	✓	✓	✓	Apols	✓	✓	9/10
M Veysey	Apols	✓	✓	✓	✓	-	-	-	-	-	4/5
T Curry	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
U Macleod	Apols	Apols	✓	✓	Apols	✓	Apols	✓	✓	✓	6/10
M Robson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
L Jackson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
C Long	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
L Bond	✓	✓	✓	✓	✓	✓	Apols	✓	✓	✓	9/10
T Cope	✓	✓	✓	✓	✓	✓	-	-	-	-	6/6
M Purva	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
B Geary	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
J Myers	✓	✓	✓	✓	✓	✓	Apols	-	-	-	6/7
S Nearney	✓	✓	Apols	✓	✓	✓	✓	✓	✓	✓	9/10
C Ramsay	✓	✓	✓	✓	Apols	-	-	-	-	-	4/5
E Ryabov	-	-	-	-	-	-	✓	✓	✓	Apols	3/4
J Bolus	-	-	-	-	-	-	✓	✓	✓	Apols	3/4
M Kemp	-	-	-	-	-	-	-	✓	✓	✓	3/3
S Rostron	-	-	-	-	-	-	-	-	-	✓	1/1

Accountability Report

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, Remuneration Committee, and a Workforce, Education and Culture Committee. The Trust also has a constituted Charitable Funds Committee. The Audit and Remuneration Committees are statutory requirements and the work of the committees is detailed below. Further detail on the work of the Quality Committee and Performance and Finance Committee can be found in the Annual Governance Statement within this annual report.

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 (RSM), External Audit (Mazars), the Chief Financial Officer, the Deputy Director of Finance, the Director of Corporate Affairs and the Deputy Director of Quality Governance and Assurance.

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 5 meetings of the Audit Committee in 2020/21 which included 1 extraordinary meeting to consider the Annual Accounts and Report. All meetings were quorate.

Members	Attendance
T Christmas (Chair)	5/5
M Robson	5/5
M Veysey (left the Trust 30.09.20)	3/4
J Bolus (joined the Trust 01.12.20)	1/1

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

The internal audit programme for 2020/21 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 2020/21 gave an overall opinion of positive assurance with an amber/green rating, which is that the Trust has an adequate and effective framework for risk management, governance and internal control and that the internal auditors' work has identified further enhancements that can be made.

The Trust's internal auditors finalised the 9 planned internal audit reports for the Trust, 5 of which resulted in positive assurance opinions (1 substantial assurance; and 4 reasonable assurance). The other 4 audits were given no opinion and were advisory only. The key findings, recommendations and agreed management actions have all been and accepted by the Audit Committee from all internal audit reports.

In 2020/21, the internal audit receiving substantial assurance was the HR Disciplinary, Grievance Management and Bullying Policies/Procedures.

Reasonable assurance was given to Outpatients, Deprivation of Liberty Safeguards, General Ledger and Cash Management and Hospital Improvement Team.

Minutes and other updates from the work of the Quality Committee and Remuneration Committees were considered by the Audit Committee, as well as routine receipt of the minutes from all other Trust Board Committees, which contributed to the overall view of governance and internal control. No concerns of gaps in the Trust's internal control framework were identified through this review work.

Work to prevent or counter fraud continued and reports were received throughout the year. The Committee reviewed the Board Assurance Framework processes as well as other documents in respect of risk. These included losses and special payments, debts, the Trust's Registers of Declared Interests and for Gifts, Hospitality and Sponsorship, legal fees, credit card expenditure and Trust Board expenses. The Audit Committee also regularly reviewed the Trust's Speaking Up arrangements, including whistleblowing and the Freedom to Speak Up Guardian, as well as other ways the Trust supports staff to raise concerns.

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 Directors who report to the Chief Executive/Chairman. The Remuneration Committee met 7 times during 2020/21. 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, the Associate Non-Executive Director and the Corporate Affairs Manager also attend the Committee. Non-Executive Director members' attendance is detailed below:

Name	Total
T Moran	7/7
S Hall	6/7
M Veysey	3/4
T Christmas	3/7
U Macleod	2/7
T Curry	6/7
M Robson	7/7
J Bolus	2/2

Accountability Report

The Trust complies with current NHS Improvement guidance on pay for Very Senior Managers. 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 months' notice. The new VSM guidance issued in 2015 and updated in 2017 requires NHS Trusts to include in relevant remuneration package an element of earn-back pay i.e. a requirement to meet agreed performance objectives. The Chief Executive Officer, the Chief Medical Officer and the Chief Financial Officer have this requirement built in to their remuneration packages as their salary packages fall in to this guidance. Other Executive Directors in post during the year did not have a component of performance related pay as their salary agreements pre-date this guidance or fall below the salary threshold where this is applied.

Key items discussed by the Committee during the year included annual performance reviews for Executive Directors, information on the top earners in the Trust and sector salary benchmarking.A summary of the Remuneration Committee is received in the closed session of the Trust Board as well as summary of issues of internal control considered by the Committee received every 6 months at the Audit Committee.

Details of the remuneration, including salary and pension entitlements of the Directors is set out in the Accounts appended to this report.

Details of company Directorships which may conflict with management responsibilities

None of the Trust Board hold company directorships that may conflict with management responsibilities. The Trust publishes the declared interests of its Trust Board members on its website, in the 'About Us' section.

Personal Data related incidents

The Trust has Information Governance arrangements in place to ensure that information is handled 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.

The Information Governance Data Security and Protection Toolkit (DSP Toolkit) is part of the Department of Health and Social Care's commitment to ensuring the highest standards of information governance. It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance. It remains Department of Health and Social Care policy that all organisations that process NHS patient information provide assurance, via the DSP Toolkit and is fundamental to the data protection and data security both within the organisations and between organisations.

The Information Governance Assurance Statement is a required element of the DSP Toolkit and is re-affirmed by the annual submission to demonstrate the organisation has robust and effective systems in place to meet statutory obligations on data protection and data security.

The Trust's Data Security and Protection Toolkit Assessment for 2019/2020 was published as: Standards Not Fully Met (Plan Agreed), and The DSP Toolkit was audited and assessed as achieving Substantial Assurance. Due to the National COVID-19 Pandemic Response, NHS Digital has announced that the 2019/2020 DSP Toolkit Assessment submission deadline has been extended to 30th September 2020.

The Trust is required to score all Information Governance Data Security and Protection Breaches using the DSP Incident Reporting Guidelines and Assessment Scoring Grid. Any breach that is scored above the threshold is required to be reported via the DSP Toolkit Incident Reporting Tool which sends an automatic notification to the ICO and also to the NHS Digital Data Security Centre where appropriate. The Information Governance Data Security and

Protection Breaches requiring reporting to the ICO via the DSP Toolkit during 2020/2021 are detailed below:

The Trust has reported 5 Data Security and Protection Breaches in 2020/2021 to the ICO as classified in the DSP Toolkit Incident Reporting Guidelines. The ICO closed all 5 cases, and no further recommendations were made. None have resulted in regulatory action being taken against the Trust.

Accountability Report

Date	Incident Description	ICO Response	Nature of Incident	People Affected	Subjects Informed
May 2020	In order to undertake COVID-19 Antibody testing, a request was made to the patient administration team to put 10,000 referrals and test requests on Lorenzo using a staff list pulled from the ESR (Electronic Staff Record) without consent. This was then shared with this data was then shared with the clinical administration team.	From the information provided it appears that the referrals were necessary to share and these have been shared with the relevant parties. Therefore, it does not appear that you have suffered a breach of security and the breach notification obligation does not apply to the incident you have described.	Disclosed in error	All staff	Staff given opportunity to opt out via staff communications emails.
June 2020	A member of staff has been identified as having inappropriately accessed a member of her family's medical records.	The ICO review determined no further action is required	Unauthorised Access/ Disclosure	1	Verbally and letter
September 2020	Physio notes for the patient were sent to the wrong Solicitor.	The ICO review determined no further action is required	Disclosed in error	1	Verbally and letter
November 2020	A Rheumatology patient had received a letter intended for another patient that outlining the patient's personal details as well as their clinical appointment details	The ICO review determined no further action is required	Disclosed in error	1	Verbally
November 2020	Pharmacy assistant contacted wife of a patient without gaining consent from the patient.	The ICO review determined no further action is required	Unauthorised Access/ Disclosure	1	Verbally

Incidents are scored using the DSP incident Reporting Guidelines and Assessment Grid and reported via the DSP Toolkit. The criteria include all reported incidents, including low scoring incidents that would have been previously excluded from the total numbers. The table below shows a breakdown of all IG incidents have been reported each month by Health Group and Corporate Function. The highest reporting months were October 2020 and February 2021.

	Corporate Functions	Clinical Support – Health Group	Emergency Medicine – Health Group	Family and Women's Health – Health Group	Medicine – Health Group	Surgery – Health Group	**Total**
Apr 2020	4	4	0	2	1	1	**12**
May 2020	4	1	0	3	3	1	**12**
Jun 2020	5	2	0	2	0	3	**12**
Jul 2020	2	5	0	5	3	4	**19**
Aug 2020	3	4	2	5	6	2	**22**
Sep 2020	6	3	1	7	1	6	**24**
Oct 2020	6	3	3	7	11	0	**30**
Nov 2020	7	3	3	0	6	5	**24**
Dec 2020	4	4	0	7	1	2	**18**
Jan 2020	5	4	1	6	4	2	**22**
Feb 2020	6	5	1	6	4	6	**28**
Mar 2020	4	3	4	4	2	5	**22**
Total	**56**	**41**	**15**	**54**	**42**	**37**	**245**

Accountability Report

The table below shows the top 5 types of IG incidents reported by Health Group reported during the last financial year 2020/21.

	Corporate Functions	Clinical Support – Health Group	Emergency Medicine – Health Group	Family and Women's Health – Health Group	Medicine – Health Group	Surgery – Health Group	**Total**
Patient documentation other	13	11	1	13	6	4	**48**
Other (case notes containing another patients details)	7	2	0	9	4	6	**28**
Verbal disclosure in error	6	7	1	4	3	3	**24**
Patient ID error	0	1	7	0	9	6	**23**
Medical records – contained notes of another patient	3	2	0	3	2	1	**11**
Total	**29**	**23**	**9**	**29**	**24**	**20**	**134**

The Trust's Caldicott Guardian takes an active role in reviewing issues including incidents involving medical records, such as inappropriate access to medical records. The Caldicott Guardian is a key part of the information governance structure, together with the Trust's Senior Information Risk Officer (SIRO) and Data Protection Officer (DPO), who all review Incidents Requiring Investigation, having taken advice from the Trust's operational level Information Risk Owners (HIROs), to ensure that investigation processes have been robust and outcomes clearly identified.

The Trust's Caldicott Guardian takes an active role in reviewing issues including incidents involving medical records, such as inappropriate access to medical records. The Caldicott Guardian is a key part of the information governance structure, together with the Trust's Senior Information Risk Officer (SIRO) and Data Protection Officer (DPO), who review Incidents Requiring Investigation, having taken advice from the Trust's operational level Information Risk Owners (HIROs), to ensure that investigation processes have been robust and outcomes clearly identified.

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 Accountable Officer's responsibilities

The Accountable 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 prepared a report to the Audit Committee in April 2020 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 Accountable 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

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Hull University Teaching Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Hull University Teaching Hospitals NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust Board sets the Risk Management Policy for the organisation. This was reviewed and updated in April 2017 and was subject to an internal audit in December 2019, resulting in positive assurance.

This Policy describes the organisation's approach to risk and risk management. It defines the leadership roles within the Trust for risk management. In addition, staff across the Trust receive risk management training, in order to identify and report risks. The Trust has a well-established process for entering risks on to its risk register and the regular review of risks, which is described below. The Trust also strengthened its approach to escalating risks at corporate level and the way in which this informs the strategic risk managed by the Trust Board. This is also described in more detail below.

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 an 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 and corporate services. 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.

At Trust Board level, the Board assesses its performance and discusses associated risks at each meeting, through the presentation of the Integrated Performance Report, which includes all NHS Improvement Single Operating Framework metrics. An exception report on these measures is discussed in more detail at the Board's Performance and Finance Committee and the more detailed quality issues at the Board's Quality Committee. The positive assurance and gaps in assurance are captured in the Board Assurance Framework, reviewed regularly by the Trust Board and its committees. The Trust Board undertook and agreed as self-assessment against the (formerly) Monitor (now NHS Improvement) licence requirements, which are now mirrored for non-Foundation Trusts, and did not report any principal risks to compliance with these requirements.

There is a mechanism for Health Groups and corporate services to escalate risks. New high level risks are notified to the Health Group triumvirates or corporate service management teams to be dealt with immediately whilst lower level risks are discussed at the Health Group/ Corporate team meetings. The Executive Management Committee reviews the highest rated risks and agrees which of these form corporate risks for the Corporate Risk Register, which is taken in to account in the Board Assurance Framework. These come via recommendation from the regular review of high-rated operational risks by the Trust Operational Quality Committee (clinical risks) and the Non-Clinical Quality Committee, recognising that risks from across the Trust have the ability to impact directly on patient care and on maintaining the Trust's statutory compliance.

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. Lessons from Serious Incidents are discussed at Health Group Governance meetings, the Serious Incident Committee and across the Trust through a Lessons Shared newsletter, cascaded through the Trust's Team Brief mechanism. The Quality Committee maintain board-level oversight of serious incident issues and lessons learned. Root Cause Analysis training is provided staff involved in Serious Incidents investigations. The Trust's Mortality Committee has overseen the formulation and implementation of a new Learning from Deaths policy, which includes a two-tier clinical case note review to identify patient deaths that have any flags for failure or impacts of care that could have been avoided. The Trust has developed a themes and trends report from this, reported to the Trust Board and the Quality Committee on a quarterly basis. The Quality Committee has also kept oversight of compliance with the national guidance requirements on Learning from Deaths and is satisfied that the Trust has made sufficient progress towards requirements to date.

Annual Governance Statement

The Trust's updated intranet site contains information to support staff in managing risks across the scope of the Trust's business. The Trust's formal communication systems (e-news, intranet, team brief cascade) are used to remind staff of their responsibilities such as reporting incidents and concerns, and sharing learning when specific initiatives or incidents have occurred. These communications include the conclusion of anti-fraud investigations and the consequences arising from information governance incidents investigations (SIRIs) during the year.

A fundamental nursing standards audit process is in place, which audits practice on each 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; each area of risk identified requires an action plan from the ward sister/manager to address. The ward-level reporting also takes in to account issues arising from complaints and patient experience, staffing numbers and types of reported incidents. These data are ordinarily published with each public Trust Board papers, to provide a risk overview of each ward. During the pandemic the fundamental audits were stood down but the process will re-start in 2021.

A framework is in place for managing and controlling risks to data security. There is a Senior Information 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 has submitted its position against the new Data Security and Protection toolkit in September 2020 with the next submission due in June 2021. The Audit Committee and the Trust Board are keeping oversight of the Trust's risk position in relation to systems security and systems resilience.

The Trust continues to review 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 full update on compliance, successes and risks in research was received by the Trust Board in March 2021.

The Trust Board reviewed its governance framework at the end of March 2020 as a result of several letters received by all NHS Trusts during the month as a result of the national Covid-19 pandemic. The effects of these were seen more from April 2020 onwards, and did not affect the system of internal control within the Trust, however had an immediate impact on the Trust's service delivery and ability to treat patients within NHS Constitutional standards. These do not reflect a lack of internal control but do represent risk areas requiring detailed assessment and mitigation in 2021.

Principal risks to compliance with the NHS provider licence conditions

The following section provides oversight of the Trust's risk identification and categorisation process, concluding with a section as to any principal risks to compliance with the NHS provider licence conditions, particularly the effectiveness of governance structures, responsibilities of directors and sub-committees, reporting lines and accountabilities to and from the Trust Board, submission of timely and assurance information to assess compliance with the licence conditions or any associated with the oversight the Board has on Trust performance.

All Trust 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 incident reporting and risk management system (Datix) and has a 'bottom up' approach to identifying risks.

1 - Each Health Group and corporate service area identify and enter risks on to their own operational risk registers; risks are required to be managed and mitigated at local level as far as possible

2 – the high-rated operational risks from each area are reviewed by the Trust's two operational risk management committees: the Operational Quality Committee reviews clinical risks and the Non-Clinical Quality Committee reviews non-clinical risks. The Committees escalate any high-rated risk that they feel cannot be managed within an individual health group or corporate service and represent a corporate risk across the organisation.

3 – the Trust's Executive Management Committee review the recommendations from the operational risk committees and agree what represent the Trust's corporate risk register

4 – The corporate risk register is considered in line with the Board Assurance Framework, which details the key risk areas that could prevent the Trust from achieving its strategic aims. This consideration of corporate risk helps the Trust Board identify the corporate risk burden being carried by the Trust and whether this impacts on achieving the Trust's strategic goals.

Annual Governance Statement

Operational Risk Register:

There were 204 operational risks on the risk register at the end of March 2021, as follows:

Risks by HG and Current Risk Rating	Very Low Risk	Low Risk	Moderate Risk	High Risk	Total
Corporate Functions	1	5	25	9	40
Clinical Support - Health Group	0	3	27	12	42
Emergency Medicine - Health Group	1	4	8	2	15
Family and Women's Health - Health Group	0	8	22	21	51
Medicine - Health Group	0	5	12	5	22
Surgery - Health Group	0	8	21	3	32
Trust wide risk managed by Falls prevention committee	0	0	1	0	1
Trust wide risk managed by Outpatients Committee	0	0	1	0	1
Total	2	33	117	52	204

This compares with 23 low risks, 139 moderate and 74 risks rated as high, and a total 244 risks at the end of March 2020. There has been an overall decrease in the number of risks on the operational risk register, however it should be noted that the use of the Trust's Corporate Risk Register has increased through the use of the escalation processes established between the Health Group and Operational Quality Committee. This reduction in the overall risks demonstrates that Trust continues to undertake regular reviews at Health Group level and is indicative of an active risk management process in respect of reviewing and closing mitigated risks.

At the end of March 2020 there were 7 risks on the operational risk register relating to the Covid-19 pandemic. At the end of March 2021 this had increases to 39 and demonstrates that the Trust continued to identify risks in response to the ongoing pandemic.

	Very Low	Low	Moderate	High	Total
Clinical Support - Health Group	0	0	2	0	2
Emergency Medicine - Health Group	0	0	2	0	2
Family and Women's Health - Health Group	0	7	8	4	19
Medicine - Health Group	0	0	3	3	6
Surgery - Health Group	0	0	2	1	3
Trust wide COVID-19 Risk	1	1	2	3	7
Total	1	8	19	11	39

Corporate Risk Register:

In January 2017, the Executive Management Committee (EMC) approved the new process for the management of the corporate risk register alongside the operational risk register and Board Assurance Framework.

The Corporate Risk Register was last reviewed at the August 2020 Non-Clinical Quality Committee (NCQC) and February 2021 Operational Quality Committee (OQC). A high level overview of all high-rated corporate risks and all other open corporate risks is presented to Operational Quality Committee (OQC) on a monthly basis. Each month OQC are asked to review and accept the risks on the Corporate Risk Register and determine if there are any other risks which need to be included.

