NHS
Hull University Teaching Hospitals
NHS Trust

ANNUAL REPORT 2021/22

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2021/22

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PERFORMANCE REPORT

This section of our Annual Report 2021/22 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.

ANNUAL REPORT 2021/22

STATEMENT FROM THE CHIEF EXECUTIVE

The fingerprints of the COVID-19 pandemic are everywhere, on the health and wellbeing of staff, on recruitment and retention, on waiting times for treatment, on rising costs and balance sheets.

The impact that COVID-19 has had on the NHS and our Trust will be felt for years to come. This year has been about understanding how we recover from COVID-19 but at the same time setting out what kind of Trust we want to be in the future as we learn to live with this virus and do whatever we can to return ourselves to some sort of normality.

If anything epitomises our current position it is the conflicting priorities of delivering more patient care activity than ever before at the same time as protecting our staff from stress and ill health. For the past twelve months we have repeatedly asked more and more of our staff and this is set to continue as we work to meet the needs of our patients, whether that be those who require emergency care or a planned operation or appointment.

I must apologise to anyone who is currently waiting longer than they expected to be seen. Like many other trusts around the country, our waiting lists for planned surgery grew notably during the pandemic when elective surgery was halted to divert staff and resources to the COVID-19 effort. This is not a situation we want for anyone and it is why so much of our current focus is on recovering this position. During the year we have used a number of independent sector providers to help reduce our waiting lists. This work includes outpatient, day case and inpatient activity. In the longer-term we are creating more theatre capacity with the opening of a brand new £10m Day Surgery Unit on the Castle Hill site which is making good progress and we hope the first phase will open early in 2022/2023. This will contain four brand new operating theatres and will enable us to perform almost 10,000 more operations per year by 2023. As I write this introduction we are also developing a business case to expand that capacity even further enabling us to open another eight operating theatres within the same facility.

Where emergency care is concerned COVID-19 has impacted greatly on our ability to admit new patients as well as move patients through our hospitals and the demand for our services is relentless. The only way to address the flow of patients through the hospital and our health system is by working closely with the local authorities, City Health Care Partnership and our commissioners to ensure services outside of hospital are able to not only receive patients from us but also prevent patients from coming to hospital in the first place. I am grateful to all of those organisations who continue to work with us to tackle this issue.

Away from direct patient care, in November 2021 I was very proud to launch our ambition to be a carbon zero organisation by 2030. The NHS has a huge impact on our carbon footprint, producing 5.4% of the UK's total vcarbon emissions. That's equivalent to the greenhouse gas emissions of 11 coal-fired power stations. Our contribution to reducing the nation's carbon footprint cannot be underestimated.

Zero30 sets out seven goals for our Trust around areas such as supply chains, buildings emissions, travel and transport, waste and water. In a relatively short space of time we have made good progress against many of these and we certainly raised a few eyebrows with the opening of our solar field at Castle Hill which is now providing all of the electricity needs for that site as the days become longer and lighter. The challenge for us now is to engage our staff and ask them for their contributions and ideas. Those of you who follow us on social media will see routine updates on our Zero30 programme throughout the next year.

In the same month we saw the opening of our new 24 bed ICU build at Hull Royal Infirmary. ICU has been on the frontline of the pandemic since the start and in many ways it was this that highlighted our need for more capacity and improved facilities. This three-storey unit, next to our Emergency Department, features modern isolation facilities which we hope will enable us to cope with further waves of Covid-19 or another pandemic in the future.

Also opening this year was the Allam Diabetes Centre, largely funded by local philanthropist Dr Assem Allam and serving as a hub to treat more than 9,000 people every year for diabetes and metabolic bone diseases such as osteoporosis. It provides a significantly expanded range of accommodation for world-class diabetes and endocrinology research and other research teams. We are incredibly grateful to Dr Allam and his family for their continued generosity in supporting our hospitals, our patients and our wider city.

My final word on 2021/2022 goes to our team here at HUTH. I have run out of superlatives to describe the depth of compassion they bring to the care of our patients, the lengths they will go to in order to keep patients safe and the physical and mental stamina they have demonstrated over the past year. We remain committed to helping and supporting them in every which way we can to protect them from being overworked, whether that's through ensuring we recruit to fill any vacancies, offering wellbeing services or simply being on hand to listen to them and help to address any concerns they might have. I cannot thank each and every one of the enough for everything they have done for this Trust and our patients over the last year.

I trust that this annual report will provide you with more of the detail that sits behind the areas I have covered here and I thank you for taking time and interest in Hull University Teaching Hospitals NHS Trust.

Chris Long, Chief Executive Officer

PURPOSE AND ACTIVITIES OF THE TRUST

We are situated in the geographical area of Kingston upon Hull and the East Riding of Yorkshire. We employ 8,356 staff, have an annual turnover of £794m (2020/21) and operate from two main sites - Hull Royal Infirmary and Castle Hill Hospital – whilst delivering a number of outpatient services from locations across the local health economy area.

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.

Our secondary care service portfolio is comprehensive, covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services are provided primarily to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

We provide specialist and tertiary services to a catchment population of between 1.05 million and 1.25 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services.

We are designated as a Cancer Centre, Cardiac Centre, Vascular Centre and a Major Trauma Centre. We are a university teaching hospital and a partner in the Hull York Medical School.

In 2021/22 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, Strategy and Planning, Finance, Human Resources including Education and Development, Quality Governance, Corporate Governance, Information Management and Technology).

We were formed in October 1999 through the merger of the former Royal Hull Hospitals and East Yorkshire Hospitals NHS Trusts and became the Hull and East Yorkshire Hospitals NHS Trust.

On 1st March 2019 the Trust formally changed its name to Hull University Teaching Hospitals NHS Trust in order to strengthen links with Hull University, particularly in respect of teaching and academic opportunities, and to bring about positive benefits in respect of recruitment, especially in relation to clinical posts across medical, nursing and professions allied to health. Research and innovation features as one of our seven organisational goals as it reflects the Trust's aspiration to be a research centre of excellence, engendering an innovation culture.

OUR TRUST IN NUMBERS

TURNOVER
£600 MILLION

POPULATION SERVED
600,000

STAFF
8,356

BIRTHS
4,900

BEDS
1,085

OUR MISSION, VISION AND VALUES AT HUTH

Our Mission is to lead the provision of outstanding care and contribute to improved population health, by being a great employer and partner, living our values and spending money wisely.