There were 25 operational risks on the risk register at the end of March 2021, as follows:

	Low	Moderate	High	Total
Corporate Functions	1	8	4	13
Clinical Support - Health Group	0	2	1	3
Emergency Medicine - Health Group	0	1	0	1
Family and Women's Health - Health Group	0	0	6	6
Medicine - Health Group	2	0	0	2
Total	3	11	11	25

Annual Governance Statement

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. It is also reviewed by the Trust Board Committees at each meeting in relation to the risks linked with that Committee's terms of reference and also by the Audit Committee as a governance mechanism. 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 nine risks on the Board Assurance Framework at the start of 2020/21 against Trust's seven strategic aims from the Trust Strategy. The highest-rated risks at the end of 2020/21 on the Board Assurance Framework related to the Trust's underlying financial position, quality of care and performance standards due to the pandemic.

In respect of any principal risks to compliance with the NHS provider licence conditions, particularly the effectiveness of governance structures, responsibilities of directors and sub-committees, reporting lines and accountabilities to and from the Trust Board, submission of timely and assurance information to assess compliance with the licence conditions or any associated with the oversight the Board has on Trust performance, the Board's assessment was as follows: at the end of the year, whilst all risks areas on the Board Assurance Framework received some positive assurance throughout the year, 2 risk areas made sufficient progress to reach the target risk ratings, which was the Trust's ability to meet its financial plan in 2020/21 and to meet its Capital plan in 2020/21. There were 9 risk areas on the Board Assurance Framework for 2020/21. In the context of these being risks against five-year strategic goals, this rate of progress can be expected to some extent, as the Trust will only be able to mitigate some aspects of each risk within one year.

In 2019/20 as part of this strategic approach to risk management through the Board Assurance Framework, the Trust Board included its approach to risk appetite in the Board Assurance Framework in addition, the Trust Board had chosen at least one Board Assurance Framework topic for a deep dive discussion at public Board meetings throughout the year, meaning that each risk on the Board Assurance Framework has received detailed, strategic discussion by the Trust Board, which has informed the assurance requirements for future reports and the Trust Board and Committee cycle of business. In 2020/21 Board meetings were held monthly due to the pandemic, but were shortened due to operational pressures so only key documents were received. This meant that the deep dives into each BAF risk area were not possible, but this process will begin again in 2021.

As noted above, the Trust Board has received positive assurance against the Board Assurance Framework risks and 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 following the comprehensive CQC inspection in May 2015 and was further developed following the CQC inspection in 2016 and visit in 2017 (published February 2018). During 2020/21, this has been subject to quarterly review and scrutiny by the Quality Committee and reported to the Trust Board periodically.

The Trust Board, this year and for the last 3 years, has undertaken a self-assessment against all NHS provider licence requirements. These self-assessments have demonstrated full compliance but flagged up risk in relation to performance, as included in the summary of the Board Assurance Framework above. This is further detailed in the 'Review of effectiveness' section of this Statement, below.

The Trust has a People Strategy in place, which was updated in 2019 for the period 2019-2022. The People Strategy provides the blueprint for the Trust's assessment of its short-, medium- and long-term workforce plans and organisational development requirements, as the Trust plans not only to fill workforce numbers, but to continuously improve the working environment and culture of the Trust, as part of retention. The People Strategy has seven strands that cover all aspects of short- and long-term planning and cultural development, with an emphasis on staff engagement as a key measure of success. The Trust's People Strategy and Workforce Development Plan detail the Trust's approach to tackling staffing and skills shortages, and good progress, including increases in staffing figures in some key areas, has been seen in 2020/21, as well as the Trust investing in new roles such as nursing associate training posts, nursing apprentices, Physicians Associates and Advanced Care Practitioners.

The Trust continues its work on staff engagement and developing staff culture around the values identified by our staff around five years ago. The People Strategy, and the work strands underneath it, are included on the Board Assurance Framework and the level of corporate risk relates to workforce. The Trust Board receives regular updates on nursing staffing and People Strategy updates including workforce metrics received at the Board assure the Board that the Trust has staffing processes in place that are safe, sustainable and effective. The Workforce, Education and Culture Committee as a Board Committee to take forward strategic oversight of the People Strategy.

The Trust complies with the *Developing Workforce Safeguards* recommendations using existing staffing data to make an assessment of staffing levels in each health group and against vacancies, which are reviewed annually as part of operational planning for capacity and demand in respect of clinical services and the staffing requirements that make up an effective service. Workforce metrics are received and reviewed on behalf of the Trust Board by the Performance and Finance Committee and the Trust is working towards embedding the additional requirements of the *Developing Workforce Safeguards* through the Trust Board and Board Committees in 2020/21. Nurse staffing is rebased twice yearly against safe staffing levels and reported to the Trust Board. Safer nursing staffing is reported to every public Trust Board meeting. The Workforce, Education and Culture Committee examines variable pay in detail to understand short-term workforce pressures, recruitment plans and current vacancy levels.

Annual Governance Statement

The trust is fully compliant with the registration requirements of the Care Quality Commission.

The trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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

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

The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Performance and Finance Committee have Board-level oversight of the economic, efficient and effective use of resources. This is discharged through the monthly review of performance against budget and against financial plan, progress towards identifying and achieving cash-releasing efficiency savings, income against plan, performance and activity delivery against plan, cash management and budgetary management. The Performance and Finance Committee reports to the Trust Board, including escalation of any areas of concern. Further detail on the work of the Performance and Finance Committee is contained in the 'review of effectiveness' section below.

Information governance

The Trust has reported 5 Serious Incidents Requiring Reporting (SIRIs) in 2020/2021 to the Information Commissioner's Office (ICO) as incidents classified as Level 2 breaches in the Information Governance Incident Reporting Tool. The ICO has closed all of these 5 cases, with no further action required. The ICO did not take any regulatory action against the Trust during the year.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

This year, the Quality Accounts will focus on providing information on the Trust's overall COVID-19 recovery plans. All quality and safety priorities previously identified for improvement will also continue to be implemented and monitored as routine continuous improvement work within the Trust.

The Trust has a number of measures in place to provide assurance on the quality and accuracy of elective waiting time data. These include:

- Business Intelligence data quality reports
- Fortnightly Operational Data Quality Meetings with Health Group and Corporate representatives
- External assurance from both NHS Improvement in 2016 to the reporting and management of elective pathways and the refresh of processes that followed this assurance, and external assurance in 2017/18 from MBI Health Group as to the internal processes and validity of the Trust's PTL (Patient Tracking List) with significant assurance around data quality
- In January 2020, the Trust was provided a peer review by an external NHS body in, which found that the data quality on the Trust's waiting list (the PTL) was robust and that the Trust had an accurate waiting list to work from
- Quarterly internal audits on compliance with the Trust's Access Policy by the Performance Team
- Monthly data checks on the RTT data submission prior to upload to UNIFY2
- Monthly checks on Data Completeness for non-admitted and admitted pathways within the tolerances of 80 – 120%
- Mandatory E-Learning for administrative staff on Referral to Treatment rules using the NHS Improvement e-learning modules

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality Committee and the Performance and Finance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board

The Trust Board is accountable for all aspects of the performance of the Trust. The Trust Board met in public on ten occasions during 2020/21 and was quorate at all meetings. The attendance of each individual Board member

member is set out in this Annual Report and on each Trust Board agenda. The Trust Board works towards an annual work plan including statutory and mandatory requirements. Arrangements for the discharge of statutory functions by the Trust Board have been checked for irregularities and were found to be legally compliant.

The Board has six 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, a Quality Committee and a Workforce, Education and Culture 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 and have Non-Executive Director majority membership. An attendance record is kept for the Board and each of its committees.

The Audit Committee including internal audit

The Audit Committee met five times during 2020/21, which is the required number as set by its Terms of Reference and was quorate for all meetings. Its work plan for 2020/21 was received at its first meeting of the financial year and was also reviewed at each meeting 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 a review of the minutes from the Trust Board's Committees for any governance or internal control issues that require further examination by the Audit Committee. There are standing agenda sections for the internal auditor including anti-fraud, followed by the external auditor. 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, use of Trust's credit cards, legal fees, off payroll expenses, effectiveness of clinical audit, claims management, losses and special payments register and debts above £50,000.

The internal audit programme for 2020/21 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 Head of Audit Opinion and Annual Report 2020/21 gave an overall opinion of positive assurance with an amber/green rating, which is that the Trust has an adequate and effective framework for risk management, governance and internal control and that the internal auditors' work has identified further enhancements that can be made. The Trust's Anti-Fraud service, undertaken as part of the internal audit contract, did not raise any issues of internal control or gaps in assurance in 2020/21.

The Audit Committee has not escalated any serious gaps in control during the year.

Board Committees with a role of risk management including clinical audit

The Performance and Finance Committee met on 8 occasions which was not in line with its Terms of Reference and was stood down due to the pandemic and operational pressures. The meetings that did go ahead were quorate. The focus of each meeting was on the detailed Integrated Performance exception report, specifically the Trust's underlying performance against the key NHS Constitution standards and the Trust's financial plan, which are standing agenda items discussed at each meeting. Other substantive agenda items have also been the financial position of the Trust, particularly the financial performance of the Trust's health groups and their contribution to the Trust's underlying run-rate issues. The Committee has also monitored capital expenditure in line with plan. The Non-Executive Chair of the meeting provided a briefing to the Board each meeting on these areas.

The Quality Committee met on 11 occasions in line with its Terms of Reference. Key issues discussed related to assurance and learning points from Serious Incident investigations, the Quality Improvement Programme linked with the outcome from the previous Care Quality Commission comprehensive inspection, compliance with the Learning from Deaths national requirements and incident reporting. The Committee received annual reports relating to claims, serious incidents and safeguarding. The Quality Committee has focussed on lessons learned and supporting the development of a learning culture and safety culture, particularly following Serious Incident Investigations. In the last quarter of the year, particular focus was given to the Quality Improvement Plan, inviting teams to provide further assurance on particular QIP projects, and start the process of identifying quality improvements for next financial year. Each meeting also received a report from the Operational Quality Committee, which included any points of escalation to the Quality Committee. The Board was advised of any escalation issues following each meeting by the Non-Executive Quality Committee Chair.

The Remuneration Committee met seven times during 2020/21, which includes additional meetings for detailed discussions relating to director role changes. The Committee was quorate for all meetings. Agenda items included annual performance reviews, information on the top earners in the Trust, sector salary benchmarking information, and changes to public sector pensions impacting on Trust staff. A summary of the Remuneration Committee is received in the closed session of the Trust Board.

Other review and assurance mechanisms

The Board has previously agreed a framework for Board Development and has chosen to invest additional Trust Board time in development. The Trust Board held five development sessions during the year. The Board Development Framework and work plan are now published with every public Trust Board agenda and papers for openness and transparency of the topics and development time of the Trust Board.

Quality governance arrangements are in place, managed through a team of Quality Assurance specialists, which include clinical audit (delivering an annual clinical audit plan), operational and corporate risk management (with support provided in to each Health Group and corporate services from a central team), compliance (including CQC,

ward standards and support to safeguarding), claims and safety. The Trust has in place a Trust-wide Quality Improvement Plan, which has detailed projects to improve quality of care in identified areas within the Trust. These are identified through internal compliance and quality checks, internal audit reports, CQC inspection reports and other internal processes. The Quality Improvement Plan has a governance and project management structure in place, which feeds up to the Trust Board Quality Committee and provides assurance to the Trust Board. The Trust's quality governance arrangements culminate annually in the formulation, approval and publication of the Trust's Quality Accounts. The Quality Accounts signed off in June 21 (relating to the previous year) are reviewed by the Audit Committee, the Quality Committee and the external auditors.

A Quality Report is received at each Board meeting. The report is divided into sections, which set out patient safety matters, healthcare associated infections, patient experience matters, incident reporting including Serious Incidents and Never Events, levels of harm caused to patients and actions being taken. On a quarterly basis, the report includes the Trust's position on the classic Patient Safety Thermometer and the Trust's Fundamental Standards audit. The report is written so as to account publically for the quality and safety of the Trust's services, including a monthly ward-by-ward read-across of patient safety reporting. The Trust Board also received a Nursing and Midwifery staffing report at each public Trust Board meeting, to report on the Trust's fill rates (number of nurses in post and hours of care delivery compared with planned levels) and the Trust's plans in nursing recruitment. I am pleased that the significant efforts from the Trust have paid off in nursing recruitment during this year. This year has also seen a continuation of some gaps in doctors' rotas, which have required additional spend to maintain safe services during the year. This has had a direct impact on the Trust's financial position this year.

In 2020/21, the Trust declared 3 Never Events, but 2 were de-escalated to Serious Incidents. The remaining Never Event related to a wrong site surgery. This is a significant concern for the Trust and requires further work on the Trust's safety culture. The Trust aims to improve even further this safety culture in the forthcoming year.

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 internal audit programme for 2020/21 was informed by the Trust's own risk and assurance framework, a 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 Head of Internal Audit Opinion and Annual Report 2020/21 gave an overall opinion of positive assurance, which stated that the Trust has an adequate and effective framework for risk management, governance and internal control, with opportunities to make further enhancements to this. This maintains the position from last year.

As part of their plan, Internal Audit carried out audits of the following areas in 2020/21, Deprivation of Liberty, General Ledger and Cash Management, Hospital Improvement Programme Team Review, HR Disciplinary, Grievance management and Bullying Policies/Procedures, Outpatients and the follow up review.

18 week Referral to Treatment Times and GIRFT Reviews have been postponed until 2021/22.

This maintains a high balance of positive assurance as seen last year in respect of internal audit.

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.

Although ED attendances were down compared to 2019/20, flow throughout the Emergency Department has continued to be significantly compromised with some excessive waits being due to an increase in the length of time patients are in the ED waiting for Covid results and then finding a suitable bed within the hospital. The ED performance standard continues to be subject to external scrutiny.

The Trust did not meet the national 18 week referral to treatment (RTT - incomplete pathway) standard or the 62-day cancer targets in 2020/21. The Trust did not meet the 31-day cancer performance against most targets although cancer activity was not stood down during the pandemic. The Trust did not meet the 1% tolerance in six-week waiting times for diagnostic tests in any month of the year. The Trust is reporting high numbers of patients waiting 52 weeks due to the pandemic and activity ceasing in the first wave. The Trust is working to reduce the waiting list size and reductions in follow-up backlogs as part of its recovery plan.

The Trust continues to operate the Vaccination Hub for the Humber, Coast and Vale area for the Covid mass vaccination programme on a 7 day basis. The Chief Nursing Officer continues to lead this work.

The Trust has continued to strive for improvement by embedding efficient and effective mechanisms for managing risks. Clearly defined processes are in place to ensure the Trust is continually working towards improvement in quality of care. This is regularly assessed through the clinical audit programme, nursing fundamental standard reviews, multi-disciplinary clinical reviews as well as internal ad-hoc reviews against the CQC's Key Lines of Enquiry as required. The Trust through its Quality Improvement Programme put in place arrangements to deliver improvements identified through previous CQC inspections and by partners and stakeholders via reviews of the Trust's Quality Accounts, Serious Incidents, claims and complaints. The Quality Improvement Plan has a project management set up to monitor progress, reporting up in the organisation to Trust Board level.

Annual Governance Statement

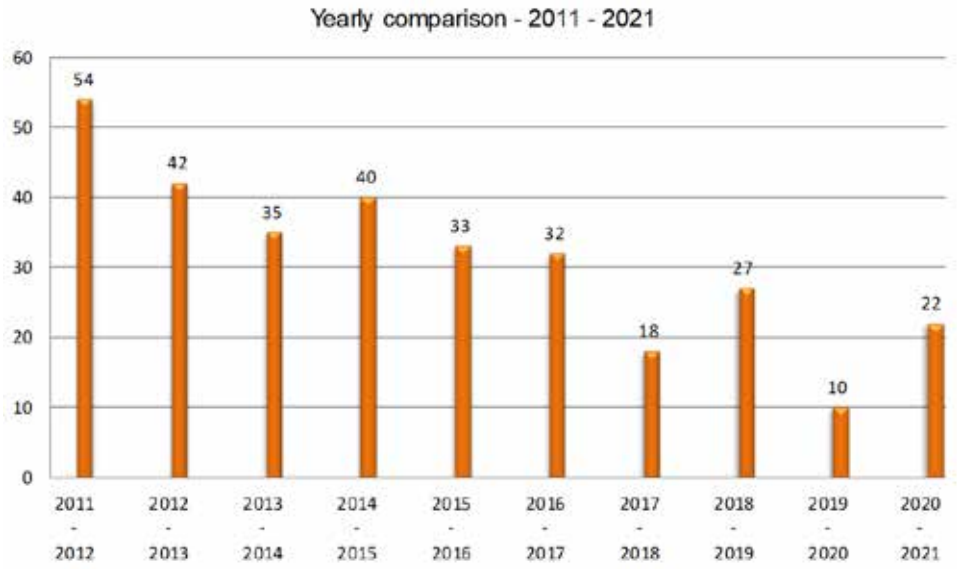
The Trust has committed to engaging regularly with key stakeholders and partners, including regular meetings with the CQC and NHS Improvement. During these meetings all parties will continue to monitor progress in an environment of openness and honestly. In particular, the Trust has supported the move of the Humber Coast and Vale Strategic Transformation Partnership to an Integrated Care System.

The Trust has received its Staff Survey results for 2020/21. Overall the survey indicates an improvement including against our key measure of staff engagement when compared with the national average of acute trusts.

Health and Safety of Staff

The Trust's excellent record with the Health and Safety regulator, the HSE, continued in 2020/21 with again no enforcement activity recorded against the Trust. There was one visit to the Trust by the HSE. This was a routine, planned inspection of the biological containment facilities within the Microbiology Laboratories. The visit concluded with no further actions. HSE also liaised closely with the Safety Manager in the early stages of the Covid pandemic regarding management of PPE and face-fit testing.
Following the Trust's best ever RIDDOR reporting numbers (10) in 2019/20, this year saw an increase, though the overall trend of reduction over the last 10 years has been maintained:

Figure 1: Incidents reported to the HSE under the RIDDOR regulations by the Trust's Safety Team over the last ten years:



The two main causes of RIDDOR reportable incidents over the last year have been 'slips, trips and falls' (6) and manual handling (9). Trends in category of causation have been identified and actions for improvement are already underway, including the removal of trip hazards through infrastructure improvements.

Management of Covid risk in non-clinical areas has been the subject much focus in 2020/21 and will remain such for the foreseeable future. This work has included staff infection investigation, the facilitation of risk assessments, 'Covid-secure' inspections and helping in the team approach to reducing Covid risk, so far as is reasonably practicable, by closely following government and now HSE-based standards.

Annual Governance Statement

Manual Handling

Although face to face training was brought to halt due to the pandemic, alternative resources were put in place to help keep staff updated with information such as on-line learning, videos and virtual meetings. Focus was given to the provision and movement of equipment such as beds and hoists to help staff maintain safe patient handling and care – often a challenge when staff are working in unfamiliar areas following pandemic-driven re-location. The Link Trainer network remains a key resource for wards and departments in the promotion of safer patient handling and their updates with the Manual Handling Lead continue via virtual meetings, updated online information and newsletters.

This year has seen a similar number of manual handling incidents reported as last year. The number of RIDDOR reportable manual handling incidents has increased however, with most attributed to non-patient handling activities. Push/pull activities and poor communication have been the commonest contributory factors, and thus an area for focussed intervention by the Manual Handling Lead.

Covid-19

The Trust received several letters of national requirements in March 2020, as the UK faced a pandemic situation. This required the Trust to cancel elective appointments, create a surge plan for ward and intensive care capacity and a staff redeployment plan, all with rapid turnaround. The Trust was no longer able to hold meetings in public and had to review its governance arrangements, the results of which were implemented in the Trust from 24 March 2020 and throughout 2020/21 as follows:

- That the Board meets virtually either by telephone or video conference every month, an increase in frequency from bi-monthly
- That the Board considers only urgent business in the following four areas:
  - Our patient impacts – the quality and safety issues and relevant priorities and CQC requirements, key risks arising and decisions required of the Board;
  - Our people – resilience, safe staffing, absences; relevant priorities, key risks arising and decisions required of the Board;
  - Our money – what financial impacts and risks are arising, relevant priorities, decisions required of the board; and
  - Covid-19 preparedness, planning and operational management - to ensure other issues not captured above are reported.
- That these Board meetings are held without the public in attendance, as physical meetings are not being held during this time and attendance at public meetings is not considered essential business under Governmental social distancing guidance. Questions from the public are invited in advance, and that a public record from each meeting will be created and published on the Trust's website. If technology allows, the public will be invited to attend meetings if this can be facilitated electronically
- Papers discussed at the Board will be published unless they contain highly sensitive information which, exceptionally, in the judgement of the Board may otherwise undermine public confidence inappropriately.
- Meetings of the Board's Committees are stood down during this period, with the exception of the Audit Committee and the Quality Committee – the other Board Committee business therefore reverts to the full Trust Board to discharge.

Trust Chief Executives received a letter from NHS E/I on 18 March 2020 containing mandatory requirements to create clinical capacity in order to manage the anticipated increase in patients due to Covid-19. This included elements such as postponing all elective procedures and non-urgent outpatient appointments, and adopting new ways of working such as video and telephone appointments. This letter outlined the type of surge capacity that Trusts should plan to create and required trusts to risk stratify the effect this would have.

There is new national guidance, including NICE guidance, on the management of patient groups and patient care in light of Covid-19, such as critical care.

The Trust has already implemented the relevant elements of the NHSE/I letter and already had in place an operational command structure to manage its Covid-19 preparations including drawing up, implementing and maintaining a surge plan with all related elements, such as staff redeployment and application of relevant national clinical guidelines. The Trust is also working through the financial implications of Covid-19, both for revenue and capital, including short-notice capital bids for infrastructure works to support long-term management of Covid-19 patients, which are captured in this 2020-21 annual report.

The Trust has commissioned a report from the University of Hull to review how the pandemic was managed, the learning from the new procedures put into place and any good practice that should be shared.

All Trusts are encouraged to form an Ethics Committee to take organisational policy decisions relating to treatment and ability to care for patients in light of anticipated numbers of acutely unwell patients with Covid-19. The Trust formed a COVID-19 Ethics and Clinical Prioritisation Policy Committee (ECPPC), which held its first meeting on 31 March 2020, chaired by a Non-Executive Director and has a membership of clinical expertise, governance input and external/patient and staff welfare focus. It is constituted as a sub-committee of this Trust Board.

Annual Governance Statement

Significant issues

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

- Covid-19 – the impact on the Trust's governance arrangements, the impact on Trust waiting lists and delivery of clinical services, the surge capacity required and the capacity to plan and delivery service recovery
- The Trust did not meet all of the NHS Constitution standards, many of which will be impacted by Covid-19 arrangements in 2020-21, and take significant resource to recover
- Prior to this, the Trust's performance against the Emergency Department four-hour target was not acceptable and will require significant support to make and sustain improvement
- Addressing the Trust's underlying financial position as part of a system financial plan, which will be constrained by commissioner affordability and the ability to make further financial savings
- Securing capital funding to address all critical and long-term infrastructure requirements
- The pace and scale of challenge from the Humber Acute Service Review programme

The Trust Board acknowledges that 2021-22 will be another challenging year that staff will experience. The need to recover during and post-Covid-19 will be a particular challenge, and the risk to patient harm is currently being assessed. The resilience of our staff is being particularly tested and we seek to maintain the highest standards of care we can, for as many patients as we can, in 2021/22.

Conclusion

This annual governance statement has identified the following significant internal control issues:

- The Trust did not meet all NHS Constitutional waiting time standards in 2020/21 and will need to continue to implement the robust recovery plan in place to ensure high quality patient care.
- The Trust is fully participating in the Integrated Care System work.
- The Trust will need to make sustained improvement in Emergency Department performance
- The Trust met its financial plan in 2020/21 but must make further progress towards addressing the underlying financial position within a system financial plan
- Our staff are our a key priority in all areas of success: we must continue to improve our staff engagement, empower staff to make improvements in their own areas and feel part of an organisation that is striving for continuous improvement with a foundation on patient safety
- The Trust is aspiring to move to a "good" Care Quality Commission rating.

Signed

Accountable Officer: Mr Chris Long
Organisation: Hull University Teaching Hospitals NHS Trust
June 2021

Remuneration and Staff Report

Remuneration Table 2020/21

audit

Name and title	Current year 2020/21 (a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) total to nearest £100 £'s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5.000) £000	(e) All pension - related benefits (bands of £2,500) £000	TOTAL (a to e) (bands of £5,000) £000	Prior Year: 2019/20 (a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) total to nearest £100 £'s	(c) Performance pay and bonuses £000	(d) Long term performance pay and bonuses (bands of £5.000) £000	(e) All pension - related benefits (bands of £2,500) £000	TOTAL (a to d) (bands of £5.000) £000
Terry Moran: Chairman	35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
Tracey Christmas: Non Executive Director	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Stuart Hall: Non Executive Director	15-20	0	0	0	0	15-20	5-10	0	0	0	0	5-10
Tony Curry: Non Executive Director	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Martin Veysey: Non Executive Director (left 30/11/2020)	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Julie Bolus: Non Executive Director (started 01/12/2020)	0-5	0	0	0	0	0-5	-	-	-	-	-	-
Mike Robson: Non Executive Director (started 01/04/2020)	10-15	0	0	0	0	10-15	-	-	-	-	-	-
Una Macleod: Non Executive Director (started 01/04/2020)	10-15	0	0	0	0	10-15	-	-	-	-	-	-
Linda Jackson: Associate Non Executive Director (started 01/04/2020)	10-15	0	0	0	0	10-15	-	-	-	-	-	-
Chris Long: Chief Executive Officer	200-205	0	0	0	0.00	200-205	190-195	0	0	0	0	190-95
Lee Bond: Chief Financial Officer	125-130	0	0	0	125-127.5	250-255	155-160	0	0	0	0-2.5	160-165
Ellen Ryabov: Interim Chief Operating officer (started 01/12/2020)	50-55	0	0	0	0.00	50-55	-	-	-	-	-	-
Teresa Cope: Chief Operating Officer (left 30/11/2020)	100-105	0	0	0	47.5-50	150-155	145-150	0	0	0	125-127.5	270-275
Makani Purva: Chief Medical Officer	200-205	0	0	0	50-52.5	250-255	195-200	0	0	0	80-82.5	275-280
Beverley Geary: Chief Nurse	150-155	0	0	0	42.5-45	195-200	145-150	0	0	0	77.5-80	225-230
Michelle Kemp: Director of Strategy and Planning (started 01/01/2021)	30-35	0	0	0	77.5-80	110-115	-	-	-	-	-	-
Jacqueline Myers: Director of Strategy and Planning (left 31/12/2020)	85-90	0	0	0	130-132.5	220-225	115-120	0	0	0	75-77.5	190-195
Simon Nearney: Director of Workforce & Organisational Development	130-135	0	0	0	30-32.5	160-165	125-130	0	0	0	15-17.5	145-150
Suzanne Rostron: Director of Quality Governance (started 01/03/2021)	5-10	0	0	0	40-42.5	50-55	-	-	-	-	-	-
Carla Ramsay: Director of Corporate Affairs (left 30/09/2020)	35-40	0	0	0	32.5-35	70-75	70-75	0	0	0	12.5-15	80-85

Notes:

Terry Moran receives a combined remuneration of £75,000/annum as Chair of both Hull University Teaching Hospitals NHS Trust and North Lincolnshire and Goole NHS Foundation Trust.
The salary banding 35-40 in the table above represents Mr Moran's remuneration relating to Hull University Teaching Hospitals NHS Trust only.
Stuart Hall receives a combined remuneration of £27,500/annum as Vice Chair of Hull University Teaching Hospitals NHS Trust and Associate Non-Executive Director of North Lincolnshire and Goole NHS Foundation Trust.
The salary banding 15-20 in the table above represents Mr Hall's remuneration relating to Hull University Teaching Hospitals NHS Trust only.
Linda Jackson receives a combined remuneration of £30,000/annum as an Associate Non-Executive Director of Hull University Teaching Hospitals NHS Trust and Vice Chair North Lincolnshire and Goole NHS Foundation Trust
The salary banding 10-15 in the table above represents Ms Jackson's remuneration relating to Hull University Teaching Hospitals NHS Trust only.
Since October 2020 Lee Bond has been Chief Financial Officer of both North Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust. Mr Bond's time is shared equally between both organisations, for which he received a combined remuneration of £176,715 during 20/21. The salary banding 125-130 in the table above represents M Bond's remuneration relating to Hull University Teaching Hospitals NHS Trust or £41,746 of Dr Makani Purva's remuneration is affiliated to clinical roles, of which £36,192 is for a clinical excellence
J Myers' whole time equivalent salary is £131,716; Ms Myers has a 0.9 whole time equivalent contract (equivalent to 33.75 hours per week)
Chris Long re-joined the pension scheme on 01/01/2021.
Ellen Ryabov has claimed her pension

Remuneration and Staff Report

Remuneration Report - Pensions Table

Name	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31/03/2021 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31/03/21 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 01/04/20 (£000)	(f) Real increase in Cash Equivalent Transfer Value (£000)	(g) Cash Equivalent Transfer Value at 31/03/21 (£000)	(h) Employer's contributions to stakeholder pension
Chris Long	0.00	0.00	55-60	175-180	1,447	0	0	0
Lee Bond	5-7.5	10-12.5	60-65	135-140	970	111	1,123	0
Jacqueline Myers (left 31/12/2020)	2.5-5	7.5-10	45-50	95-100	649	83	788	0
Michelle Kemp (started 01/01/2021)	0-2.5	0-2.5	30-35	60-65	500	15	588	0
Simon Nearney	0-2.5	0.00	15-20	0.00	202	15	239	0
Carla Ramsay (left 30/09/2020)	0-2.5	0.00	15-20	0.00	130	6	154	0
Suzanne Rostron (started 01/03/2021)	0-2.5	0.00	25-30	50-55	379	1	418	0
Makani Purva	2.5-5	0-2.5	50-55	95-100	850	44	937	0
Teresa Cope (left 30/11/2020)	0-2.5	0-2.5	50-55	120-125	842	27	919	0
Beverley Geary	2.5-5	0-2.5	50-55	140-145	979	46	1,064	0
Ellen Ryabov (started 01/12/2020)	-	-	-	-	-	-	-	-

Notes
Chris Long re-joined the pension scheme on 01/01/2021.
Ellen Ryabov - pension already claimed.
No CETV is shown where normal pension age (NPA) has been reached.

Remuneration and Staff Report

Pay Multiples - Fair-pay Disclosures

These figures have been subject to audit

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.

	20/21 (£)	19/20 (£)	18/19 (£)
Median Pay	**30,615**	30,112	28,860
Multiple	**6.7**	6.6	6.4
Highest paid Director at 31.3.2021	**204,081**	197,477	185,436
Change in pay multiple	**1.65%**	2.07%	-21.33%
Change in highest paid Director pay	**3.34%**	6.49%	-14.53%
Change in median average pay	**1.67%**	4.34%	8.64%
Range of staff remuneration	**8,115 - 250,922**	7,626 - 290,499	-
Highest paid employee	**250,922**	290,499	321,820

The Trust's highest paid Board Director in 2020-21 was the Chief Executive Officer. The banded remuneration of the highest paid Board Director in Hull University Teaching Hospitals in the financial year 2020-21 was £200,000 to £205,000, the midpoint of which is £202,500 (2019/20: £195,000-£200,000, the midpoint of which is £197,500). This was 6.7 times the median remuneration of the workforce (2019/20: 6.6 times), which was £30,615 (2019/20 - £30,112).

The median level of remuneration has increased by 1.67% and the remuneration of the highest paid Director has increased by 3.34%. The combination of these two factors has culminated in an increase in the pay multiple from 6.6 to 6.7. The median salary has increased primarily as a result of the 3-year NHS pay deal introduced in April 2018.

In 2020/21, seven employees received remuneration in excess of the highest paid Board Director. The remuneration for those employees was in the range of £205,000 to £255,000 (2019/20 - £200,000 to £295,000). All seven employees paid more than the highest paid Director are Senior Medical Consultants.

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.

Staff Report

These figures have been subject to audit

Number of Senior Managers by Band

Senior Manager is defined as any employee whose post is coded to a national occupational code as a 'senior manager' and who reports directly to a Director. This does not include Trust Board members, who are detailed below.

Band	WTE
Band 8b	13
Band 8c	7
Band 8d	6
VSM	15

Staff Composition

Trust Total

Gender	Headcount	%
Male	2,345	24
Female	7,583	76

Executive Director Grade (voting and non- voting Directors)

Gender	Headcount	%
Male	4	44
Female	5	56

Remuneration and Staff Report

Modernising Policy, Practice and Technology within Workforce and OD

Throughout 2020/21, in the context of a pandemic, the Workforce and Organisational Development Team continued to work towards delivering a supportive culture defined and requested by it's workforce.

1. Employee Service Centre

Three years after it's launch, the Employee Service Centre (ESC) continues to provide a 'one stop shop' to all employees, offering first line support on recruitment, HR, Payroll, Smartcards, Medical Staffing and other related topics.

The ESC has played a key role in supporting the Trust response to the COVID-19 pandemic.

The ESC Helpdesk became the first point of contact for COVID-19 related queries, including booking staff and family members for COVID-19 tests (undertaken on site at Castle Hill Hospital) and working with clinical nursing colleagues to enable staff to get tested in a safe and timely manner.

Via a database used to record all absences, returns to work, data on testing and isolation, the ESC Helpdesk ensured that COVID-19 command meetings had point in time, up-to-date information on attendance levels across the Trust.

To support the COVID-19 response, the ESC Helpdesk extended it's opening times from normal office hours. At the peak of the crisis opening hours increased to 12 hours a day from Monday to Friday and 8 hours a day over Saturday and Sunday and bank holidays (including Christmas Day).

The Medical Staffing Team also extended to a 7 day a week service at the height of the pandemic to support the Trust in filling as many rota gaps as possible. They also supported significant rota changes for the Junior Doctors whose working rotas changed to adapt to the new working environment.

Over the last year, the ESC has received and dealt with just under 88,000 calls and emails. This is a significant increase compared to 2019/2020 figures, where there were 26,000 calls and/or emails.

Between April 2020 to March 2021, 2,346 new starters were recruited, either as permanent, casual workers or on an honorary contract basis. This was an increase in activity of 28% compared to 2019/2020.

The increase in new starters required the introduction of regular socially distanced on-boarding sessions (to ensure recruitment checks were in place, to create and issue ID badges and Smartcards and to complete all the necessary paperwork) were developed to replace the large monthly induction events. These not only enabled the Trust to comply with social distancing requirements but also facilitated a more flexible approach to start dates for new employees.

In March 2020, to ensure the key function of Payroll was protected in the event of any significant outbreak of COVID-19 that would impact the capacity of the team, immediate arrangements were made for Payroll colleagues to work safely and securely from home.

It is to all the ESC Team's credit how well they have adapted to significant and ongoing changes in the services they offer to support front line colleagues. Processes developed as a response to the COVID-19 pandemic will be reviewed and where appropriate will be adopted moving forwards.

2. Human Resources Advisory Service

Whilst aspects of the core HR Advisory Service were paused during the pandemic, key elements continued, including working in partnership with staff side colleagues to maintain progression of serious employee relations cases. There has been a year on year improvement in the length of time to complete cases, with 60% of conduct cases managed via accepted responsibility which negated the need for formal panel processes and meant cases were progressed quicker, with less emotional impact on staff. Core HR policies continue to be improved, focusing on a compassionate leadership perspective.

A positive external review, undertaken as part of the Trust's Annual Audit timetable, provided Substantial Assurance for the Trust Board on Employee Relations Management.

Maintaining up-to-date knowledge of changing national and local guidance and advice from multiple sources, the team undertook a range of duties to support the Trust's COVID-19 response.

This included regular and timely reviews of Staff Risk Assessments, reviewing these as national advice rapidly changed. Frequently Asked Questions for staff and managers were developed, which were updated regularly and communicated widely. These supplemented numerous person specific management and staff queries. Welfare calls to staff self-isolating to check on their wellbeing, and discuss planned return to work dates etc. were also facilitated.

3. EEA Staff – EU Exit

The Trust's EEA staff have faced a period of uncertainty both during and following the UK's departure from the EU.

Therefore, it has been really important for the Trust to provide it's valued EEA staff with relevant information regarding the EU Settlement Scheme and to encourage them to apply.

Any loss of current EEA staff or delays in recruitment due to the introduction of a new immigration system (which came into place on 1 January 2021) could seriously compromise service delivery and impact on patient care.

The Workforce and OD Team has continued to actively communicate with EEA staff across the Trust to ensure they feel supported and are kept aware of changes that may impact on affected staff living and working in the UK. This includes circulating details of the EU Settlement Scheme to staff.

Remuneration and Staff Report

Modernising Policy, Practice and Technology within Workforce and OD

Workforce reports have been shared with relevant groups/ committees to ensure awareness of ongoing issues relating to the UK's exit from the EU.

Workforce risk assessments for each Health Group/ Directorate were developed and collated to create a summary of identified issues across the workforce.

Assurance from Contractors and Agencies about the impact of EU exit and immigration changes on non-directly employed workforce/agency staff was sought, together with their actions to mitigate risk, including future contingency plans to maintain staffing for key services.

The Workforce and OD Directorate/HRBPs continue to raise and action workforce issues related to the EU exit in conjunction with Service Managers.

4. Nurse and Staff Bank, e-Rostering (electronic roster) and e-Medical Workforce Teams

During the COVID-19 pandemic, the HealthRoster Suite of systems were used to dynamically reflect the fast-paced changes of the staffing picture across the Trust. This enabled teams to plan staffing cover effectively in order to keep patients and staff safe.