Our vision is 'Great Staff, Great Care, Great Future', as 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.

GREAT STAFF

- We will have one of the most engaged and satisfied staff in the NHS
- We will be the employer of choice locally and regionally
- We will have fewer vacancies and lower turnover
- Our leadership team will be more diverse
- We will provide leadership to the health and social care system and support the emerging Integrated Care System
- We will have a strong culture of team led continuous improvement

GREAT CARE

- We aim to achieve an 'Outstanding' overall rating by the CQC
- We will increase harm free care
- More of our patients will recommend us to friends and family; we will becomeone of the highest rated Trusts
- Working with partners, we will transform the care for frail, older patients and those with long term conditions
- We will radically improve our outpatient service, using technology to enable better access
- We will further develop our specialist cancer, cardiac and major trauma services

GREAT FUTURE

- We will forge lasting and impactful partnerships with our neighbouring hospitalsthat sustain acute services
- We will develop our new international partnerships to mutually benefit our research and training programmes
- Our research programme will deliver ambitious goals and secure good national rankings in key areas
- We will become a 'digital first' organisation
- We will agree an ambitious estates plan that delivers our clinical strategy and replaces or renews our oldest clinical facilities
- We will secure the long term financial health in the Trust and working with partners, across the system

OUR VALUES

We have developed a set of organisational values - 'Care, Honesty, Accountability' - in conjunction with our staff and these form the basis of a Staff Charter which sets out the behaviours which staff expect from each other and what staff can expect from the Trust in return. The values are reflected in our organisational goals for 2022-2024.

CARE

We are polite and courteous, welcoming & friendly. We smile and we make time to listen to our patients and staff. We consider the impact our actions have on patients and colleagues. We take pride in our appearance and our hospitals and we try to remain positive.

We do not treat anyone unfairly. We do not let our mood affect the way we treat people. We don't talk negatively about colleagues or other teams. Offensive language, shouting, bullying and spreading rumours are unacceptable.

HONESTY

We tell the truth compassionately. We involve patients in decisions about their care and we are honest when things go wrong. We always report errors and raise concerns we have about care. Our decisions and actions are based on facts not stories and opinions.

We do not withhold information from colleagues or patients. We never discourage staff from reporting concerns. We are not careless with confidential information. We do not present myths as facts.

ACCOUNTABILITY

We are all responsible for our decisions and actions and the impact these have on care. All staff are responsible for maintaining high standards of practice and we take every opportunity to continuously learn. Everyone is encouraged to speak up and contribute their ideas to improve the care we provide.

We do not unfairly blame people. We positively embrace change and we don't discourage people from having opinions. Controlling behaviours and silo working should not be exhibited in our trust.

We have developed a set of organisational values - 'Care, Honesty, Accountability' - in conjunction with our staff and these form the basis of a Staff Charter which sets out the behaviours which staff expect from each other and what staff can expect from the Trust in return. The values are reflected in our organisational goals for 2022-2024.

Supporting our over-arching Trust Strategy, are some specific strategies, which will help us develop and deliver our aims:

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

Details of these strategies can be found on our website: **https://www.hey.nhs.uk/about-us/corporate-documents/**

Over the coming months we will be refreshing our Trust Strategy and its accompanying enabling strategies to reflect current and future external and internal influences on our organisation and ensure harmonisation with those of NLaG, the Humber Acute Services Programme, and the Humber Coast and Vale Integrated Care System.

OUR CARE QUALITY COMMISSION (CQC) RATING

The Trust was not inspected during 2021/22 by the Care Quality Commission. The Care Quality Commission undertook an inspection of a selection of the Trust's core services in March 2020 but due to Covid-19, was not able to complete the scheduled Well-led assessment.

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.

PARTNERSHIPS AND INTEGRATED SERVICES

In 2021/22, 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.

VALUED, SKILLED AND SUFFICIENT STAFF

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 2022 had already commenced prior to year-end.

The Trust has seen a deterioration in the Staff Survey in 2021/22. Re-deployment of staff and pressures due to the pandemic are the key factors.

The Trust focussed on the detailed findings of the national Staff Survey and the following have been put into place:

- A series of virtual executive led focus groups
- Staff Survey results presented at the Health Group business meetings
- Launch of a bi-monthly staff forum from April 2022
- Barrett Values survey to be rolled out in 2022
- Executive led manager briefing/feedback sessions

HONEST CARING ACCOUNTABLE FUTURE

The Trust's financial position was less challenging throughout 2021/22 due to the pandemic and the 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

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The Trust will recruit from the newly qualifying nurses in September each year; the recruitment process for September 2022 had already commenced prior to year-end.

HIGH QUALITY CARE

The Trust has not been inspected by the CQC in 2021/22 but regular engagement meetings have taken place. The Trust also submitted an Infection Prevention Control Board Assurance Framework.

In April 2021, NHSEI submitted the Quality Risk Profile tool for the Trust to complete and provide supporting evidence. It was agreed that the Trust would move to enhanced monitoring surveillance for the following risks:

- Discharges and Patient Flow with impact on quality and safety
- Significant waiting list issues including access to screening and follow-up programmes
- Persistent failure of A&E target – percentage of patients who spend 4 hours or less in A&E
- Quality issues identified due to handover delays
- > 52 week waiters
- All cancers – maximum 62-day wait for first treatment from an urgent GP referral for suspected cancer. NHS cancer screening referral

The Trust has reported 5 Never Events compared to 3 in the previous year. A full investigation has taken place for each incident.

It is a key aim of the Trust to move its CQC 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.

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 2021/22 due to the pandemic on our waiting lists and ability to achieve the constitutional standards.

Our Recovery Plans for the coming year include actions to reduce our longest waits and restore our elective services to pre-pandemic levels and above.

The Trust recognises that changes are needed to the way in which clinical services are configured, delivered and resourced.

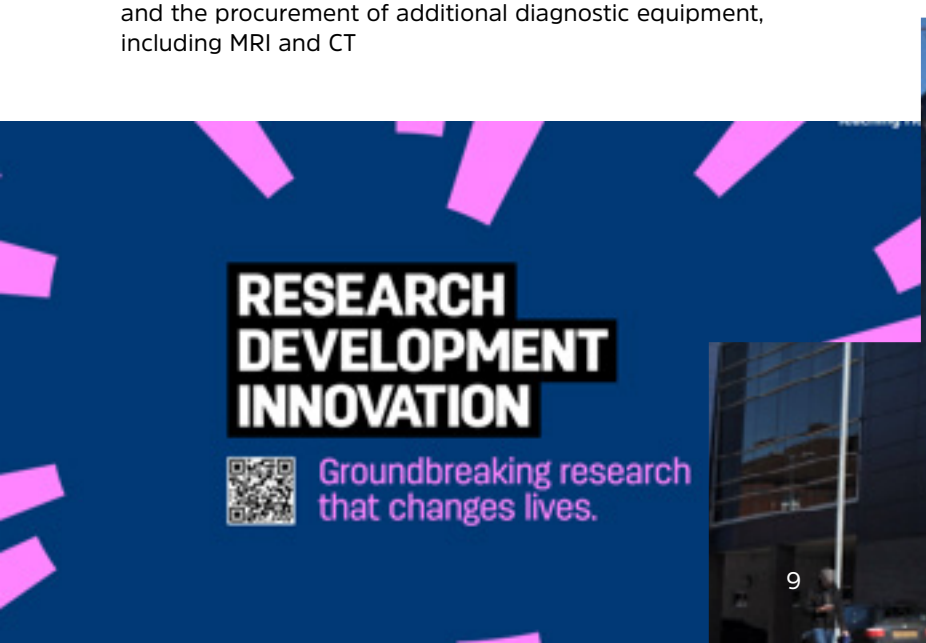
New developments at Hull Royal Infirmary have included:

- Improvements to the urgent and emergency care pathways through the reconfiguration of accommodation and the procurement of additional diagnostic equipment, including MRI and CT
- New ward accommodation (H37 and H38) at the rear of the site
- A new £8m Intensive Care Unit block with capacity for 2 additional theatres
- Opening of the Allam Centre for Diabetes Research
- At Castle Hill Hospital building works have commenced on the following developments:
- A new day surgery facility (12 theatre capacity)
- Allam Centre for Digestive Diseases
- Expansion of the PET/CT facility to include a new £8.8m Molecular Imaging Research Centre

RESEARCH AND INNOVATION

The Trust Board approved the 2018-2023 Research and Innovation Strategy in July 2018.

Further information relating Research and Innovation in 2021/22 can be found in this report.



FINANCIAL SUSTAINABILITY

The Trust has reported that it has delivered a surplus of £200k for 2021/22 which is £200k above plan.

The reported capital position at month 12 showed gross capital expenditure of £84.3m. This was against the original plan of £58.1m. The main areas of expenditure related to the Salix Energy Efficiency scheme (£12.2m), Day surgery (£10m), Medical Equipment (£14.4m) and Urgent and Emergency Care (£16.4m). The capital programme had increased due to additional PDC funding and ICS slippage.

PERFORMANCE SUMMARY

The Trust's position on 'responsive' was adversely affected in 2021/22 due to the pandemic and subsequent backlogs due to elective activity being stood down in 2020/21 following national directives.

Trust requirements for 2021 in respect to RTT were to:

- Maintain the total Waiting List variation (WLV) at or below the September 2021 baseline
- Continue to reduce 52 week+ breaches
- Achieve zero 104-week waits by end of March 2022

The current WLV position is 65,707 which is higher than the baseline by 7,000. The Trust did not achieve the 52-week trajectory at the end of March 2022 and this was mainly due to the Covid surge and reduction in elective activity.

The Trust achieved its revised 104-week trajectory by the end of March 2022 against which the Trust had reported delivery of 531 breaches, 81 under-trajectory.

The submitted plan for 63+ day cancer breaches was above the planned trajectory at 315 (trajectory 130).

The 2-week wait attendances was above trajectory at 2,126 (trajectory 1680). Delivery against this is subject to actual referrals received, which is outside of the Trust's control.

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

- Mixed sex accommodations breaches
- Stroke - % of patients spending at least 90% of their time on a stroke ward
- Clostridium difficile

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
- Patient Safety Alerts

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.

Chris Long, Chief Executive Officer

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PERFORMANCE ANALYSIS

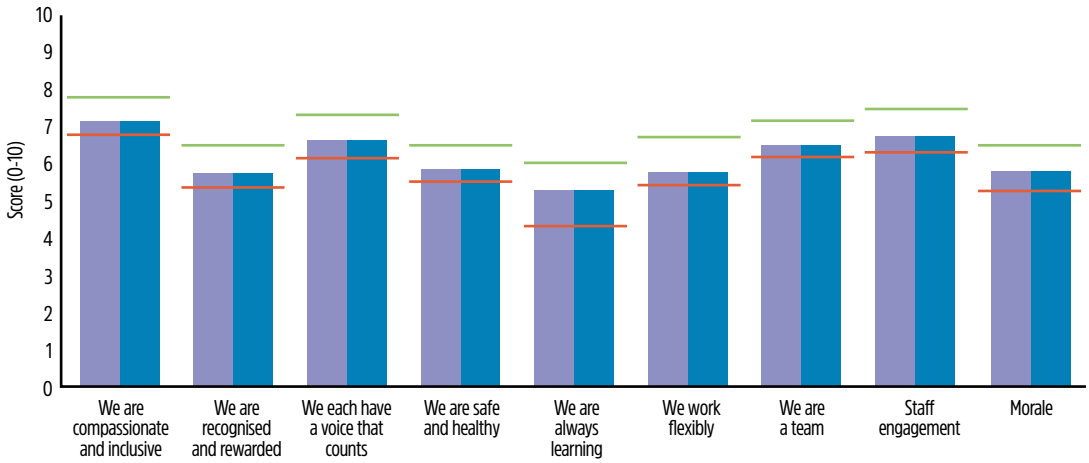
ANNUAL REPORT 2021/22

GREAT STAFF

The annual staff survey ran during September until the start of December 2021. The Trust's response rate improved on the previous year with 44% of staff returning a survey. This equated to 3977 staff.

There are nine key themes in the survey of which seven, for the first time, align to the NHS People Plan. In addition staff engagement and morale remain from the previous year.