Over the last year successful initiatives for the Nurse and Staff Bank, e-Rostering and e-Medical Workforce Teams include:

- The newly implemented initiatives of Bank and Agency Direct Bookings were embedded throughout the year with staff and agencies able to book shifts using the appropriate portals 24 hours a day, 7 days a week. Vacant duties can be sent to Bank at any point throughout the day and picked up by Pool and Bank Staff using EmployeeOnline.
- Pool and Bank staff moved from paper to e-timesheets, where HealthRoster is fully utilised. This has delivered a number of efficiencies across the Bank and Payroll Teams and has also supported the infection control efforts during the pandemic reducing the amount of paper being passed from person to person.
- The e-Rostering Team supported the deployment of new roles across the organisation which included Aspirant Nurses/Student Nurse Support Workers, Medical Support Workers and internationally Recruited Nurses who required an alternative approach to rostering.
- The project to implement the e-Rostering system to all remaining clinical services continued throughout the pandemic, with the priority being areas with the greatest need for implementation, including Staff Testing, COVID-19 Vaccine Hubs and Mortuary and Bereavement Services. The increase in the number of live rosters (from 300 to 350) by the end of the financial year supports efficient use of the Trust's staffing resource. This also included e-Timesheet link up for each of the new areas, thus reducing paper transactions, saving time and money for service areas and Payroll.

In addition to the above, the Team played a pivotal role in the Humber, Coast and Vale (HCV) COVID-19 Vaccination Programme. The Team developed a Bank of Vaccinators to be deployed across the HCV patch in a short timeframe, which required the Team to think creatively to ensure any issues were dealt with promptly and the requirements of the Programme were met.

There were a number of improvements to processes within the teams to support the Trust response to deal with the challenges of the COVID-19 pandemic. This will allow the opportunity to look at how the service can continue to evolve to better support patient care.

5. Reserve Forces Training and Mobilisation

The Trust continues to take steps to embed the Armed Forces Covenant, which aims to support positive outcomes for the Armed Forces community.

The Trust has received the Gold Award under the Employer Recognition Scheme for it's work supporting the Armed Forces, as well as Veteran Aware Accreditation in recognition of it's commitment to improve NHS care for Veterans, Reservists and serving members of the Armed Forces.

In achieving the Gold award, the Trust has demonstrated it's forces-friendly credentials as part of the recruitment and selection process, has ensured that the workforce is aware of it's positive policies towards defence people issues and has signed the Armed Forces Covenant.

There are Armed Forces Champions within the Trust who proactively advocate and support defence through the provision of information regarding relevant internal policies and external services including the Veterans Hub and the City Council.

6. Equality, Diversity and Inclusion

Developing an organisational culture that encourages every member of staff, whatever their role or background, to succeed remains one of the Trust's key priorities.

The following provides an overview of work undertaken over the last year to support this commitment.

6.1 Appointment to EDI Roles

To embed the Trust's commitment to Equality, Diversity and Inclusion, funding has been secured to make appointments to the following roles:

- Equality, Diversity and Inclusion Lead (Workforce)
- Equality, Diversity and Inclusion Senior Advisor (Workforce)
- A six-month secondment opportunity as OD Facilitator (with a focus on disability or a long term condition)

6.2 Gender Pay Reporting

The Trust's overarching Gender Pay Gap Report for 2020, the fourth since the regulations were introduced, has been published. The Trust is using the workforce gender pay gap

figures to help understand the underlying causes for it's gender pay gap and to identify suitable steps to minimise it.

Some elements of the Trust's gender pay gap have a historical/national context which will take a period of time to resolve. For example, the Trust gender pay gap data for the period including 31 March 2020, which shows the difference in average pay between men and women in the workforce, reflects that the Trust has a majority of men in higher-paid roles, predominantly medical staff.

The mean and median hourly pay gap percentages across the health sector and bonus pay gap are significantly affected by the presence of the Medical Consultant body – due to both their high base wage and the historical differences in bonuses awarded under the Clinical Excellence Awards scheme.

The Trust's mean gender pay gap at 29.21% and median gender pay gap at 19.21% have increased slightly since the previous reporting period, and are above the national averages of 14.6% (mean) and 15.50% (median). Excluding medical and dental staff the Trust figures would be 3.80% and 0.30% respectively.

The mean and median data has been impacted by changes to the composition and pay of medical staff, together with the disproportionate and increased percentage of females that pay into salary sacrifice schemes compared to males.

Pleasingly the mean bonus gap improved by 8.41% on last year's data. Analysis of those who have achieved a new style local CEA for the 2020 reporting period suggest positive changes in addressing the bonus pay gap for future years. Eligibility for the new CEA/Discretionary points was broadly consistent with the Consultant gender split. Notably however, when it came to applying, of those eligible, a slightly higher percentage of females applied compared to males. In addition, the percentage of applications resulting in a successful new CEA award was higher for female medical staff.

Any national changes, including the recommendations contained within the 'Mend the Gap; The Independent Review into Gender Pay Gaps in Medicine in England', will be pivotal in helping reduce the Trust's gender pay gap.

The full Gender Pay Gap Report for 2020, which includes what actions the Trust has taken to date and next steps is available on the Trust's website.

6.3 Disability Equality

The Trust's Workforce Disability Equality Standard (WDES) report, covering the period 1 April 2019 to March 2020, has shown some improvement, including the number of staff declaring a disability has increased in comparison to the previous year. However, there continues to be a gap between the experiences of disabled and non-disabled staff.

Funding from the WDES Innovation fund has allowed the creation of a secondment and programme of work that will ensure the Trust is able to fully engage with staff who identify as having a disability or a long term condition. Following a number of focus groups and 1:1 listening sessions, a new staff network, the 'Enabled Staff Support Network', will be launched in Spring 2021, to continue to provide an inclusive environment for all Trust colleagues.

The Network aims to create a meaningful and permanent change to the working lives of disabled staff within the Trust; to ensure that disability confidence becomes second nature within the organisation. The Network will be a place of 'supportive action', created by and run by disabled members of staff and their allies.

For full details, the Trust's WDES submission is available on the Trust's website.

6.4 Race Equality

The NHS Workforce Race Equality Standard (WRES) was commissioned in 2015 to ensure employees from Black, Asian Minority Ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Whilst the Trust's latest WRES data highlights that the lived experiences of BAME colleagues within the Trust is different to other groups; working in partnership with the BAME Leadership Network, the Trust is committed to addressing this and areas for improvement have been identified.

As a result of WRES findings, in partnership with the BAME Leadership Network, work plans have been created to help understand and address bullying and harassment and ensuring diversity in recruitment for BAME colleagues.

For full details, the Trust's WRES submission is available on the Trust's website.

6.5 BAME (Black, Asian Minority Ethnic) Leadership Network

With the successful appointments of the BAME Leadership Network Chair and Joint Deputy Chairs in 2020, the Network has continued to go from strength to strength, in what has been a challenging year due to the COVID-19 pandemic.

Alongside the Senior Management Team, the BAME Chair and Deputy Chairs have played a fundamental role in supporting BAME staff during the COVID-19 pandemic. Following evidence that the BAME population nationally were more adversely impacted by COVID-19 compared to White people, the Trust introduced a number of proactive measures to support BAME staff. These included:

- Priority COVID-19 testing for BAME staff and their family members with mild symptoms.
- Priority antibody testing.
- Promoted avenues of support to BAME staff if they have any concerns about the support that they are receiving from line management during the pandemic.

The Trust continues to work with the BAME Leadership

Remuneration and Staff Report

Modernising Policy, Practice and Technology within Workforce and OD

Network and BAME colleagues across the organisation to review any additional support measures that are required as a result of the pandemic.

The Network meetings have continued during the pandemic via Webex to enable members to connect and important work, such as the WRES work plans etc. to continue.

The Trust continues to be committed to developing BAME staff, with leadership development opportunities being promoted on a regular basis, including BAME Leadership Programmes 20/21, Great Leaders Coaching Network, Great Leaders Leadership Programmes, Reverse mentoring and the NHS Leadership Academy.

'Let's talk about discrimination – Become an Ally' sessions were provided for staff across the Trust in October 2020 during Black History Month. These sessions focus on the importance of fostering an inclusive culture where all staff feel they belong and can progress at work, regardless of their identity. Further sessions will continue throughout 2021.

As part of the work to support the COVID-19 vaccine roll out, the Chair of the BAME Leadership Network has been working with NHS Hull CCG's Vaccine Strategy Engagement Group. This is a partnership group which includes organisations such as Hull City Council, Healthwatch and Humber All Nations Alliance and identifies and engages with communities with low vaccine take up. The Chair of the BAME Leadership Network has taken part in a vaccine webinar for BAME communities to help myth bust some of the common misconceptions around the vaccine. BAME staff from the Trust have also been working with NHS Hull CCG to produce videos in different languages for the vaccine roll out programme to combat misinformation.

6.6 Success at the National BAME Health and Care Awards 2021

The Trust was very proud to have the work of three staff recognised as part of the National BAME Health and Care Awards 2020. These successes were in the Workforce Innovator of the Year, Compassionate and Inclusive Leader/Initiative and Outstanding Corporate Achievement categories.

6.7 Our Voices Project

In September 2020, an exciting six-month project, 'Our Voices', launched to inform the Trust's Equality, Diversity and Inclusion Strategy and work going forward.

The project asked staff, volunteers and trainees to share their voices and lived experiences to improve staff experiences as measured by the National Staff Survey and other feedback forums.

Understanding the lived experience of staff from all backgrounds will enable the Trust to meaningfully work towards a culture where, both in employment and service provision, no individual is discriminated against or treated less favourably due to age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010) and the vision as set out in the Trust's Equality, Diversity and Inclusion Strategy.

Remuneration and Staff Report

Learning and Organisational Development

Learning Environment

In response to the current and perhaps future climate, the Learning Team have successfully introduced a virtual classroom which is incorporated into the current learning platform, hey247.net. This method is easy to access for our staff as some 99% regularly access the platform for all learning needs in addition to appraisal resources. As it is already integrated, any sessions which are accessed are automatically included in training records and are immediately visible for staff and managers.

Many colleagues throughout the organisation are being assisted to develop meaningful and educationally appropriate content to deliver via this approach and over 40 educators have been trained in how to be an effective virtual classroom teacher. This group includes many clinicians from a range of professions and many subject specialists.

With demands on a reduced capacity within our training facilitates, this move to an effective and virtual training environment has been vital to keep high quality clinical and non-clinical training in place. It has ensured that a safe environment can be kept in our training rooms and essential clinical face to face training can be accommodated with minimal risk with around 3700 staff accessing development virtually from April 20 through to March 21. Ten individual training pods (7 at Suite 22, Castle Hill and 3 at MEC, Hull Royal Infirmary), have also been added to our suite of facilities, which allow delivery or receiving of training in a safe and secure environment where working from home or singular offices are not available. It has effectively created an extra 10 classrooms!

Leadership and People Development

All normal scheduled leadership development programmes have been paused throughout the pandemic and have now been fully re-written to take place in the virtual classroom going into a new financial year. During the pandemic two offers have been in place to support leaders.

- Management Clinics – one hour bitesize content, facilitated by a trained coach. Key hot topics were covered to support our leaders to best support their staff. An ongoing 2 weekly "support the supporters" session remains in place. Over 120 people have attended these sessions.
- Leading through Covid Series - this was a Covid hot topic programme that replace our usual bitesized content and covered:
    - Leading remote teams
    - Supporting staff through redeployment
    - Introduction to Coaching
    - Managing beyond the policy
    - Civility and Inclusions
- Coaching Service – All our active coaches have switched from their usual activity to be able to support staff drop in session or offer a more personal coaching/ first aid approach. All our coaching development programmes have been converted for the new virtual training environment and have run monthly since October 2020. Specific coaching development has been created to support our colleagues as part of the BAME Leadership Network.

Inclusion

To support the inclusion agenda and series of management clinics have been held to support our leaders and staff to take an inclusive approach and explore how they can better become allies to staff from a BAME, LGBTQ+. Disabled or other protected characteristics background. Over 80 members of staff have attended these sessions in 20/21. They focus on self-reflection and how to take active action to support colleagues.

Staff Psychosocial Support Through Covid-19

The multidisiciplinary team was created in response to wave 1 of the COVID-19 pandemic and is designed to add extra support and capacity into the system for staff in addition to Occupational Health Services and Pastoral & Spiritual Support Services.

The team includes:

- Occupational Health Team
- Pastoral and Spiritual Care Department
- Psychological Services Department
- Organisational Development (including Coaching Network) Team
- Practice Development Team (nursing)

Wave 1 April – July 2020

The following services were provided:

- 24 Hour Hotline set up within one week of lockdown staff by the psychology team and chaplaincy until June 2020 and logged over 100 calls offering 1:1 support
- Physical Drop in session on both Castle Hill Hospital and Hull Royal Infirmary sites see over 330 staff members access psychological first aid and small items such as hand creams as little pick me up treats.
- Self-referral to Focus counselling services (Occupational Health)
- Staff support email signposted and supported over 330 enquiries
- Team reflection sessions co-delivered by psychology and chaplaincy teams
- Manager support session "management clinics" in place run on a weekly basis covering everything from risk assessment through to managing remote teams
- Wobble Room resource boxes (Over 50) funded by WISHH Charity to support staff to create spaces that were psychological safe to relax and gain some calm
- Psychological First Aid, Compassion Fatigue and Burnout, Recognising the Signs of Trauma Training were offer by the Psychology Team

Waves 2&3 November 2020 to March 2021

After a small feedback exercise, services were adapted and extra capacity was reinstated in November to match the increase in COVID-19 cases and reflect again the increase in pressure on the staff of HUTH.

- 24 Hour Hotline (This has continued from June and is staff by our Pastoral and Spiritual Care Team
- Staff support email has continued to signpost people and book appointments for 1:1 support with over 100 new enquiries dealt with.

Remuneration and Staff Report

Learning and Organisational Development

- Virtual Drop in sessions and bookable personal coaching 1:1's provided by a qualified coach in the OD team have seen 87 people supported
- Clinical psychology (bookable 1:1 slots) have seen 45 people and provide psychological assessment and support
- Chaplaincy team daily in reach to wards and departments connecting with and support staff directly
- Coaching/Clinical Supervision led support to Charge Nurses and ward drop ins have support over
- Wellbeing and resilience training sessions
- Wellbeing champions recruitment campaign to get more in department support means we have over 75 wellbeing champions in place.
- Management clinics continued and a "Leading through Covid" series is created to provide direct support to line managers with over 200 leaders supported through the year invarious different formats
- "Quick Guide to Staff Support during Covid-19 " available in an interactive leaflet to ensure that all information is easy to access and in one place. This covers all local services alongside the national offers from NHS People and NHS Employers. It also includes a wide range of support ideas from family to financial support. Over 2400 members of staff have accessed the guide. A hard copy is also packed within wobble room box resources distributed to over 50 clinical areas during wave 1.
- Our Pattie pages have been migrated to be with the UP! Health and Wellbeing pages and are signposted directly from the COVID19 workforce section. An overview can be accessed by clicking here.

All these services are in addition to the outstanding services currently provided by our Occupational Health Team and were design to compliment and provide extra capacity.

UP! Health and Wellbeing Programme

The wellbeing programme has continued at a lower level alongside the specific support highlighted in the section focus on staff psychosocial support.

Wellbeing champions have been part of the active support for the Trust throughout the year and there are now over 75 champions in place to support and signpost their colleagues across the Trust.

Physical and social groups have remained active throughout the pandemic (in line with social distancing guidance) e.g. HUTH Harriers running club and the Football Team. Many activities went online with Hull NHS Choir releasing their first virtual performance in July 2020. Our book club went virtual along with a number of other activities.

Lockdown Losers, the group set up to support staff seeking healthier lifestyles was set up in September 2020 and got off to a fantastic start after its members lost 17 stone in the first four weeks. The group was set up to help staff who had put on weight during the pandemic or who have always struggled with their weight. Staff get support through the closed Facebook page, with members helping each other by posting advice and tips, recipes and ideas of how to stay on track. Because everyone is empowered to take control of their journey, we don't advocate one particular healthy eating programme. By March 2021 the group has supported their members to lose over 60 stones in collective weight.

Remuneration and Staff Report

Staff Costs

	Permanent £000	Other £000	2020/21 Total £000	2019/20 Total £000
Salaries and wages	323,804		323,804	298,487
Social security costs	43,890		43,890	28,298
Apprenticeship levy	1,575		1,575	1,459
Employer's contributions to NHS pensions *	51,941		51,941	48,336
Pension cost - other	143		143	144
Temporary staff (including agency)		8,575	8,575	11,297
Total gross staff costs	421,353	8,575	429,928	388,021
Of which				
Costs capitalised as part of assets	1,247	57	1,304	1,321

* This includes employer's contribution to NHS pensions of the additional 6.3% for which there is a corresponding entry on income.

Average number of employess (WTE Basis)

	Permanent Number	Other Number	2020/21 Total Number	2019/20 Total Number
Medical and Dental	1,218	126	1,344	1,232
Ambulance staff	0	0	0	0
Administration and Estates	1,636	11	1,647	1,575
Healthcare assistants and other support staff	549	37	586	567
Nursing, Midwifery and Health Visiting staff	3,040	50	3,090	3,029
Nursing, Midwifery and Health Visiting learner	33	0	33	30
Scientific, Therapeutic and Technical staff	1,079	31	1,110	1,059
Healthcare science staff	454	0	454	432
Other	1	-	1	-
Total average numbers	8,010	255	8,265	7,924
Of which:				
Number of employees (WTE) engaged on capital projects	39	2	41	39

Consultancy Costs for 2020/21

There were no Consultancy Costs in 2020/21

NHS
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NHS Trust

Annual Accounts

for the YEAR ENDED 31st March 2021

Remarkable people. Extraordinary place.

Appendix 1

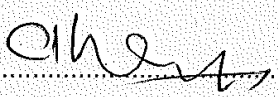
Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum*. 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 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, other items of comprehensive income and cash flows for the year.

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 entity's auditors are aware of that information.

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

Signed.....  .....Chief Executive

Date 10th June 2021

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 HM 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, other items of comprehensive income and cash flows for the year. In preparing those accounts, the 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 and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

10/06/2021 Date.....Chief Executive

10/06/2021 Date.....Finance Director

NHS
Hull University Teaching Hospitals
NHS Trust

Mark Dalton
Mazars LLP
5th Floor
3 Wellington Place
Leeds
LS1 4AP

10 June 2021

Dear Mark

Hull University Teaching Hospitals NHS Trust - audit for year ended 31 March 2021

This representation letter is provided in connection with your audit of the financial statements of Hull University Teaching Hospitals NHS Trust for the year ended 31 March 2021 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with the DHSC Group Accounting Manual. I confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy ourselves that I can properly make each of the following representations to you.

My responsibility for the financial statements and accounting information

I believe that I have fulfilled my responsibilities for the true and fair presentation and preparation of the financial statements in accordance with the Group Accounting Manual and relevant legislation and International Financial Reporting Standards (IFRS) as adapted and adopted by HM Treasury.

My responsibility to provide and disclose relevant information

I have provided you with:

- access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other material;
- additional information that you have requested from us for the purpose of the audit; and
- unrestricted access to individuals within the Trust you determined it was necessary to contact in order to obtain audit evidence.

I confirm as Accountable Officer that I have taken all the necessary steps to make me aware of any relevant audit information and to establish that you, as auditors, are aware of this information. As far as I am aware there is no relevant audit information of which you, as auditors, are unaware.