The Trust's performance reflected a national position of deterioration against the themes and was as follows:



Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.1	5.7	6.6	5.8	5.2	5.8	6.4	6.7	5.8
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,817	3,920	3,743	3,805	3,555	3,893	3,836	3,926	3,912

The board has committed to address areas where the Trust has seen performance deteriorate. A series of focus groups with staff have been held to understand what the barriers are to delivering Great Care. The themes from these groups will be shared with senior managers during July 2022 and a set of minimum leadership expectations are being developed focusing on communication, training and wellbeing.

Health Groups are all developing their own local plans to address specific challenges in their areas.

FREEDOM TO SPEAK UP

Following the Francis review of Mid Staffordshire NHS hospital Trust, all NHS Trusts are required to have a Freedom to Speak Up Guardian (FTSUG).

In previous years the Director of Corporate Affairs, Carla Ramsay, held the FTSUG post. Due to a change in role and Suzanne Rostron commencing as the new Director of Quality Governance and incorporating FTSU as part of the Executive portfolio. Following an interim period and recruitment process, in June 2021 Fran Moverley was appointed as the new substantive FTSUG and the role is supported through ring fenced time.

The FTSUG supports staff, trainees, students and volunteers to speak up about any workplace concerns and/or ideas for improvement, including patient or worker safety concerns, inappropriate behaviours, discrimination, bullying and harassment, concerns about workload, roles or service delivery or any other concerns in an individual's working life. Concerns that fall within the legal remit of whistleblowing 'when a worker raises a concern about dangerous or illegal activity that they are aware of through their work' can also be raised with the FTSUG.

It can be difficult to know how to speak up and the FTSUG is able to act as an independent channel to raise concerns. The FTSUG also plays a key role in signposting staff to the appropriate staff support services available at the Trust.

In January 2022 the Staff Advisory and Liaison (SALs) service was integrated into the remit of the FTSUG, due to the duplication between the two services and to ensure staff are clear who they can contact.

During 2021/2022 the new FTSUG has focused on increasing the profile and accessibility of the FTSUG role. This has included creating dedicated pages on the

staff intranet, building on working relationships with key stakeholders across the Trust and implemented a variety of 'drop in sessions'. Sessions have been offered over the telephone, virtual meetings and face to face and included the opportunity to speak with the FTSUG on an evening outside of normal office hours.

During 2021/2022 71 individuals at the Trust contacted the FTSUG; in comparison to 2020/2021 when 24 individuals made contact.

On a quarterly basis the FTSUG attends and reports directly to the Trust Board and the Workforce, Education and Culture Committee and annually to the Audit Committee. This includes presenting a high level summary of the types of concerns being raised through this role and any learning. The FTSUG is also part of other Committees and working groups, including the Equality, Diversity and Inclusion Committee.

FTSUGs are supported by the National Guardian's Office (NGO). The NGO office leads and trains Guardians across the healthcare section and conducts speaking up reviews to identify learning. The NGO publishes an annual FTSU Index which is a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey. The 2021 Index for HUTH (from the 2020 survey results) was 79.1%; compared to the highest scoring Trust 87.6%. Due to changes to the staff survey questions, the index will not be published in the future.

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 doctor's contract terms and conditions and fines are issued to the department if these rules are broken.

GETTING IT RIGHT FIRST TIME (GIRFT)

Project support for Girft delivery within the Trust 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.

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 Trust also explores 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.

GENDER PAY GAP

The Trust is using the gender pay gap figures, contained within the Gender Pay Gap report which covers the period 1 April 2020 to 31 March 2021, to help understand the underlying causes for its gender pay gap and to identify suitable steps to minimize it.

The Trust gender pay gap data for the period including 31 March 2021, 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.

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

Further details can be found on the Trust's website.

WORKFORCE RACE EQUALITY STANDARD

The Workforce Race Equality Standard (WRES) report covering the period 1 April 2020 to March 2021 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.

WORKFORCE DISABILITY EQUALITY STANDARD

The Workforce Disability Equality Standard (WDES) report covering the period 1 April 2020 to March 2021 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.

GREAT CARE

INFECTION PREVENTION AND CONTROL ARRANGEMENTS

Greta Johnson is the Trust Director of Infection Prevention and Control (DIPC) and was responsible for leading and managing the Trust's Infection Prevention and Control (IPC) plan during 2021-22.

Beverley Geary, Chief Nursing Officer, and executive responsibility for infection prevention and control during 2021- 22. During 2021-22 the role of Infection Control Doctor was facilitated by Dr. Debbie Wearmouth, Consultant Microbiologist. During 2021-22, ongoing recruitment for Infectious Diseases Consultants and a Consultant Microbiologist continues.

During 2021/22, following feedback from NHS Improvement the DIPC who was also the Lead Nurse for the service concentrated on the DIPC role and recruited a Matron to support her in the delivery of the infection prevention & control team and Infectious Diseases specialist nurse teams. Additional support to the team was provided by a further matron who has focused on team development and expansion. The further restructuring of the Infection Prevention & Control Team has strengthened the team structure with the additional bonus of team expansion and development.

Infection prevention & control meetings are held to ensure the Trust remain compliant with the Health & Social Care Act: code of practice on the prevention and control of infections. During 2021-22, Strategic Infection Reduction Committee (SIRC) continued to meet monthly, in light of the ongoing challenges related to the COVID-19 pandemic. 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 Operational Infection Reduction Committee (OIRC), continued to meet monthly. During 2021-22 this committee was chaired by the Senior Infection Prevention & Control Nurses and/or the DIPC. From August 2021, the responsibility of chairperson was transferred to the Infection Control Doctor. 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, 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.

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 continued to be impacted during 2021-22 by the COVID-19 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.

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 2021-22 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 2021-22, a global IPC team email address remained available for staff to access and email the team with queries, concerns and/or requests for advice or assistance.

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 , in antimicrobial prescribing data , in antimicrobial resistance data and in other IPC measured initiatives.

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.

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.

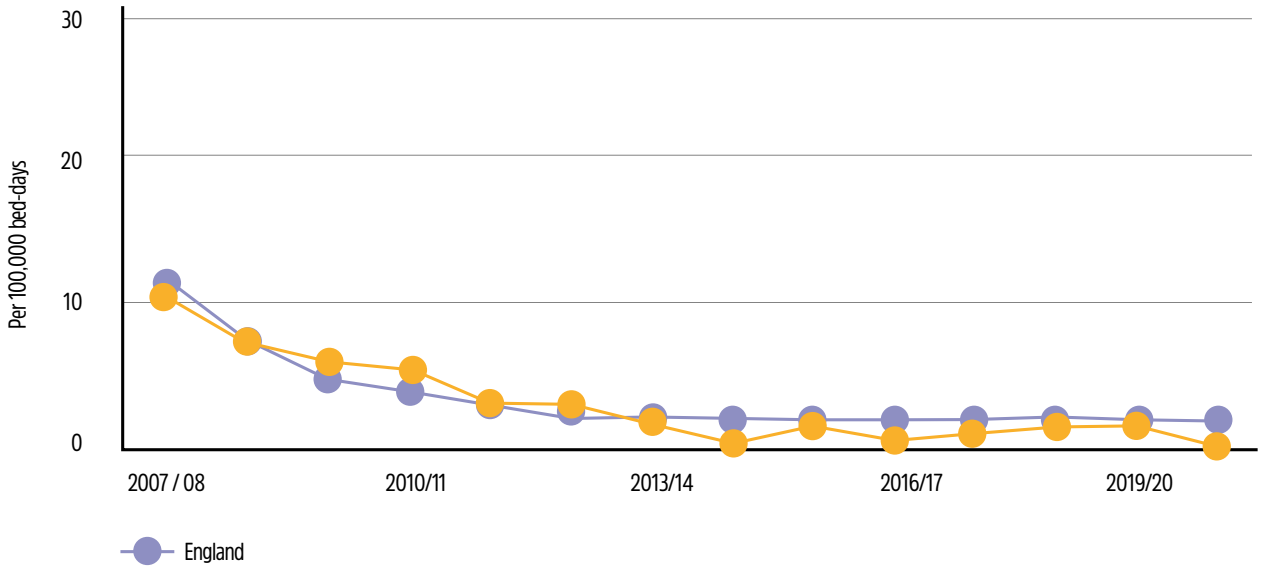


Figure 1. MRSA BSI rates in England 2007-2019 in comparison with Hull University Teaching Hospitals NHS Trust (red lines indicate introduction of universal screening)

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.

MRSA bacteraemia infections by month & year from 2016 – 2021

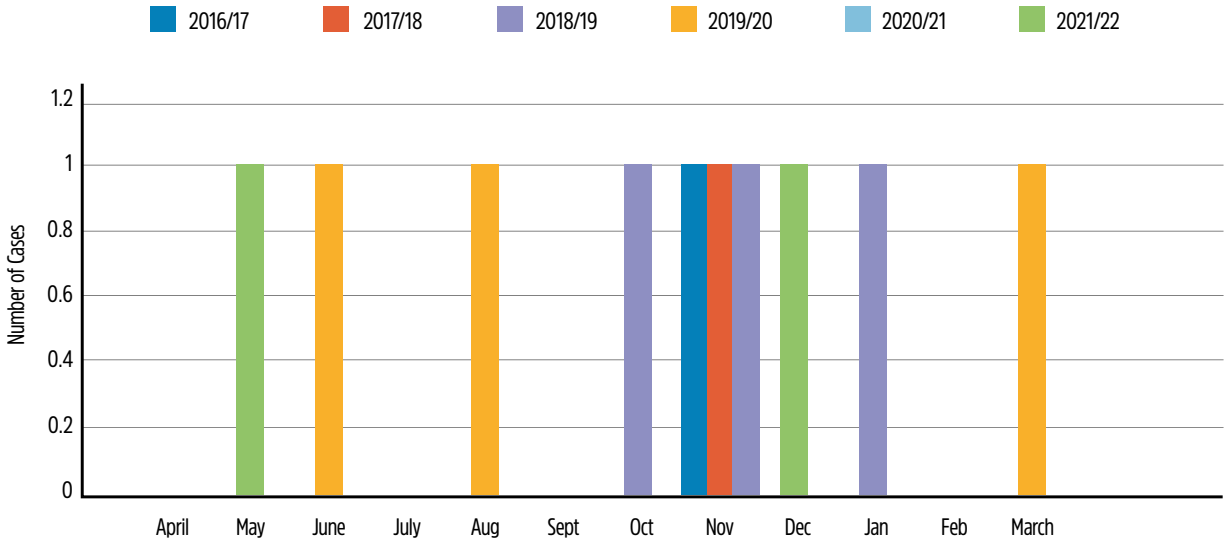


Table 1. MRSA bloodstream infection diagnosed in HUTHT 2016-21

During 2021-22, two hospital apportioned cases were reported, one in May 2021 and the other in December 2021 and investigated via Post Infection Reviews (PIR) by both the Trust and Commissioning Team, both represented patients with complex histories and multiple comorbidities but at the time of writing the report no lapses in practice were identified with regards the care the patients received whilst admitted to the Trust

During 2021-22, there were four further MRSA bacteraemia cases reported, one community onset healthcare associated which represented a patient not screened for MRSA prior to surgery and was subsequently found to be colonised with an underlying infection which resulted in a surgical site infection on readmission to the Trust this has resulted in a change in patient pathways and screening protocols for this type of surgery. There were a further three community onset community associated cases. This is a marked increase in community cases which the Commissioners are aware of, possibly as a result in patients not accessing or seeking healthcare during the ongoing COVID-19 pandemic. Again all cases were investigated by the respective organisations via PCR and at the time of writing this report again no known lapses have been reported.

From a national perspective, the incidence rate of hospital-onset MRSA bacteraemia peaked at 1.4 cases per 100,000 bed-days in January and March 2021. This was the highest rate seen for hospital-onset MRSA bacteraemia since April to June 2011. The reasons for this increase are still being investigated by UKHSA, although it has been observed that this increase coincided with a rise in the percentage of hospital-onset bacteraemia cases who were also positive for COVID-19.

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 regards the fluctuation in reported MRSA bacteraemia cases experienced during 2019-20 & 2020/21 and the competing priorities experienced during the ongoing COVID-19 pandemic, therefore, the Trust continues to screen all admissions for MRSA. 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 still 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.

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 2021/22 cases continued to be reported and 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)
- 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 until September 2021 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.

From a national perspective, since the initiation of C. difficile (CDI) surveillance in April 2007, there has been an overall decrease in the count and incidence rate of both all-reported and hospital-onset cases of CD

In 2021-2022 there were 38 HOHA and 14 COHA cases reported, taking the total of CDAD cases to 52, against a threshold of 53 cases, combining HOHA & COHA cases.