Accounting records

I confirm that all transactions that have a material effect on the financial statements have been recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all Board and relevant committee meetings, have been made available to you.

Accounting policies

I confirm that I have reviewed the accounting policies applied during the year in accordance with Group Accounting Manual and International Accounting Standard 8 and consider these policies to faithfully represent the effects of transactions, other events or conditions on the Trust's financial position, financial performance and cash flows.

Accounting estimates, including those measured at fair value

I confirm that any significant assumptions used by the Trust in making accounting estimates, including those measured at fair value, are reasonable.

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Contingencies

There are no material contingent losses including pending or potential litigation that should be accrued where:

- information presently available indicates that it is probable that an asset has been impaired or a liability had been incurred at the balance sheet date; and
- the amount of the loss can be reasonably estimated.

There are no material contingent losses that should be disclosed where, although either or both the conditions specified above are not met, there is a reasonable possibility that a loss, or a loss greater than that accrued, may have been incurred at the balance sheet date.

There are no contingent gains which should be disclosed.

All material matters, including unasserted claims, that may result in litigation against the Trust have been brought to your attention. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with the Group Accounting Manual and relevant legislation and IFRSs as adapted and adopted by HM Treasury.

Laws and regulations

I confirm that I have disclosed to you all those events of which I am aware which involve known or suspected non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

We have complied with all aspects of contractual agreements that would have a material effect on the accounts in the event of non-compliance.

Fraud and error

I acknowledge my responsibility as Accountable Officer for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

I have disclosed to you:

- all the results of my assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- all knowledge of fraud or suspected fraud affecting the Trust and Group involving;
  - management and those charged with governance;
  - employees who have significant roles in internal control; and
  - others where fraud could have a material effect on the financial statements.

I have disclosed to you all information in relation to any allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

Related party transactions

I confirm that all related party relationships, transactions and balances, have been appropriately accounted for and disclosed in accordance with the requirements of the Group Accounting Manual and relevant legislation and IFRSs as adopted by HM Treasury.

I have disclosed to you the identity of the Trust's related parties and all related party relationships and transactions of which I am aware.

Impairment review

To the best of my knowledge, there is nothing to indicate that there is a permanent reduction in the recoverable amount of the property, plant and equipment and intangible assets below their carrying value at the statement of financial position date. An impairment review is therefore not considered necessary.

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NHS Trust

Charges on assets

All the Trust's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

Future commitments

I am not aware of any plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

Service Concession Arrangements

I am not aware of any material contract variations, payment deductions or additional service charges in 2020/21 in relation to the Trust PFI schemes that you have not been made aware of.

Ultimate parent company

I confirm that the ultimate parent company for Hull University Teaching Hospitals NHS Trust is the Department of Health and Social Care.

Subsequent events

I confirm all events subsequent to the date of the financial statements and for which the Group Accounting Manual, relevant legislation and IFRSs require adjustment or disclosure have been adjusted or disclosed.

Should further material events occur after the date of this letter which may necessitate revision of the figures included in the financial statements or inclusion of a note thereto, I will advise you accordingly.

Other matters

I can confirm in relation to the following matters that:

- Brexit - we have assessed the potential impact of the United Kingdom leaving the European Union and that any disclosure in the Annual Report fairly reflects that assessment.
- COVID-19 - we have assessed the impact of the COVID-19 Virus pandemic on the Trust and the financial statements, including the impact of mitigation measures and uncertainties, and are satisfied that the financial statements and supporting notes fairly reflect that assessment.

Going concern

To the best of my knowledge there is nothing to indicate that the Trust will not continue as a going concern in the foreseeable future. The period to which I have paid particular attention in assessing the appropriateness of the going concern basis is not less than twelve months from the date of approval of the accounts.

I have updated our going concern assessment in light of the Covid-19 pandemic. I continue to believe that the Trust's financial statements should be prepared on a going concern basis and have not identified any material uncertainties related to going concern on the grounds that there will be continuity of services. We believe that no further disclosures relating to the Trust's ability to continue as a going concern need to be made in the financial statements.

Annual Governance Statement

I am satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust's risk assurance and governance framework and I confirm that I am not aware of any significant risks that are not disclosed within the AGS

Annual Report

The disclosures within the Annual Report and Remuneration Report fairly reflect my understanding of the Trust's financial and operating performance over the period covered by the financial statements

Yours sincerely

Chief Executive

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	2	640,267	606,587
Other operating income	3	86,541	56,089
Operating expenses	4, 6	(725,505)	(651,396)
Operating surplus/(deficit)		**1,303**	11,280
Finance income	9	8	263
Finance expenses	10	(6,245)	(6,912)
PDC dividends payable		(6,049)	(5,659)
Net finance costs		**(12,286)**	(12,308)
Other gains / (losses)	11	10	18
Surplus / (deficit) for the year		**(10,973)**	(1,010)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	5	(11,519)	(1,113)
Revaluations	15	1,979	19,691
Fair value gain on financial assets at FV through OCI	32	392	-
Total comprehensive income / (expense) for the period		**(20,121)**	17,568

The adjusted financial performance for 2020/21 is a surplus of £246k (2019/20 £10,495k) and is disclosed in Note 38

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	12	5,980	5,038
Property, plant and equipment	13	334,338	311,670
Investment property	16	100	3,100
Other Investments/financial assets	32	392	-
Receivables	19	3,722	4,071
Total non-current assets		**344,532**	323,879
Current assets			
Inventories	18	14,982	14,600
Receivables	19	19,169	38,496
Cash and cash equivalents	20	58,927	19,434
Total current assets		**93,078**	72,530
Current liabilities			
Trade and other payables	21	(96,895)	(66,104)
Borrowings	23	(2,917)	(38,632)
Provisions	25	(202)	(200)
Other liabilities	22	(730)	(511)
Total current liabilities		**(100,744)**	(105,447)
Total assets less current liabilities		**336,866**	290,962
Non-current liabilities			
Borrowings	23	(54,350)	(57,248)
Provisions	25	(5,683)	(2,224)
Total non-current liabilities		**(60,033)**	(59,472)
Total assets employed		**276,833**	231,490
Financed by			
Public dividend capital		292,247	226,783
Revaluation reserve		21,556	31,096
Financial assets at FV through OCI reserve		392	-
Income and expenditure reserve		(37,362)	(26,389)
Total taxpayers' equity		**276,833**	231,490

The notes on pages 5 to 46 form part of these accounts.

Christopher Long
Chief Executive

Date 10th June, 2021

Statement of Changes in Taxpayers' Equity for the year ended 31 March

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2020 - brought forward	**226,783**	**31,096**	**(26,389)**	**231,490**
Surplus/(deficit) for the year	-	-	(10,973)	**(10,973)**
Impairments	-	(11,519)	-	**(11,519)**
Revaluations	-	1,979	-	**1,979**
Public dividend capital received	65,464	-	-	**65,464**
Taxpayers' equity at 31 March 2021	**292,247**	**21,556**	**(37,362)**	**276,441**

Statement of Changes in Taxpayers' Equity for the year ended 31 March

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2019 - brought forward	219,253	12,518	(25,379)	206,392
Deficit for the year	-	-	(1,010)	(1,010)
Impairments	-	(1,113)	-	(1,113)
Revaluations	-	19,691	-	19,691
Public dividend capital received	7,530	-	-	7,530
Taxpayers' equity at 31 March 2020	226,783	31,096	(26,389)	231,490

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		1,303	11,280
Non-cash income and expense:			
Depreciation and amortisation	4.1	16,506	14,540
Net impairments	5	15,258	11,720
Income recognised in respect of capital donations	3	(2,608)	(116)
(Increase) / decrease in receivables and other assets		20,206	10,190
(Increase) / decrease in inventories		(382)	(2,072)
Increase / (decrease) in payables and other liabilities		12,047	9,767
Increase / (decrease) in provisions		3,442	1,384
Net cash flows from / (used in) operating activities		**65,773**	56,693
Cash flows from investing activities			
Interest received		8	263
Purchase of intangible assets		(1,569)	(1,645)
Purchase of PPE and investment property		(42,225)	(31,219)
Sales of PPE and investment property		3,069	2,974
Receipt of cash donations to purchase assets		807	116
Net cash flows from / (used in) investing activities		**(39,910)**	(29,511)
Cash flows from financing activities			
Public dividend capital received		65,464	7,530
Movement on loans from DHSC		(36,555)	(6,989)
Capital element of finance lease rental payments		(56)	(56)
Capital element of PFI, LIFT and other service concession payments		(1,929)	(1,894)
Interest on loans		(512)	(1,083)
Interest paid on finance lease liabilities		(4)	(3)
Interest paid on PFI, LIFT and other service concession obligations		(5,783)	(5,821)
PDC dividend (paid) / refunded		(6,994)	(5,043)
Net cash flows from / (used in) financing activities		**13,631**	(13,359)
Increase / (decrease) in cash and cash equivalents		**39,494**	13,823
Cash and cash equivalents at 1 April - brought forward		**19,434**	5,611
Cash and cash equivalents at 31 March	20.1	**58,927**	19,434

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that 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 are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

The Treasury's Financial Reporting Manual (FReM) provides the following interpretation of the going concern requirements set out in IAS1 "that the anticipated continued provision of the service is the important determinant of the basis of preparation of the financial statements for public sector entities".

Hull University Teaching Hospitals NHS Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

For NHS bodies, whilst the management of the Covid surges does cause uncertainty and operational pressures, there is no risk to the Trust's Going Concern status. The pandemic has, however, resulted in changes to the financial arrangements during 2020/21 that will continue to be in place for at least the first six months (H1) of 2021/22, as reflected in the detailed financial and planning guidance, but this does not impact on the 'going concern' status of the Trust.

The Directors, having made appropriate enquiries and are assured that the Trust will continue to provide services in the foreseeable future which is in line with the latest Department of Health Group Accounting Manual. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

Note 1.3 Critcial judgement in applying accounting policies

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 1,5,12,13, 14, 15 and 16)
- provisions needed and the value of the provision (note 25)
- the current value of future costs under PFI and other finance lease contracts (note 28)
- the accounting treatment of service concession arrangements in terms of whether they should be reported on or off the Statement of Financial Position.
- 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 independent 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.

Valuation services are provided to the Trust by Cushman & Wakefield, a property services firm whose valuers are registered with the Royal Institute of Chartered Surveyors (RICS), the regulatory body for the valuation services industry. A desktop valuation of land and buildings as at 31 March 2021 has been undertaken, the previous full valuation being undertaken as at 31 March 2020. These valuations reflect the current economic conditions and the location factor in and around Hull. The valuation for PFI buildings excludes VAT on the basis that the replacement of these assets would be carried out under a special purchase vehicle where VAT would be recoverable.

Note 1.4 Associated and Interests in other entities

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.

Note 1.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability

Revenue from NHS Contracts

The main source of income for the Trust is from commissioners in respect of healthcare services provided under local agreements. Income which is the subject of a contract or local agreement is recognised in the period in which the contractual performance obligations are met. Performance obligations can be performed over time or at a point in time.

NHS Injury Recovery Scheme

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.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract

Note 1.6 Other forms of income

Apprenticeship service income

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

Donated/Grant Income

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

Note 1.7 Measurement

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.

Note 1.8 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period. The normal Trust policy is that annual leave cannot be carried forward unless there are exceptional circumstances. The impact of the Covid-19 pandemic is deemed to be exceptional and has meant that an estimate for annual leave carry-forward has been included in the financial statements..

Pension 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.

Clinicians who are members of the NHS Pension scheme may face a tax charge in respect of the growth of their NHS pension benefits above their pensions savings annual allowance threshold. The government has committed to allowing this charge to be paid by the NHS Pension scheme. The NHS employer will make a contractually binding commitment to pay them a corresponding amount on retirement so that they are not disadvantaged by the charge. The Trust has therefore calculated a provision broadly equal to the tax charge owed by clinicians which is offset by a commitment from NHS England and the Government to fund the payment to clinicians as and when they arise. The provision has been calculated based on the consultant headcount within the NHS pension scheme multiplied by the nationally calculated 'average discounted value per nomination'

Note 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.

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

Measurement

Valuation

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

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

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

- Non-specialised buildings - market value for existing use
- Specialised buildings and land - depreciated replacement cost on a modern equivalent asset basis

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust's land, buildings and dwellings assets have been valued on the basis of modern equivalent asset on the same site.

Operational equipment - is valued at depreciated historic cost

Equipment surplus to requirements is valued at net recoverable amount.

Assets in the course of construction for service or administration purposes are carried at cost less any impairment loss. Cost includes professional fees but not borrowing costs which are recognised as an expenses. Assets under construction are revalued as appropriate and depreciation commences the quarter after which the asset comes into use.

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, and it is probable that future economic benefits or service potential will flow to the Trust, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to operating expenses in the period in which it occurs

Depreciation

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 in a manner that reflects the consumption of economic benefits or service potential of the assets. 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, are subject to annual review and reflect the period over which the NHS expects to obtain economic benefits or service potential:

Plant and Machinery 1-20 years
Buildings (incl. internal fixtures & fittings) 7-74 years
Transport 7-10 years
IT Equipment 1-25 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 current 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 current value), evenly over the estimated life of the asset.

Impairments

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

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.

Other Impairments are treated as valuation losses and reversals of 'other impairments' are treated as revaluation gains. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income, as an item of 'other comprehensive income'.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:
- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as ‘held for sale’ and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

Note 1.10 Donated and grant funded assets

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

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

Note 1.11 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 assets 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. Assets lives vary from 1-12 years.

Note 1.12 Government granted assets

Government grant funded assets are capitalised at their current value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Note 1.13 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 is regarded as being the case 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.

Note 1.14 Inventories

Inventory is valued 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. Where payment for inventory has been deferred, the additional cost of the inventory is recognised as an expense in the Statement of Comprehensive Income.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.15 Investment Properties

Investments are property that is held solely to earn a return, is not used in the delivery of operational services and is not occupied by staff. Assets are only recognised as Investments where it is probable that future economic benefits will flow to the Trust as a result of the investment and the cost can be easily measured. They are initially measured at cost and uplifted to fair value as appropriate to "highest and best cost" in accordance with IAS40. In determining a fair value we take account of a professional valuation or use actual values, for example where a formal offer to purchase has been made.

Note 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.

Note 1.17 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.

The Trust as a lessor

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.18 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 as published in the Government Accounting Manual.

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.

Note 1.19 Clinical Negligence costs

The NHS Resolution (NHSR) operates a risk pooling scheme under which the NHS Trust pays an annual contribution to NHSR which in return settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHSR on behalf of the Trust is disclosed at note 25.

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 NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when they become due.

Note 1.20 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 current value determined by the independent valuers, Cushman and Wakefield. The current value is determined as set out in note 1.10. 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:

a) Payment for the fair value of services received;
b) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'
c) Payment for the finance lease liability, including finance costs;

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.

Services received

The cost 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 current value in existing use and are subject to regular revaluations as set out in 1.20.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is initially measured at the initial value of the PFI asset it represents 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 is determined by the contract, and is independent of the actual cost of works to the contractor. The lifecycle maintenance costs are capitalised where they meet the Trust's criteria for capitalisation. The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively

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.

Note 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. See Note 26.

Note 1.22 Financial Assets and financial liabilities

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

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made

Classification and Measurement

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.
Financial assets are classified as subsequently measured at amortised cost or FVOCI. The Trust has no financial assets at fair value through profit and loss or fair value through other comprehensive income.
Financial liabilities classified as subsequently measure at amortised cost. The Trust has no financial liabilities at fair value through profit and loss.

Impairment of financial assets

For all financial assets measured at mortised cost or FVOCI including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.
The Trust adopts the simplified approach to impairment for contract and other receiavables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).
HM Treasury has ruled that central government bodies may not recognise stage 1 impairments against other government deepartments, their executive agencies, the Bank of England, Excheequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 and stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 impairments against thes bodies.
For Financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

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

Note 1.23 Public Dividend Capital

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 and Social Care 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 assets purchased from Covid-19 PDC and cash balances with the Government Banking Services. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

Note 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.

Note 1.25 Third Party Assets

No material assets belonging to third parties (such as money held on behalf of patients and staff) are recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 20.2 to the accounts. The Trust benefits from Charitable donations that are held separately to the Trust's own finances.

Note 1.26 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).

Note 1.27 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.

Note 1.28 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.

Note 1.29 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

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

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to the retail price index (RPI). The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Note 2 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 2.1 Income from patient care activities (by nature)

	2020/21	2019/20
	£000	£000
Block contract / system envelope income*	540,318	-
High cost drugs income from commissioners (excluding pass-through costs)	68,475	66,694
Elective income		103,903
Non elective income		174,568
First outpatient income		34,179
Follow-up outpatient income		38,931
A & E income		20,116
Other NHS clinical income **	12,482	147,359
Income from Other Sources	370	-
Private patient income	303	453
Additional pension contribution central funding***	15,796	14,727
Other clinical income	2,523	5,657
Total income from activities	**640,267**	606,587

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are not comparable with 2019/20 given the changes in financial flows as a result of Covid-19.

** The figure for 2020/21 includes income relating to the Flowers Case for the last 2 years £2.1m and an additional £6.7m relating to the costs of annual leave that is to be carried forward to 2021/22 which is exceptional due to the operational pressures associated with Covid-19.

***The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 2.2 Income from patient care activities (by source)

	2020/21	2019/20
Income from patient care activities received from:	**£000**	£000
NHS England	228,745	209,706
Clinical commissioning groups	406,718	388,112
Department of Health and Social Care	79	106
Other NHS providers	1,606	2,194
NHS other	1	344
Local authorities	370	537
Non-NHS: private patients	303	453
Non-NHS: overseas patients (chargeable to patient)	128	320
Injury cost recovery scheme	2,081	2,256
Non NHS: other	236	2,559
Total income from activities	**640,267**	606,587

All income related to continued activities for 2020/21 and 2019/20

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2020/21	2019/20
	£000	£000
Income recognised this year	128	320
Cash payments received in-year	72	178
Amounts added to provision for impairment of receivables	615	89
Amounts written off in-year	16	-

Note 3 Other operating income

	2020/21			2019/20		
	Contract income	**Non-contract income**	**Total**	Contract income	Non-contract income	Total
	£000	**£000**	**£000**	£000	£000	£000
Research and development	6,139	-	**6,139**	6,100	-	6,100
Education and training	31,210	1,022	**32,232**	25,347	776	26,123
Non-patient care services to other bodies	7,766		**7,766**	4,633		4,633
Provider sustainability fund (2019/20 only) *			**-**	9,550		9,550
Marginal rate emergency tariff funding (2019/20 only) *			**-**	2,077		2,077
Reimbursement and top up funding	24,705		**24,705**			-
Income in respect of employee benefits accounted on a gross basis	2,182		**2,182**	1,318		1,318
Receipt of capital grants and donations		2,608	**2,608**		116	116
Charitable and other contributions to expenditure		7,870	**7,870**		-	-
Rental revenue from operating leases		39	**39**		39	39
Other income	3,000	-	**3,000**	6,133	-	6,133
Total other operating income	**75,002**	**11,539**	**86,541**	55,158	931	56,089

All operating income relates to continuing operations

* in 2019/20 the Trust received core PSF of £8,973k and an additional £577k re-allocated from 2018/19 totally the £9,550k.