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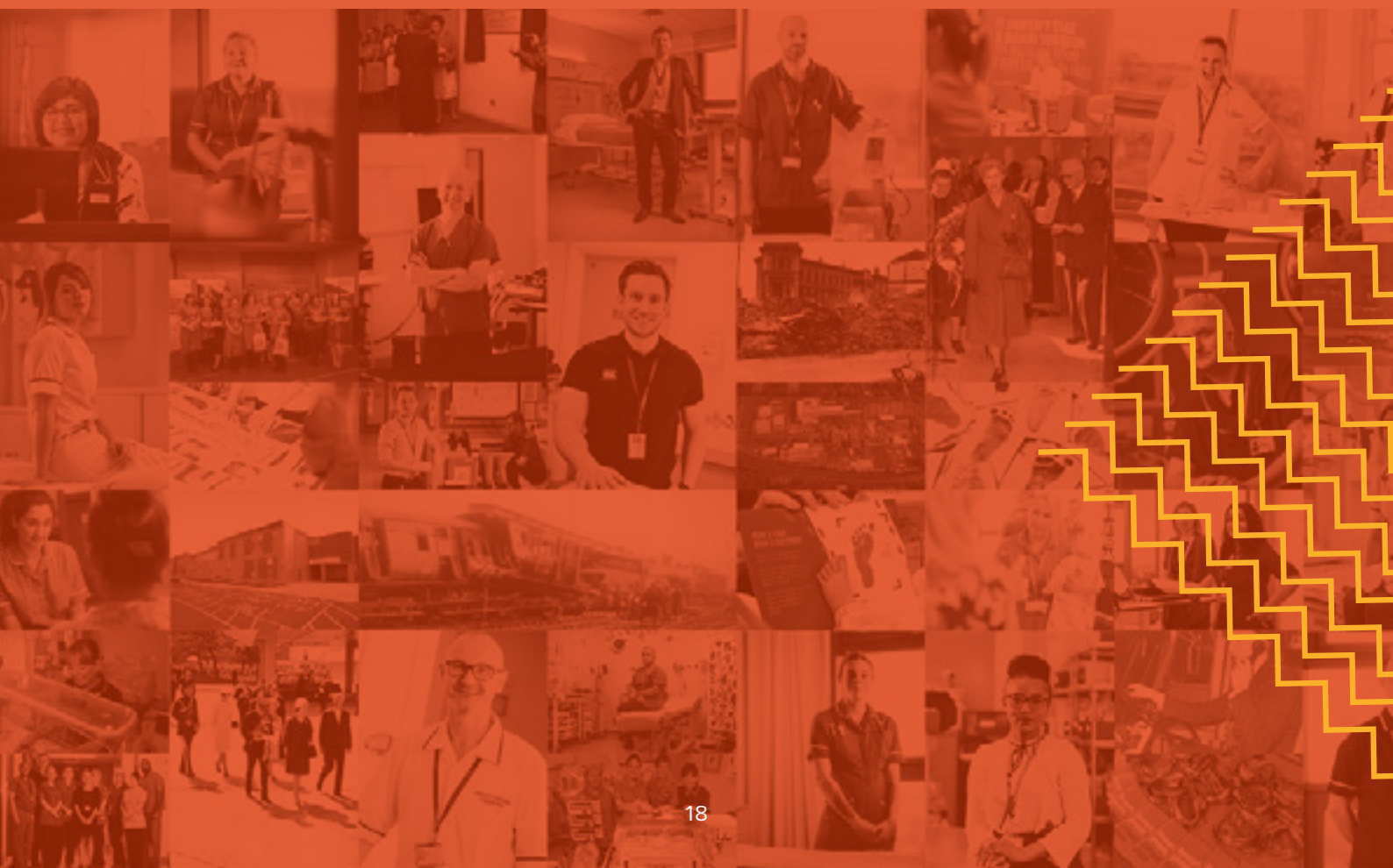


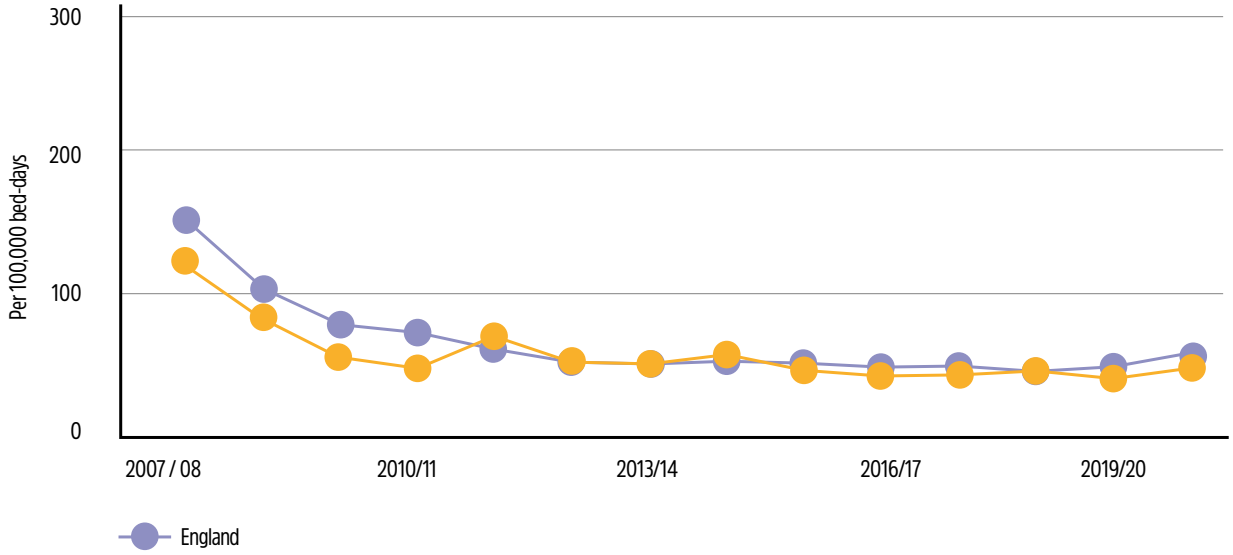


Figure 2. C. difficile rates in England 2007-2020 in comparison with Hull University Teaching Hospitals NHS Trust per 100,000 bed-days (PHE Fingertips)

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. In December 2021, the Commissioner Led HCAI Review Group was reconvened and continues to meet monthly to discuss community and hospital onset cases of Clostridioides difficile along with scope to discuss other complex infections.

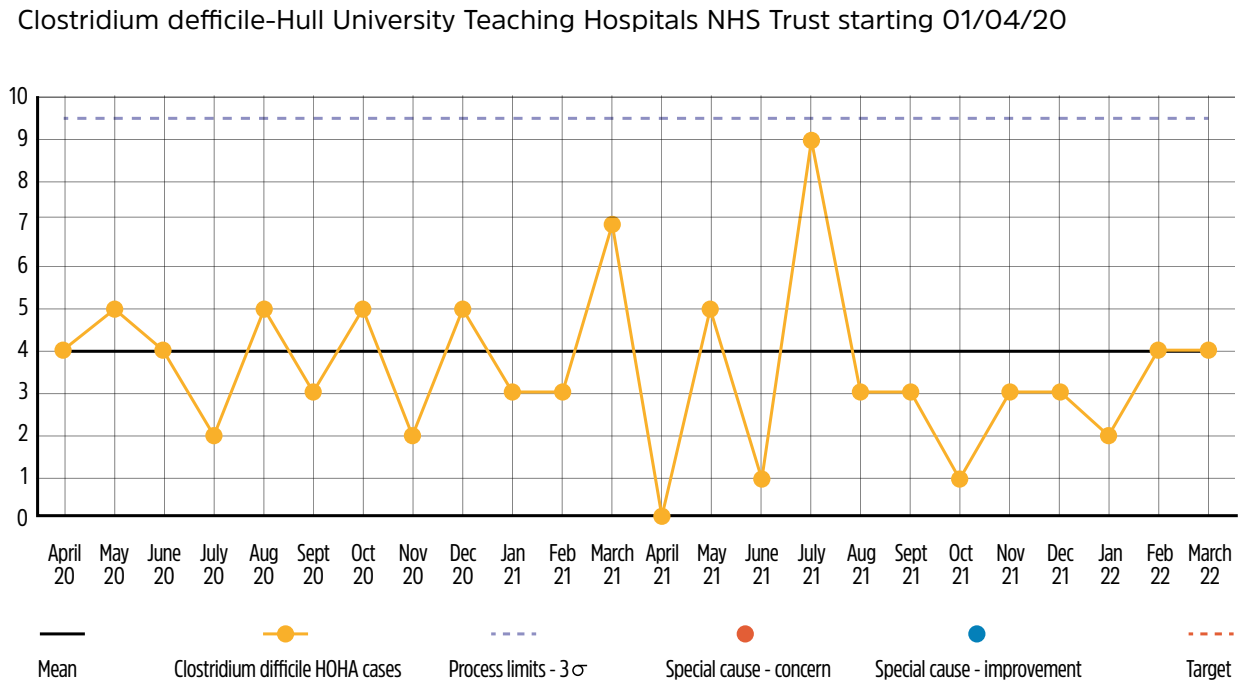


Table 2. Hospital onset Clostridioides difficile infections diagnosed in HUTHT 2020-22

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 OIRC. 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.

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 2021-22 HUTH reported the slight reduction by one case of infection as experienced during 2020/21 it however, remains the one major HAI indicator for which we are significantly worse than the national benchmark.

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. From a national perspective, the count of all reported cases of MSSA bacteraemia increased by 43.7% from 2,199 to 3,160 between January to March 2011 and October to December 2021. This was accompanied by a 32.4% increase in incidence rate from 16.8 to 22.2 per 100,000 population. These increases are primarily driven by increases in community-onset cases. Between January to March 2011 and October to December 2021, the count and the incidence rate of community-onset cases increased by 49.1% and 37.4% respectively from 1,464 to 2,183 cases and from 11.2 to 15.4 cases per 100,000 population.

Over the same period, the count of hospital-onset cases increased by 32.9% from 735 to 977 cases, while the hospital-onset incidence rate increased 38.9% from 8.3 to 11.6 cases per 100,000 bed-days.

Since April 2020, there has been a national increase in the incidence rate of hospital-onset MSSA bacteraemia cases. The overall growth is, in part, a result of reduced hospital admissions and overnight bed-days. This has caused a large increase in the rate of hospital onset cases over a relatively short time since overnight bed-days is used as a denominator for rate calculations. This culminated in a peak during January to March 2021 of 13.4 cases per 100,000 bed-days and 998 cases, which was the highest MSSA hospital-onset rate and count that has been observed since the inception of MSSA surveillance.

It is worthy to note that the Trust has not seen an increase in hospital onset MSSA bacteraemia cases, compared to 2020-21 with numbers remaining static at 62 hospital onset cases being reported. However, The Trust remains an outlier with regards the reporting of hospital onset bacteraemia cases, with the Surgery & Medicine Health Groups reporting the majority of cases.

The Neonatal Intensive Care Unit (NICU) reported two MSSA bacteraemia cases, one in January 2022 and the other in February 2022. Both were related to time and place and isolates sent to Staphylococcal Reference Laboratory confirmed likely transmission on the unit, with both neonates nursed adjacent to one another in the Blue Room. Both cases were subject to root cause analysis investigation and reported via the respective Health Group governance structure and Infection Reduction Committee meetings. No further cases have been reported to date.