Note 3.1 Additional information on contract revenue (IFRS 15) recognised in the period

Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end was nil for this year, with £1,193k relating to 2019/20

Note 3.2 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

Summary	**2020/21**	2019/20
	£000	£000
Income	1,498	4,629
Full cost	(2,746)	(3,095)
Surplus / (deficit)	**(1,248)**	1,534
Staff & Visitor catering		
Income	1,163	2,634
Full cost	(2,120)	(2,496)
Surplus / (defict)	**(957)**	138
Car parking		
Income	335	1,995
Full cost	(626)	(599)
Surplus / (defict)	**(291)**	1,396

Note 4.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	-	-
Purchase of healthcare from non-NHS and non-DHSC bodies	15,124	11,346
Staff and executive directors costs	415,986	384,392
Remuneration of non-executive directors	225	103
Supplies and services - clinical (excluding drugs costs)	73,059	69,711
Supplies and services - general	16,366	15,027
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	89,024	78,134
Inventories written down	193	-
Consultancy costs	-	75
Establishment	6,482	5,582
Premises	27,449	24,512
Transport (including patient travel)	2,563	2,934
Depreciation on property, plant and equipment	14,730	13,277
Amortisation on intangible assets	1,776	1,263
Net impairments	15,258	11,720
Movement in credit loss allowance: contract receivables / contract assets	1,230	586
Increase/(decrease) in other provisions	971	327
Audit fees payable to the external auditor		
audit services- statutory audit	102	85
other auditor remuneration (external auditor only)	6	6
Internal audit costs	114	106
Clinical negligence	18,589	17,193
Legal fees	337	378
Insurance	408	416
Research and development	6,008	4,253
Education and training	11,673	3,578
Rentals under operating leases	1,765	2,094
Redundancy	345	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	2,255	2,188
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	81	81
Car parking & security	1,475	1,300
Hospitality	83	31
Losses, ex gratia & special payments	179	65
Other services, eg external payroll	430	563
Other	1,220	70
Total	**725,505**	651,396

All expenditure relates to continued operations

Note 4.2 Other auditor remuneration

	2020/21 £000	2019/20 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	6	5
2. Audit-related assurance services	-	1
Total	**6**	6

(These figures are inclusive of VAT)

Note 4.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial year.

Note 5 Impairment of assets

	2020/21 £000	2019/20 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	1,243	-
Changes in market price	14,015	11,720
Total net impairments charged to operating surplus / deficit	**15,258**	11,720
Impairments charged to the revaluation reserve	11,519	1,113
Total net impairments	**26,777**	12,833

The £1.243k relating to the loss from normal operations relates to the demolition of assets required as part of the Capital developments. Within the £14,015k, there is the impact of valuing the £23.9m relating to the new capital additions during 2020/21 that have been valued as at 31st March 2021.

Note 6 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	336,817	298,487
Social security costs	30,877	28,298
Apprenticeship levy	1,575	1,459
Employer's contributions to NHS pensions *	51,941	48,336
Pension cost - other	143	144
Temporary staff (including agency)	8,575	11,297
Total gross staff costs	**429,928**	388,021
Of which		
Costs capitalised as part of assets	1,304	1,321

* The employer's contribution to NHS pensions figure includes the additional 6.3% for which there is a corresponding entry on income.

Note 6.1 Retirements due to ill-health

During 2020/21 there were 2 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £47k (£286k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 7 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) NEST

From 1 April 2013, Hull University Teaching Hospitals NHS Trust offered an alternative pension scheme to all employees who are not eligible to be members of the NHS pension scheme at the Trust. This includes employees who are members of the NHS pension scheme through another role outside of the Trust and those that are not eligible to join the NHS pension scheme.

Every three years all eligible employees are auto-enrolled in either the NHS or alternative pension scheme. The auto-enrolment exercise was last carried out in June 2019 and following this process, all employees who meet the criteria for the alternative pension scheme are enrolled each month on a continuous basis, unless they specifically opt out.

The alternative pension scheme is a defined contribution scheme operated by the National Employment Savings Trust (NEST). Employee and employer contribution rates are a combined minimum of 8%(with a minimum 3% being contributed by the Trust.

Note 8 Operating Leases

Note 8.1 Hull University Teaching Hospitals NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Hull University Teaching Hospitals NHS Trust is the lessor.

The income earned relating to this operating lease is from a rental agreement with Humber Teaching NHS Foundation Trust for the land at Mill View on the Castle Hill Hospital site.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	39	39
Total	**39**	39

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	39	39
- later than one year and not later than five years;	156	156
- later than five years.	2,691	2,730
Total	**2,886**	2,925

Note 8.2 Hull University Teaching Hospitals NHS Trust as a lessee

Operating leases are predominantly for medical equipment and vary in lease terms from 1 to 10 years. Lease payments are fixed. Any contingent rent is determined according to inflationary increases.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	1,765	2,094
Total	**1,765**	2,094

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,365	1,702
- later than one year and not later than five years;	2,905	3,567
- later than five years.	464	733
Total	**4,734**	6,002

Note 9 Finance income

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

	2020/21 £000	2019/20 £000
Interest on bank accounts	8	263

Note 10.1 Finance expenditure

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

	2020/21 £000	2019/20 £000
Interest expense:		
Loans from the Department of Health and Social Care	439	1,078
Finance leases	4	4
Main finance costs on PFI and LIFT schemes obligations	3,374	3,502
Contingent finance costs on PFI and LIFT scheme obligations	2,409	2,318
Total interest expense	**6,226**	6,902
Unwinding of discount on provisions	19	10
Total finance costs	**6,245**	6,912

Note 10.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2020/21 £000	2019/20 £000
Compensation paid to cover debt recovery costs under this legislation	-	1

Note 11 Other gains / (losses)

	2020/21 £000	2019/20 £000
Gains on disposal of assets	99	18
Losses on disposal of assets	(89)	-
Total gains / (losses) on disposal of assets	**10**	18

Note 12.1 Intangible assets - 2020/21

	Software licences £000	Development expenditure £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**447**	**10,704**	**11,151**
Additions	-	1,569	**1,569**
Reclassifications	531	647	**1,178**
Disposals / derecognition	-	(1,598)	**(1,598)**
Valuation / gross cost at 31 March 2021	**978**	**11,322**	**12,300**
Amortisation at 1 April 2020 - brought forward	**288**	**5,825**	**6,113**
Provided during the year	282	1,494	**1,776**
Reclassifications	50	(21)	**29**
Disposals / derecognition	-	(1,598)	**(1,598)**
Amortisation at 31 March 2021	**620**	**5,700**	**6,320**
Net book value at 31 March 2021	**358**	**5,622**	**5,980**
Net book value at 1 April 2020	**159**	**4,879**	**5,038**

Note 12.2 Intangible assets - 2019/20

	Software licences £000	Development expenditure £000	Total £000
Valuation / gross cost at 1 April 2019	447	9,373	9,820
Additions	-	1,645	1,645
Reclassifications	-	(314)	(314)
Valuation / gross cost at 31 March 2020	447	10,704	11,151
Amortisation at 1 April 2019	288	4,562	4,850
Provided during the year	-	1,263	1,263
Amortisation at 31 March 2020	288	5,825	6,113
Net book value at 31 March 2020	159	4,879	5,038

Intangible assets comprise of software licences and internally generated developments, all are treated as purchased assets. They are shown on the Statement of Financial Position at depreciated historic cost, as a proxy for fair value. The lives of intangible assets are disclosed in note 1 to these accounts. The depreciation is based on the life of the asset, and is applied on a straight line basis.

The total gross book value of intangible assets with a nil net value is £2.031m (2019/20 £2.748m)

Note 13.1 Property, plant and equipment - 2020/21

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Valuation/gross cost at 1 April 2020 - brought forward	**9,641**	**250,387**	**9,927**	**69,561**	**342**	**21,183**	**361,041**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	21,269	21,957	13,396	-	6,782	**63,404**
Impairments	-	(33,811)	-	-	-	-	**(33,811)**
Reversals of impairments	-	476	-	-	-	-	**476**
Revaluations	-	1,979	-	-	-	-	**1,979**
Reclassifications	-	2,616	(6,883)	3,999	-	(661)	**(929)**
Disposals / derecognition	-	-	-	(5,256)	(32)	(2,100)	**(7,388)**
Valuation/gross cost at 31 March 2021	**9,641**	**242,916**	**25,001**	**81,700**	**310**	**25,204**	**384,772**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**169**	**-**	**37,057**	**271**	**11,874**	**49,371**
Provided during the year	-	7,230	-	5,614	18	1,868	**14,730**
Impairments	-	(7,034)	-	-	-	-	**(7,034)**
Reversals of impairments	-	476	-	-	-	-	**476**
Revaluations	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	(21)	-	241	**220**
Disposals / derecognition	-	-	-	(5,198)	(32)	(2,099)	**(7,329)**
Accumulated depreciation at 31 March 2021	**-**	**841**	**-**	**37,452**	**257**	**11,884**	**50,434**
Net book value at 31 March 2021	**9,641**	**242,075**	**25,001**	**44,248**	**53**	**13,320**	**334,338**
Net book value at 1 April 2020	**9,641**	**250,218**	**9,927**	**32,504**	**71**	**9,309**	**311,670**

Note 13.2 Property, plant and equipment - 2019/20

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Valuation / gross cost at 1 April 2019	9,641	237,920	4,307	57,733	342	16,742	326,685
Additions	-	11,929	5,620	11,931	-	4,290	33,770
Impairments	-	(15,516)	-	-	-	-	(15,516)
Revaluations	-	16,054	-	-	-	-	16,054
Reclassifications	-	-	-	163	-	151	314
Disposals / derecognition	-	-	-	(266)	-	-	(266)
Valuation/gross cost at 31 March 2020	9,641	250,387	9,927	69,561	342	21,183	361,041
Accumulated depreciation at 1 April 2019	-	-	-	32,222	242	10,210	42,674
Provided during the year	-	6,489	-	5,095	29	1,664	13,277
Impairments	-	(2,683)	-	-	-	-	(2,683)
Revaluations	-	(3,637)	-	-	-	-	(3,637)
Disposals / derecognition	-	-	-	(260)	-	-	(260)
Accumulated depreciation at 31 March 2020	-	169	-	37,057	271	11,874	49,371
Net book value at 31 March 2020	9,641	250,218	9,927	32,504	71	9,309	311,670
Net book value at 1 April 2019	9,641	237,920	4,307	25,511	100	6,532	284,011

Note 13.3 Property, plant and equipment financing - 2020/21

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Net book value at 31 March 2021							
Owned - purchased	9,641	175,756	24,589	41,178	53	13,320	**264,537**
Finance leased	-	1,762	-	-	-	-	**1,762**
On-SoFP PFI contracts and other service concession arrangements	-	59,606	-	-	-	-	**59,606**
Owned - donated/granted	-	4,951	412	3,070	-	-	**8,433**
NBV total at 31 March 2021	**9,641**	**242,075**	**25,001**	**44,248**	**53**	**13,320**	**334,338**

Note 13.4 Property, plant and equipment financing - 2019/20

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Net book value at 31 March 2020							
Owned - purchased	9,641	182,479	9,927	31,341	71	9,309	242,768
Finance leased	-	1,818	-	-	-	-	1,818
On-SoFP PFI contracts and other service concession arrangements	-	60,981	-	-	-	-	60,981
Owned - donated/granted	-	4,940	-	1,163	-	-	6,103
NBV total at 31 March 2020	9,641	250,218	9,927	32,504	71	9,309	311,670

Note 14 Donations of property, plant and equipment

The Hull and East Yorkshire Hospitals NHS Trust General Charitable Trust provided donations of medical and general equipment to the Trust to a value of £395k (2019/20 - £116k). There were no restrictions in respect of any of the donations.

In addition the Trust has also received donated equipment from DHSC/NHSE relating to the Covid-19 response. The donated equipment totalled £1.8m

Note 15 Revaluations of property, plant and equipment

Land and buildings were valued as at 31 March 2021 to ensure they were carried on the Statement of Financial Position at current value. The valuation was undertaken by independent RICS qualified valuers Cushman and Wakefield and the valuation was undertaken in line with RICS standards.

The valuation of our buildings has been assessed by a desktop exercise as there was a full valuation last year. This desk top valuation takes into account any updates on their current condition and agreed obsolescence, and assumes that the buildings will be maintained to their current condition over their remaining lives. The valuation has been undertaken on a modern equivalent asset basis and reflects the current service potential of the assets to the Trust.

Whilst in 2019/20 there was a material uncertainty disclosed with regard to the asset valuation, due to the market at the time which was related to the pandemic, there is no such 'material valuation uncertainty' in 2020/21, as defined by VPS 3 and VPGA 10 of the RICS Valuation - Global Standards.

There was an overall net increase in property, plant and equipment of £22.7m which was after a £26.8m impairment of assets of which £11.5m is charged to the revaluation reserve and £15.3m is charged to the SOCI.

Within the above, after accounting for additions, in year depreciation and the impact of the valuation, the movement in the net book value of the buildings from opening 1st April 2020 to closing March 2021, was a reduction of £8.1m.

The gross cost of property plant and equipment with a Nil net book value is £23.99m.

Note 16 Investment Property

Investment assets comprise of land adjacent to the Castle Hill Hospital site. The first part of the land was sold in 2018/19 and a further sale in 2019/20 for £2.95m; the remaining land as part of the staged agreement was sold during 2020/21 for £2.94m

Note 17 Disclosure of interests in other entities

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 £392,165, which has been included in the accounts. The company's main activity is the sale of hardware and software used to train Radiotherapists. Mr D Haire sits on the board on behalf of the Trust.

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.

Note 18 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	5,159	5,414
Consumables	9,823	9,186
Total inventories	**14,982**	14,600
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £160,555k (2019/20: £144,775k). Write-down of inventories recognised as expenses for the year were £193k (2019/20: £0k).

All inventories were valued in accordance with the Trusts accounting policy (note 1), none were held at fair value less costs to sale.

Despite the Covid19 outbreak the majority of Trust stocktakes were able to be completed as expected. Stock takes with a previous year value of £437k were unable to be completed but estimates were made based on an average of the previous 3 years at 75% across the areas, after having discussions with ward managers, these areas included Interventional Radiology, Rheumatology and ICU at HRI. The estimated value came to £321k (75% of previous value). The value of any over or under statement is expected to be small.

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £7,859k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	14,361	33,393
Allowance for impaired contract receivables / assets	(2,104)	(1,440)
Prepayments (non-PFI)	3,798	4,628
PDC dividend receivable	530	-
VAT receivable	1,295	880
Other receivables	1,289	1,035
Total current receivables	**19,169**	38,496
Non-current		
Contract receivables	3,075	3,719
Allowance for impaired contract receivables / assets	(822)	(899)
Other receivables	1,469	1,251
Total non-current receivables	**3,722**	4,071
Of which receivable from NHS and DHSC group bodies:		
Current	8,871	25,576
Non-current	1,469	1,251

Since the adoption of IFRS 15 in April 2018, trade receivables and accrued income have been reclassified as contract assets or other types of receivable.

Note 19.2 Allowances for credit losses

	2020/21 receivables and contract assets £000	2019/20 Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	**2,339**	**1,753**
New allowances arising	713	586
Changes in existing allowances	517	-
Utilisation of allowances (write offs)	(643)	-
Allowances as at 31 Mar 2021	**2,926**	**2,339**

Since the adoption of IFRS 15 in April 2018, trade receivables and accrued income have been reclassified as contract assets or other types of receivable.

Note 20.1 Cash and cash equivalents movements

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

	2020/21	2019/20
	£000	£000
At 1 April	**19,434**	5,611
Net change in year	39,493	13,823
At 31 March	**58,927**	19,434
Broken down into:		
Cash at commercial banks and in hand	12	25
Cash with the Government Banking Service	58,915	19,409
Total cash and cash equivalents as in SoFP	**58,927**	19,434

Note 20.2 Third party assets held by the trust

The Trust operates a staff lottery and the cash balance owed to the lottery is £98,586 which is included in the Trusts financial statements

Note 21 Tade and other Payables

	2021	31 March 2020
	£000	£000
Current		
Trade payables	3,120	1,408
Capital payables	26,808	7,430
Accruals	61,785	43,928
Social security costs	7	4,394
Other taxes payable	17	3,670
PDC dividend payable	-	415
Other payables	5,158	4,859
Total current trade and other payables	**96,895**	66,104
Of which payables from NHS and DHSC group bodies (all current)	2,550	6,796

All payables are due within one year

Included in the figures above are outstanding pension contributions of £5.16m (2019/20 £4.72m). All payables are due within one year.

Note 22 Other liabilities

Other financial liabilities of £0.7m consist entirely of deferred income (2019/20 £0.5m)

Note 23.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	1,278	36,647
Obligations under finance leases	56	56
Obligations under PFI, LIFT or other service concession contracts	1,583	1,929
Total current borrowings	**2,917**	38,632
Non-current		
Loans from DHSC	9,427	10,686
Obligations under finance leases	1,855	1,911
Obligations under PFI, LIFT or other service concession contracts	43,068	44,651
Total non-current borrowings	**54,350**	57,248
Total Borrowings	**57,267**	95,880

Borrowings / Loans - repayment of principal falling due in:	**31 March 2021**		31 March 2020
	£000 DH	**£000 Other**	£000 Total
0-1 Years	1,278	1,639	38,632
1 - 2 Years	1,260	1,713	2,899
2 - 5 Years	3,780	6739	9,787
Over 5 Years	4,387	36,471	44,562
Total	**10,705**	**46,562**	95,880

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalled £35.3m and were classified as current liabilities 0-1 year as at 31 March 2020.

Note 23.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2020	**47,333**	**1,967**	**46,580**	**95,880**
Cash movements:				
Financing cash flows - payments and receipts of principal	(36,555)	(56)	(1,929)	**(38,540)**
Financing cash flows - payments of interest	(512)	(4)	(3,374)	**(3,890)**
Non-cash movements:				
Application of effective interest rate	439	4	3,374	**3,817**
Carrying value at 31 March 2021	**10,705**	**1,911**	**44,651**	**57,267**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2019	54,327	2,022	48,474	104,823
Cash movements:				
Financing cash flows - payments and receipts of principal	(6,989)	(56)	(1,894)	(8,939)
Financing cash flows - payments of interest	(1,083)	(3)	(3,502)	(4,588)
Non-cash movements:				
Application of effective interest rate	1,078	4	3,502	4,584
Carrying value at 31 March 2020	47,333	1,967	46,580	95,880

Note 24 Finance leases

Note 24.1 Hull University Teaching Hospitals NHS Trust as a lessor

Future lease receipts due under finance lease agreements where the trust is the lessor:

The Trust has only one finance lease, and also accounts for its 3 PFI facilities as finance leases. Details of PFI schemes are set out in note 28 to these accounts.

The Daisy charity have constructed a PET CT facility on the Castle Hill site, the facility became operational from April 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 buildings are set out in section 24.2.

Note 24.2 Hull University Teaching Hospitals NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2021 £000	31 March 2020 £000
Gross lease liabilities	**1,979**	2,039
of which liabilities are due:		
- not later than one year;	60	60
- later than one year and not later than five years;	240	240
- later than five years.	1,679	1,739
Finance charges allocated to future periods	(68)	(72)
Net lease liabilities	**1,911**	1,967
of which payable:		
- not later than one year;	56	56
- later than one year and not later than five years;	225	224
- later than five years.	1,630	1,687

There was no contingent rent recognised as an expense during the year (2019/20 £nil)

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Other £000	Total £000
At 1 April 2020	**323**	**631**	**219**	**1,251**	**2,424**
Arising during the year	287	653	118	2,634	**3,692**
Utilised during the year	(65)	(64)	(34)	-	**(163)**
Reversed unused	-	-	(87)	-	**(87)**
Unwinding of discount	(5)	24	-	-	**19**
At 31 March 2021	**540**	**1,244**	**216**	**3,885**	**5,885**
Expected timing of cash flows:					
- not later than one year;	65	65	72	**-**	**202**
- later than one year and not later than five years;	260	258	144	**-**	**662**
- later than five years.	215	921	-	**3,885**	**5,021**
Total	**540**	**1,244**	**216**	**3,885**	**5,885**

The provision for early departure costs represents amounts payable to the NHS Business Services Authority, pensions division, to meet the costs of early retirement and industrial injury benefits. The provision is based on estimate using the ONS figures for life expectancy and therefore there is a degree of uncertainty about the value of payments in the future.

The provision for legal claims relates to claims for injury to staff or members of the Public, where the likelihood of a settlement is probable. All claims are handled by NHS Resolution on behalf of the Trust and they advise on likelihood and value of settlement. The timing and value of settlements are subject to both local negotiation and the judgement of NHS Resolution. The Trust's liability in respect of each claim is limited to the level of excess determined by NHS Resolution.

Included within Legal Claims are permanent injury benefits and Employer's Liability claims; these are linked with contingent liabilities relating to Employer's Liability as disclosed in the note below:

At 31 March 2021 the NHS Resolution held provisions in respect of the Trust's clinical negligence claims of £264.4m (2019/20 - £252m)

With the 'Other' category, we have included a provision for the Flowers legal case of £2,416k

Clinician pension tax reimbursement
Clinicians who are members of the NHS Pension scheme may face a tax charge in respect of the growth of their NHS pension benefits above their pensions savings annual allowance threshold. The government has committed to allowing this charge to be paid by the NHS Pension scheme. The NHS employer will make a contractually binding commitment to pay them a corresponding amount on retirement so that they are not disadvantaged by the charge. The Trust has therefore calculated a provision broadly equal to the tax charge owed by clinicians which is offset by a commitment from NHS England and the Government to fund the payment to clinicians as and when they arise. The provision has been calculated based on the consultant headcount within the NHS pension scheme multiplied by the nationally calculated a 'average discounted value per nomination'

The Clinician pension tax reimbursement for this finanical year is £1,469k, (in 2019/20 it was £1,251k)

Note 25.2 Clinical negligence liabilities

At 31 March 2021, £264,381k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Hull University Teaching Hospitals NHS Trust (31 March 2020: £252,392k).

Note 26 Contingent assets and liabilities

	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(2)	(2)
Employment tribunal and other employee related litigation	(90)	-
Other	-	(571)
Gross value of contingent liabilities	**(92)**	(573)

All contingencies relate to legal claims made against the Trust (Employer and Public liability claims) and 3 employment tribunals, which are accounted for as a contingent liability to the extent that they are not included in any formal provision.

There are no contingent assets

Note 27 Contractual capital commitments

The Trust has contractual capital commitments of £6.3m (2019/20 £1.8m) in respect of equipment & building purchases.

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has three on SOFP PFI schemes none of which have total commitments in excess of £500m

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 February 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.

Note 28.1 Inputed finance lease obligations

Hull University Teaching Hospitals NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2021 £000	31 March 2020 £000
Gross PFI, LIFT or other service concession liabilities	**72,630**	77,932
Of which liabilities are due		
- not later than one year;	4,838	5,302
- later than one year and not later than five years;	20,136	19,851
- later than five years.	47,656	52,779
Finance charges allocated to future periods	(27,979)	(31,352)
Net PFI, LIFT or other service concession arrangement obligation	**44,651**	46,580
- not later than one year;	1,583	1,929
- later than one year and not later than five years;	8,285	7,476
- later than five years.	34,783	37,175

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**196,904**	209,875
Of which payments are due:		
- not later than one year;	12,179	11,925
- later than one year and not later than five years;	51,995	50,901
- later than five years.	132,730	147,049

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21 £000	2019/20 £000
Unitary payment payable to service concession operator	**11,686**	11,418
Consisting of:		
- Interest charge	3,374	3,502
- Repayment of balance sheet obligation	1,929	1,894
- Service element and other charges to operating expenditure	2,255	2,188
- Capital lifecycle maintenance	1,719	1,516
- Contingent rent	2,409	2,318
Total amount paid to service concession operator	**11,686**	11,418

Note 29 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust accounts for the provision of staff residences on its Castle Hill Hospital site as an off SOFP PFI scheme and incurred the following charges

	31 March 2021 £000	31 March 2020 £000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	**81**	81
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	81	81
- later than one year and not later than five years;	324	324
- later than five years.	405	486
Total	**810**	891

Note 30 Financial instruments

Note 30.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with its commissoners (Clinical Commissioning Groups and NHS England) and funding flows from the Treasury, the Trust is not exposed to the degree of financial risk faced by business entities. The pandemic has, however, resulted in changes to the financial arrangements during 2020/21 that will continue to be in place for at least the first six months (H1) of 2021/22. These arrangements are to provide greater certainty and promote System collaboration and will not cause any additional risk. 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 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 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. The Trust's 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 NHS Improvement. 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.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

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 2021 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 Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 30.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Total book value £000
Trade and other receivables excluding non financial assets	15,799
Other investments / financial assets	392
Cash and cash equivalents	58,927
Total at 31 March 2021	**75,118**

Carrying values of financial assets as at 31 March 2020	Total book value £000
Trade and other receivables excluding non financial assets	35,808
Cash and cash equivalents	19,434
Total at 31 March 2020	55,242

All financial assets are held at amortised cost

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Total book value £000
Loans from the Department of Health and Social Care	10,705
Obligations under finance leases	1,911
Obligations under PFI, LIFT and other service concession contracts	44,651
Trade and other payables excluding non financial liabilities	96,871
Total at 31 March 2021	**154,138**

Carrying values of financial liabilities as at 31 March 2020	Total book value £000
Loans from the Department of Health and Social Care	47,333
Obligations under finance leases	1,967
Obligations under PFI, LIFT and other service concession contracts	46,580
Trade and other payables excluding non financial liabilities	57,625
Total at 31 March 2020	153,505

Note 30.4 Maturity of financial liabilities

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	105,463	100,056
In more than one year but not more than five years	25,416	26,422
In more than five years	53,722	60,711
Total	**184,601**	187,189

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 30.5 Fair values of financial assets and liabilities

The carrying value of short term trade and other payables is a reasonable approximation to fair value, all trade payables are considered to be short term. The nature of obligations relating to Finance lease, PFI agreements and other borrowings are that they are arms length transaction with values determined by contract. There is no significant difference between the carrying value and the fair value of these liabilities.

Note 31 Losses and special payments

	2020/21		2019/20	
	Total number of cases	**Total value of cases**	Total number of cases	Total value of cases
	Number	**£000**	Number	£000
Losses				
Bad debts and claims abandoned	4	17	-	-
Stores losses and damage to property	2	-	-	-
Total losses	**6**	**17**	-	-
Special payments				
Ex-gratia payments	15	90	13	65
Total special payments	**15**	**90**	13	65
Total losses and special payments	**21**	**107**	13	65
Compensation payments received		-		-

No compensation payments were received in respect of any of the above.

Note 32 Related parties

Hull University Teaching Hospitals NHS Trust is a corporate body established by order of the Secretary of State for Health.

During the year none of the Board Members or key management staff or parties related to them has undertaken any material transactions with Hull University Teaching Hospitals NHS Trust. However, the Trust had received invoices totalling £23,789.58 from Taywel Engineering Ltd of which the Trust's Director of Estates and Facilities is a Director.

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 £392,165. This is included in the accounts. The company's main activity is the sale of hardware and software used to train Radiotherapists. Mr D Haire sits on the board on behalf of the Trust.

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 and Social Care is also regarded as a related party. During the year Hull University Teaching 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:

NHS Litigation Authority (Resolution)
NHS Blood And Transplant
Leeds Teaching Hospitals NHS Trust
Northumbria Healthcare NHS FT
North Lincolnshire And Goole NHS FT
York Teaching Hospital NHS FT
Humber Teaching NHS Foundation Trust
Salford Royal NHS FT
Calderdale And Huddersfield NHS FT
University Hospitals Birmingham NHS FT
North Tees And Hartlepool NHS FT
Sheffield Teaching Hospitals NHS FT
Oxford Health NHS FT
NHS Business Services Authority
NHS England
NHS Hull CCG
NHS East Riding Of Yorkshire CCG
NHS North Lincolnshire CCG
NHS North East Lincolnshire CCG
NHS Vale Of York CCG
NHS North Yorkshire CCG
NHS Lincolnshire CCG
NHS Doncaster CCG
NHS Leeds CCG

In addition to the above, Hull University Teaching Hospitals NHS Trust has also had a significant number of material transactions with The University of Hull and the two local authorities as listed below;

Hull City Council
East Riding of Yorkshire Council

Note 33 Better Payment Practice code

	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	96,855	277,917	111,858	250,000
Total non-NHS trade invoices paid within target	93,648	253,865	104,821	217,243
Percentage of non-NHS trade invoices paid within target	96.7%	91.3%	93.7%	86.9%
NHS Payables				
Total NHS trade invoices paid in the year	4,237	22,594	3,832	30,934
Total NHS trade invoices paid within target	3,685	19,367	3,280	27,677
Percentage of NHS trade invoices paid within target	87.0%	85.7%	85.6%	89.5%

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 valid invoice, whichever is later.

Note 34 External financing limit

The trust is given an external financing limit against which it is permitted to underspend

	2020/21 £000	2019/20 £000
Cash flow financing	(12,569)	(15,232)
Finance leases taken out in year		
Other capital receipts	-	
External financing requirement	**(12,569)**	(15,232)
External financing limit (EFL)	26,381	(12,352)
Under / (over) spend against EFL	**38,950**	2,880

Note 35 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	64,973	35,415
Less: Disposals	(3,059)	(2,956)
Less: Donated and granted capital additions	(2,608)	(116)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**59,306**	32,343
Capital Resource Limit	59,354	32,349
Under / (over) spend against CRL	**48**	6

Note 36 Breakeven duty financial performance

	2020/21 £000
Adjusted financial performance surplus / (deficit) (control total basis)	246
Remove impairments scoring to Departmental Expenditure Limit	1,243
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**1,489**

Note 37 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		7,601	4,701	4,878	5,420	5,943	2,926
Breakeven duty cumulative position	3,180	10,781	15,482	20,360	25,780	31,723	34,649
Operating income		469,995	480,633	499,538	497,132	506,703	526,559
Cumulative breakeven position as a percentage of operating income		2.3%	3.2%	4.1%	5.2%	6.3%	6.6%

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(8,051)	2,616	(7,134)	25,220	11,072	1,489
Breakeven duty cumulative position	26,598	29,214	22,080	47,300	58,372	59,860
Operating income	526,253	561,128	579,847	629,192	662,676	726,808
Cumulative breakeven position as a percentage of operating income	5.1%	5.2%	3.8%	7.5%	8.8%	8.2%

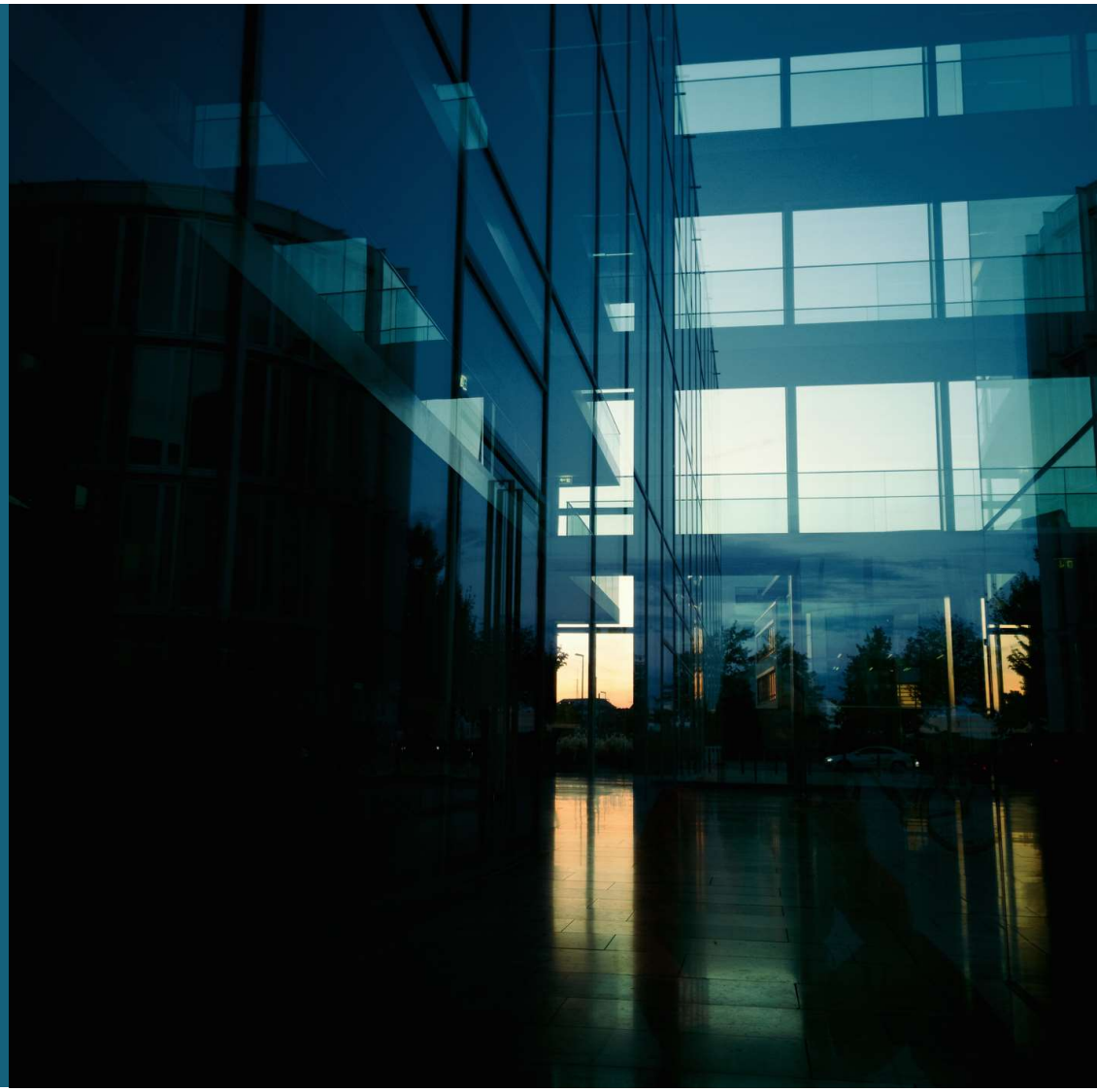
Note 38 Adjusted Financial Performance (SoCI control total basis)

	2020/21	2019/20
Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	(10,973)	(1,010)
Remove net impairments not scoring to the Departmental expenditure limit	14,016	11,720
Remove I&E impact of capital grants and donations	(2,162)	362
Remove 2018/19 post audit PSF reallocation (2019/20 only)	-	(577)
COVID response	(635)	-
Adjusted financial performance surplus / (deficit)	**246**	10,495

Auditor's Annual Report

Hull University Teaching Hospitals NHS Trust– year ended 31 March 2021

August 2021



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Contents

01

Section 01:

Introduction

1. Introduction

Purpose of the Auditor's Annual Report

Our Auditor's Annual Report (AAR) summarises the work we have undertaken as the auditor for Hull University Teaching Hospitals NHS Trust ('the Trust') for the year ended 31 March 2021. Although this report is addressed to the Trust, it is designed to be read by a wider audience including members of the public and other external stakeholders.

Our responsibilities are defined by the Local Audit and Accountability Act 2014 and the Code of Audit Practice ('the Code') issued by the National Audit Office ('the NAO'). The remaining sections of the AAR outline how we have discharged these responsibilities and the findings from our work. These are summarised below.

Opinion on the financial statements
We issued our audit report on 15 June 2021. Our opinion on the financial statements was modified. This was due to us not being able to obtain sufficient appropriate audit evidence, through stocktake attendance, on the inventory balances within the Trust's financial statements as a result of the COVID-19 government guidance.

Wider reporting responsibilities
In line with group audit instructions issued by the NAO, on 15 June 2021 we reported that the Trust's consolidation schedules were consistent with the audited financial statements.

Value for Money arrangements
In our audit report issued on the 15 June we reported that we had not completed our work on the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources and had not issued recommendations in relation to identified significant weaknesses in those arrangements at the time of reporting. Section 3 confirms that we have now completed this work and provides our commentary on the Trust's arrangements.

Following the completion of our work we have issued our audit certificate which formally closes the audit for the 2020/21 financial year.

02

Section 02:

Audit of the financial statements

2. Audit of the financial statements

The scope of our audit and the results of our opinion

Our audit was conducted in accordance with the requirements of the Code, and International Standards on Auditing (ISAs).

The purpose of our audit is to provide reasonable assurance to users that the financial statements are free from material error. We do this by expressing an opinion on whether the statements are prepared, in all material respects, in line with the financial reporting framework applicable to the Trust and whether they give a true and fair view of the Trust's financial position as at 31 March 2021 and of its financial performance for the year then ended. Our audit report, issued on 15 June 2021 gave a modified opinion on the financial statements for the year ended 31 March 2021. This was due to us not being able to obtain sufficient appropriate audit evidence, through stocktake attendance, regarding the condition and existence of inventory at 31 March 2021 and 31 March 2020 as a result of the COVID-19 government guidance.

Qualitative aspects of the Trust's accounting practices

We reviewed the Trusts accounting policies and disclosures and concluded they comply with Department of Health and Social Care Group Accounting Manual 2020/21, appropriately tailored to the Trusts circumstances.

Draft accounts were received from the Trust on 27 April 2021 and were of a good quality.

Significant difficulties during the audit

We did not encounter any significant difficulties during the course of the audit and we had the full co-operation of management. It is however worth noting that our audit work was carried out through remote working arrangements as a result of the constraints imposed by the COVID-19 pandemic. This included the effective use of technology and close liaison with finance and other officers of the Trust. We would like to thank the Finance Team for the quality of their supporting working papers and for being available throughout the audit to answer our queries.

Internal control recommendations

As part of our audit we considered the internal controls in place that are relevant to the preparation of the financial statements. We did this to design audit procedures that allow us to express our opinion on the financial statements, but this did not extend to us expressing an opinion on the effectiveness of internal controls.

We identified a small number of opportunities to improve internal control as part of our audit and raised three internal control recommendations. All three related to opportunities for the Trust to better evidence performance and review of routine bank and payroll reconciliations. Management agreed to address these recommendations with immediate effect.

03

Section 03:

Commentary on VFM arrangements

3. VFM arrangements – Overall summary

Approach to Value for Money arrangements work

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The NAO issues guidance to auditors that underpins the work we are required to carry out and sets out the reporting criteria that we are required to consider. The reporting criteria are:

- **Financial sustainability** - How the Trust plans and manages its resources to ensure it can continue to deliver its services
- **Governance** - How the Trust ensures that it makes informed decisions and properly manages its risks
- **Improving economy, efficiency and effectiveness** - How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

At the planning stage of the audit, we undertake work so we can understand the arrangements that the Trust has in place under each of the reporting criteria; as part of this work we may identify risks of significant weaknesses in those arrangements. Where we identify significant risks, we design a programme of work (risk-based procedures) to enable us to decide whether there is a significant weakness in arrangements. Although we describe this work as planning work, we keep our understanding of arrangements under review and update our risk assessment throughout the audit to reflect emerging issues that may suggest there are further risks of significant weaknesses.

Where our risk-based procedures identify actual significant weaknesses in arrangements, we are required to report these and make recommendations for improvement.

The table below summarises the outcomes of our work against each reporting criteria. On the following page we outline further detail of the work we have undertaken against each reporting criteria, including the judgements we have applied.

Reporting criteria	Commentary page reference	Risks of significant weaknesses in arrangements identified?	Actual significant weaknesses in arrangements identified?
Financial sustainability	9	No	No
Governance	11	No	No
Improving economy, efficiency and effectiveness	13	No	No

3. VFM arrangements – Financial Sustainability

Overall commentary on the Financial Sustainability reporting criteria

Overall responsibilities for financial governance

We have reviewed the Trust's overall governance framework, including Board and committee reports, the Annual Governance Statement, and Annual Report and Accounts for 2020/21. These confirm the Trust Board undertook its responsibility to define the strategic aims and objectives, approve budgets and monitor financial performance against budgets and plans to best meet the needs of the Trust's service users.

The Performance and Finance Committee oversees all aspects of financial management and operational performance on behalf of the Board.

The Performance and Finance Committee met on 8 occasions during the year and was stood down between October 2020 and January 2021 due to the pandemic and operational pressures. The focus was on the detailed Integrated Performance exception report, specifically the Trust's underlying performance against the key NHS Constitution standards and the Trust's financial plan, which are standing agenda items discussed at each meeting. Other substantive agenda items have also been the financial position of the Trust, particularly the financial performance of the Trust's health groups and their contribution to the Trust's underlying and overall position. The Committee has also monitored capital expenditure to ensure it remains in line with plan. The Non-Executive Chair of the Performance and Finance Committee provides a briefing to the Board after each meeting.

Our review of supporting papers confirmed the Committee complied with its Terms of Reference effectively throughout 2020/21.

Background to the NHS financing regime in 2020/21

Following the onset of the Covid-19 pandemic in March 2020, the original NHS Planning Guidance 2020-21 was suspended and a new financial regime was implemented. For the first half of the year (April to September 2020) all NHS trusts and NHS foundation trusts were moved to block contract payments 'on account' and the usual Payment by Results national tariff payment process was suspended. The Financial Recovery Fund was also suspended and NHS providers were able to claim for additional costs due to COVID-19. Whilst commissioner allocations for 2020-21 had already been notified, individual commissioner financial positions were kept under review and top-up payments were issued to CCGs to cover the difference between allocations and expected costs to pass on to providers.

For the second half of the year (October 2020 to March 2021) there was a move to "system envelopes" with funding allocations covering most NHS activity made at the health economy or system level, including resources to meet the additional costs of the Covid-19 pandemic. There were no further general retrospective top-up payments and all Covid-19 costs from that point were funded through the fixed Covid-19 funding allocation with a few exceptions.

Systems or local health economies were expected to achieve financial balance within this envelope and individual organisations were able to deliver surplus or deficit positions by mutual agreement within the system. However, NHS trusts and foundation trusts were still required to meet statutory break-even duty and CCGs required to meet their resource limits.

At 31 March 2021 the Trust reported an adjusted surplus of £246,000, against a deficit plan of £6.5m. This was due to a number of non-recurrent nationally funded items.

The Trust's arrangements and approach to 2020/21 and 2021/22 financial planning

Throughout the year the Trust reported its financial position to the Performance and Finance Committee. This detailed any variances from the plan and provided explanations. The financial position was appropriately challenged at these meetings, with appropriate corrective action identified and implemented.

The Trust manages any identified funding gaps through its efficiency programme, which the Productivity and Efficiency Board has oversight of. As a result of the changes to the financial regime, the efficiency programme for 2020/21 was suspended. A small amount of central efficiencies were delivered during the period. There is a small efficiency programme in place for the first half of 2021/22, with the Trust planning for the full programme to recommence in October 2021. The current expectation is around 3% efficiency savings will be expected.

The Trust's financial plans are underpinned by the national planning guidance and is also closely linked to the Trust's Strategy, which ensures that its financial plans are consistent with other plans (e.g. workforce, capital and other operational plans). These financial plans are subject to review and approval – first by the Performance and Finance Committee and then by the Board. This includes scrutiny and challenge of the key risks and assumptions and consideration of the plans to manage the risk including sensitivity analysis. The plans are then subject to approval by the Integrated Care System ('ICS') and NHS England which add a further layer of scrutiny and challenge.

The financial framework for 2021/22 will continue to build on the system envelopes based on the H2 2020/21 funding envelopes and including a continuation of the system top-up and Covid-19 fixed allocation arrangements. The total quantum will be adjusted to issue additional funding for known pressures and key policy priorities (including inflation, primary care and mental health services).

3. VFM arrangements – Financial Sustainability

Overall commentary on the Financial Sustainability reporting criteria - continued

System envelopes will also be adjusted to reflect an efficiency requirement increasing through the second quarter and with an increased requirement for those systems that had deficits compared to 2019/20 financial trajectories at the end of 2019/20. Specific system productivity measures will be developed to align with national priorities. The current block contract payments approach will continue for NHS providers.

The Trust have submitted a financial plan up to September 2021 to NHS Improvement which is in accordance with national guidance and plans to deliver a £1.7m deficit.

Given the NHS's national response to the Covid-19 pandemic, and the changes to the financial regime, the Trust have had to adapt their arrangements during the year. We have not identified any significant weaknesses in relation to financial sustainability.

Conclusion

Whilst there are ongoing challenges to the Trust's financial position, we have not identified any significant weakness in the Trust's arrangements in relation to the financial sustainability reporting criteria.

3. VFM arrangements – Governance

Overall commentary on the Governance reporting criteria

The Trust's arrangements for financial and performance monitoring

As noted above, the financial regime changes for 2020/21 removed the need for Trust's to produce detailed annual budgets as previously required. However, the Trust did continue to monitor and report its financial position on a monthly basis which included reasons for any variances to the plan and any mitigations that had been put in place.

On a monthly basis the Trust have reported their performance against the required NHS standards to the Performance and Finance Committee. The reports detail the Trust's performance against the target for all standards, as well as highlighting the key concerns, most improved and most deteriorated. As part of the reporting, peer comparison is included to assess the Trust's performance against its peers. Mitigating actions are also reported to show how poor performance will be improved.

The Trust's risk management and monitoring arrangements

The Trust Board is responsible for setting the Risk Management Policy for the organisation. This Policy describes the organisation's approach to risk and risk management. It defines the leadership roles within the Trust for risk management. In addition, staff across the Trust receive risk management training, in order to identify and report risks. The Trust has a well-established process for entering risks on to its risk register and risks are regularly reviewed.

All risks entered on the Trust risk management system are assigned an 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 and corporate services. 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.

At Trust Board level, the Board assesses its performance and discusses associated risks at each meeting, through the presentation of the Integrated Performance Report, which includes all NHS Improvement Single Operating Framework metrics. An exception report on these measures is discussed in more detail at the Board's Performance and Finance Committee and the more detailed quality issues at the Board's Quality Committee. The positive assurance and gaps in assurance are captured in the Board Assurance Framework, reviewed regularly by the Trust Board and its committees.

The Trust's decision-making arrangements and control framework

The Trust has an established governance structure in place which is set out within its Annual Governance Statement. This is supported by the Trust's Constitution and scheme of delegation. Executive Directors have clear responsibilities linked to their roles and the Board Sub-Committee structure in place at the Trust allows for effective oversight of the Trust's operations and activity.

Throughout 2020/21 the Trust continued to operate its Board meetings and sub committees as in prior years, however these were all held remotely. The Performance and Finance Committee was stood down between October 2020 and January 2021 to enable the Trust to respond to the Covid-19 second wave. The papers and minutes from the Committee meetings demonstrate a good level of challenge from committee members. The information presented to the Committees is timely and sufficiently detailed to support properly informed decision making.

The Trust has approved Terms of Reference for the Board and each sub-committee. These ensure each committee works within the approved remit and that responsibilities are clear. The Trust has Standing Orders and Standing Financial Instructions in place which are available to staff via the intranet. They are sufficiently detailed to ensure appropriate standards are adhered to.

The Trust has a full suite of governance arrangements in place. These are set out in the Trust's Annual Report and Annual Governance Statement. We reviewed these documents as part of our audit and confirmed they were consistent with our understanding of the Trust's arrangements in place. This includes arrangements such as a register of interests and gifts and hospitality being maintained which are regularly reviewed and updated and considered by the Audit Committee on a regular basis.

In order to provide assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud, the Trust has appointed internal auditors and local counter fraud specialists. Work plans are agreed with management at the start of the financial year and reviewed by Audit Committee prior to final approval.

3. VFM arrangements – Governance

Overall commentary on the Governance reporting criteria - continued

We have reviewed the Internal Audit Plans for 2020/21 and 2021/22 and confirmed planned work is reasonable and relevant to the Trust. Progress reports are presented to each Audit Committee meeting including follow up reporting of recommendations not fully implemented by agreed due dates. This allows the Committee to effectively hold management to account on behalf of the Board. Our attendance at Audit Committees throughout the period confirms the significance placed on internal audit findings. Members of the committee actively request management attendance at committees to discuss findings from internal audit reports.

Audit Committee members are appropriately skilled to undertake their role and provide appropriate challenge to Management and Internal and External Audit.

Conclusion

Given the above, we are satisfied there is not a significant weakness in the Trust's arrangements in relation to the governance reporting criteria.

3. VFM arrangements – Improving Economy, Efficiency and Effectiveness

Overall commentary on the Improving Economy, Efficiency and Effectiveness reporting criteria

The Trust's arrangements for assessing performance and evaluating service delivery

The Trust has access to a number of sources of data to identify areas for improvement, this includes the Use of Model Hospital data and Trust Patient Level Costing Data (PLICS) data, National Cost Collection Index (NCCI), and Benchmarking data. This data is used by the Trust to assess its performance and identify areas for improvement. The Productivity and Efficiency Board are responsible for co-ordinating activities for driving improvements across the Trust. An action tracker to monitor actions and output is maintained and updated regularly. As a result of Covid-19 and in accordance with national directives, many of the actions/meetings have been put on hold during 2020/21. Health Groups are involved in this process to ensure maximum engagement and efficiencies are achieved.

The Trust has a Quality committee that considers lessons learned and supports the development of a learning culture and safety culture, particularly following Serious Incident Investigations. At each meeting the Committee receive a report from the Operational Quality Committee, which includes any points of escalation to the Quality Committee. The Board is advised of any escalation issues following each meeting by the Non-Executive Quality Committee Chair. This escalation process ensures issues are communicated and addressed across the Trust.

The latest full CQC inspection of the Trust was undertaken in 2018 and the Trust was rated as requires improvement overall but obtained good ratings in the effective, caring and well-led domains. The Trust received a further inspection in March 2020, but the well-led inspection was not completed, due to all routine inspections being suspended on 16 March 2020 as a response to the Covid-19 pandemic.

The Trust's arrangements for effective partnership working

The Trust has historically demonstrated strong partnership working with key stakeholders across the Humber Coast and Vale (HCV) Integrated Care System. The Trust is a member of a number of groups across the Humber region including the HCV Partnership Board, HCV Acute Provider Collaborative Board, Cancer Alliance Board and HCV Local Maternity System.

Due to the revised arrangements in place in 2020/21, the Trust has worked even closer with partner organisations across the Humber, Coast and Vale Care Partnership to deliver a sustainable financial position for the wider area in addition to agreeing the Trust's financial control totals.

In 2020-21, the Trust continued working as a key partner within the Humber Coast and Vale Health and Care Partnership (HCP). The Trust is jointly leading a Humber Acute Services Review within the HCP together with Northern Lincolnshire and Goole NHS Foundation Trust and the four Humber Clinical Commissioning Groups.

The aim of the collaboration is to make services more sustainable. The first phase is due to go live in 2021/22 which will see The Trust combining services for three specialities with Northern Lincolnshire and Goole Hospitals NHS Foundation Trust. During 2020/21 workstreams have been set up to review how the services will be provided, and ensure the financial flows support the clinical models.

The Trust's arrangements for commissioning services

The Trust has a dedicated, professionally qualified procurement team in place. The team is led by the Head of Procurement and sits centrally within the Trust and provides procurement expertise to health groups. The Head or Procurement reports directly to the Director of Finance. Procurement policies and procedures are set out within the Trust's Standing Financial Instructions and Contracts Department Procedure Manual.

Six monthly reports are sent out to health groups, detailing the tenders they have in process and those contracts that are coming up for renewal. Each tender has a service specification that is drawn up in consultation with the health group and sets out the requirements for the contract. A selective questionnaire sets out the minimum requirements and confirms compliance with the Modern Slavery Act, outlines contingency planning and specifies other mandatory questions that form part of the core selection process. Evaluation teams are set up, including representatives from the relevant health group. The evaluation team assess the bids against the award criteria and recommend who should be awarded the contract. Approval thresholds are set, with all contracts over £1m having to be approved by the Performance and Finance Committee and all contracts over £3m being approved by Trust Board. Our review of the Committee and Board papers confirmed that contract award recommendations are taken to and approved by the Performance and Finance Committee and Trust Board.

Conflicts of interest are monitored and the evaluation team are asked to declare any interests, which are documented as part of the overall procurement process. Any waivers to Standing Financial Instructions are subject to approval. Our attendance at the Audit Committee confirms it receives regular reports on any breaches of Standing Financial Instructions and Single Tender Waivers to assure the Board that the Trust is working in accordance with relevant legislation, professional standards and internal policies. Sufficient information is provided to enable an adequate level of review and we have observed an appropriate level of challenge from Committee members through the year.

Conclusion

Given the above, we are satisfied there is not a significant weakness in the Trust's arrangements in relation to the economy, efficiency and effectiveness reporting criteria.

04

Section 04:

Other reporting responsibilities and our fees

4. Other reporting responsibilities and our fees

Matters we report by exception

The Local Audit and Accountability Act 2014 provide auditors with specific powers where matters come to our attention that, in their judgement, require specific reporting action to be taken. Auditors have the power to:

- issue a report in the public interest;
- make a referral to the Secretary of State Trusts; and
- Make a written recommendation to the Trust which must be responded to publicly.

We have not exercised any of these statutory reporting powers.

We are also required to report if, in our opinion, the governance statement does not comply with relevant guidance or is inconsistent with our knowledge and understanding of the Trust. We did not identify any matters to report in this regard.

Reporting to the NAO in respect of consolidation data

The NAO, as group auditor, requires us to report to them whether consolidation data that the Trust has submitted is consistent with the audited financial statements. We completed the required procedures and concluded and reported, on the 15 June 2021, that the consolidation data is consistent with the audited financial statements.

4. Other reporting responsibilities and our fees

Fees for work as the Trust's auditor

We reported our proposed fees for the delivery of our work under the Code of Audit Practice in our Audit Strategy Memorandum presented to the Audit Committee in January 2021. Having completed our work for the 2020/21 financial year, we can confirm that our fees are as follows:.

Area of work	2020/21 fees
Fee in respect of our work under the Code of Audit Practice	£85,000
Total fees	**£85,000**

Fees for other work

We have been engaged to carry out the audit of the charitable fund. The fee for 2020/21 is £3,500.

Mark Dalton, Director – Public Services

Mazars
5th Floor
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Mazars is an internationally integrated partnership, specialising in audit, accountancy, advisory, tax and legal services*. Operating in over 90 countries and territories around the world, we draw on the expertise of 40,400 professionals – 24,400 in Mazars' integrated partnership and 16,000 via the Mazars North America Alliance – to assist clients of all sizes at every stage in their development.

*where permitted under applicable country laws.

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Audit Completion Certificate issued to the Directors of Hull University Teaching Hospitals NHS Trust for the year ended 31 March 2021

In our auditor's report dated 15 June 2021 we explained that the audit could not be formally concluded until we had completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

This work has now been completed.

No matters have come to our attention since 15 June 2021 that would have a material impact on the financial statements on which we gave our qualified opinion.

The Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in this respect.

Certificate

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

Mark Dalton, Key Audit Partner
For and on behalf of Mazars LLP

5th Floor
3 Wellington Place
Leeds
LS1 4AP

23 August 2021

Independent auditor's report to the Directors of Hull University Teaching Hospitals NHS Trust

Report on the audit of the financial statements

Qualified opinion on the financial statements

We have audited the financial statements of Hull University Teaching Hospitals NHS Trust ('the Trust') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2020/21 as contained in the Department of Health and Social Care Group Accounting Manual 2020/21, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, except for the possible effects of the matter described in the 'Basis for qualified opinion' section of our report, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

The carrying amount of the Trust's inventory balance held at 31 March 2021 is £14.982 million. We were unable to obtain sufficient appropriate audit evidence about the existence and condition of the inventory balance held by the Trust at 31 March 2021 because we were unable to attend the year-end physical inventory counts due to COVID-19 related travel restrictions. We were unable to satisfy ourselves by alternative means concerning the existence and condition of inventory held by the Trust as at 31 March 2021 by using other audit procedures because of the nature of the Trust's accounting records. Consequently, we were unable to determine whether any adjustments to this amount were necessary.

In addition, the predecessor auditor was unable to obtain sufficient appropriate audit evidence about the existence and condition of the inventory balance held by the Trust at 31 March 2020 of £14.600 million because the predecessor auditor was unable to attend the year-end physical inventory counts due to COVID-19-related travel restrictions. Consequently, we were unable to determine whether any adjustment to this amount at 31 March 2020 was necessary, or whether there was any consequential effect on operating expenses in relation to inventory expenditure for the year ended 31 March 2021.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern
In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

Other information
The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of the Directors and the Accountable Officer for the financial statements
As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2020/21 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

Auditor's responsibilities for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the NAO in April 2021.

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

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception
We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2021.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accountable Officer
As explained in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources
We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice
We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS Improvement; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Board of Directors of Hull University Teaching 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 Directors of the Trust 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 Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

Mark Dalton, Key Audit Partner
For and on behalf of Mazars LLP

5th Floor
3 Wellington Place
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15 June 2021