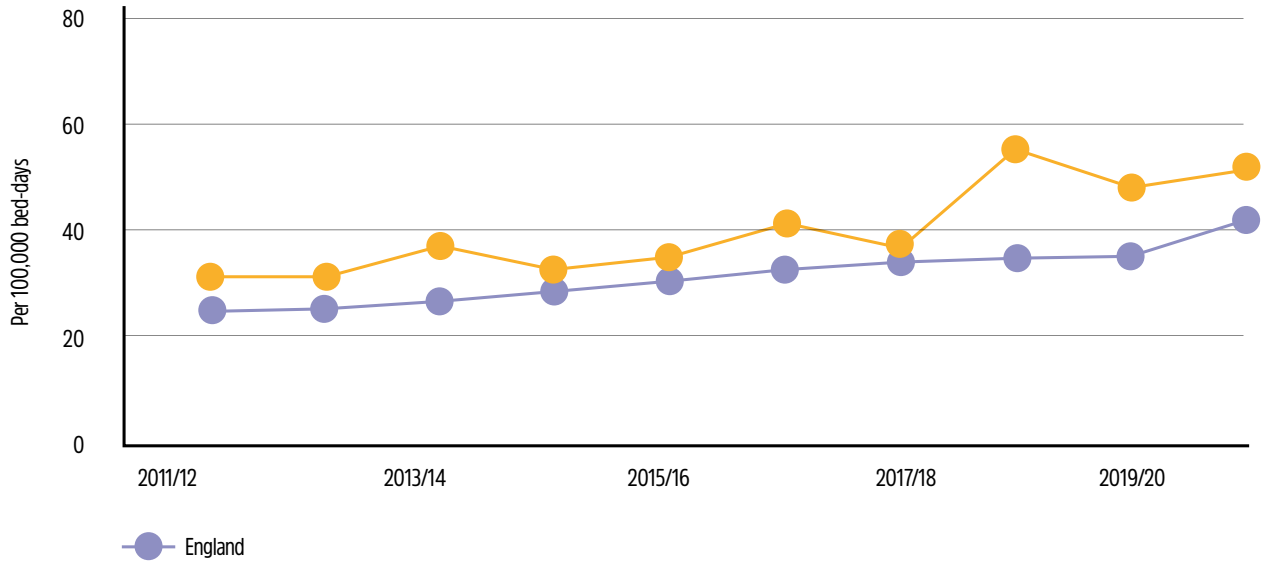


Figure 3. MSSA BSI rates in England 2011 - 2020 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

MSSA bacteraemia-Hull University Teaching Hospitals NHS Trust starting 01/04/20

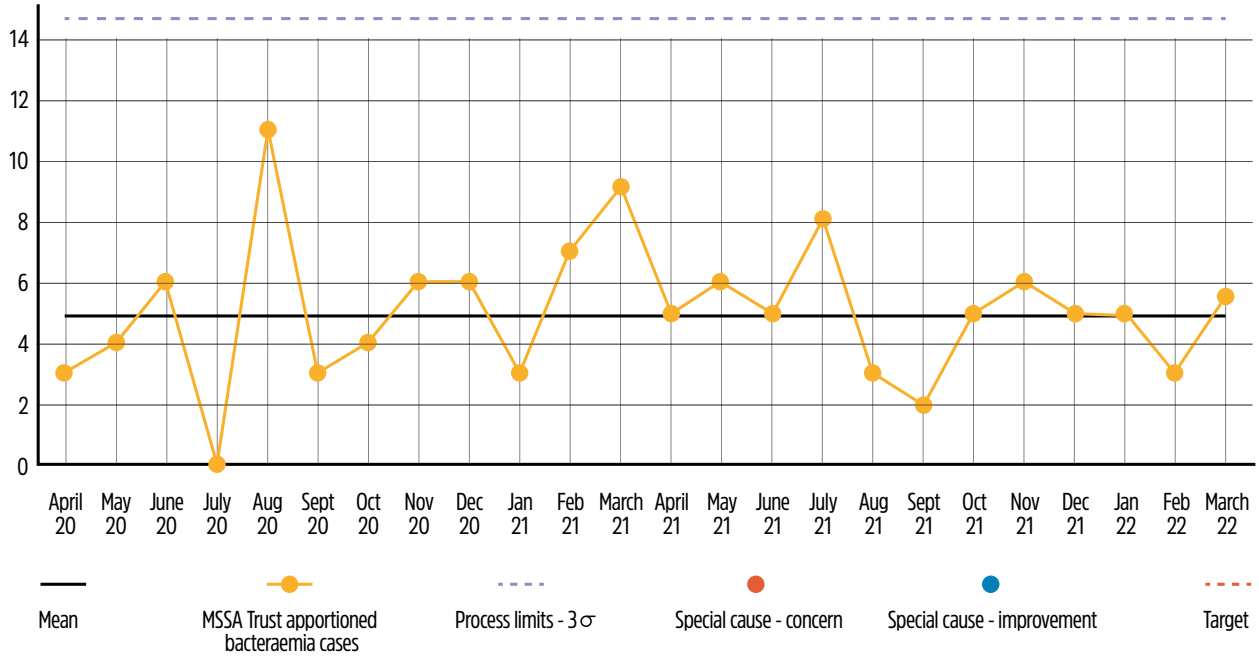


Table 3. MSSA bloodstream infection diagnosed in HUTHT 2020-22

Reasons for the continued rate of MSSA BSI during 2021-22 are multifactorial and relate to a variety of causes including skin and soft tissue infections, ventilator associated pneumonia, and ongoing poor intravascular line insertion and care, specifically peripheral vascular devices but thankfully in lesser numbers during 2021-22 yet these should be avoidable. During 2021-22, in spite of the COVID-19 pandemic the Device Task, Challenge & Finish Group continued to meet to progress work with regards cannula insertion and ongoing management, with the Trust linking in with BBraun to deliver training, disseminate updated products, including an extension line to mitigate manipulation at the cannula site and risk the development of thrombophlebitis and posters. 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 2021- 22, focus has primarily been working alongside the respective Health Groups to address concerns with regards a number of 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 was previously noted. Community Apportioned MSSA bacteraemia cases across Hull & East Riding of Yorkshire during 2021-22 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 incidence rate of all reported E. coli bacteraemia increased each year between the initiation of the mandatory Surveillance of E. coli bacteraemia in July 2011 and the start of the COVID-19 pandemic (January to March 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 2021, the count and the incidence rate of all reported cases of E. coli bacteraemia increased by 10.8% from 8,275 cases to 9,166 and from 61.8 to 64.5 cases per 100,000 population, respectively. Similarly, over the same period, the count of community-onset cases increased by 16.3% from 6,279 to 7,300, while the incidence rate increased by 9.5% from 46.9 to 51.4 cases per 100,000 population. Whilst, the count of hospital-onset cases decreased by 6.5% from 1,996 to 1,866 cases. This corresponded to a decrease in the incidence rate of hospital-onset cases by 6.2% from 23.6 per 100,000 bed-days to 22.1 per 100,000 bed-days.

While hospital admissions were lower during the pandemic, over the same period, between October to December 2020 and October to December 2021, there has been a slow increase in hospital admissions. However, this is happening at a greater magnitude than the increase in cases, which is why a decline in incidence rate is observed.

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 data during 2021-22 as the Trust has seen a reduction in cases and hospital elective 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.

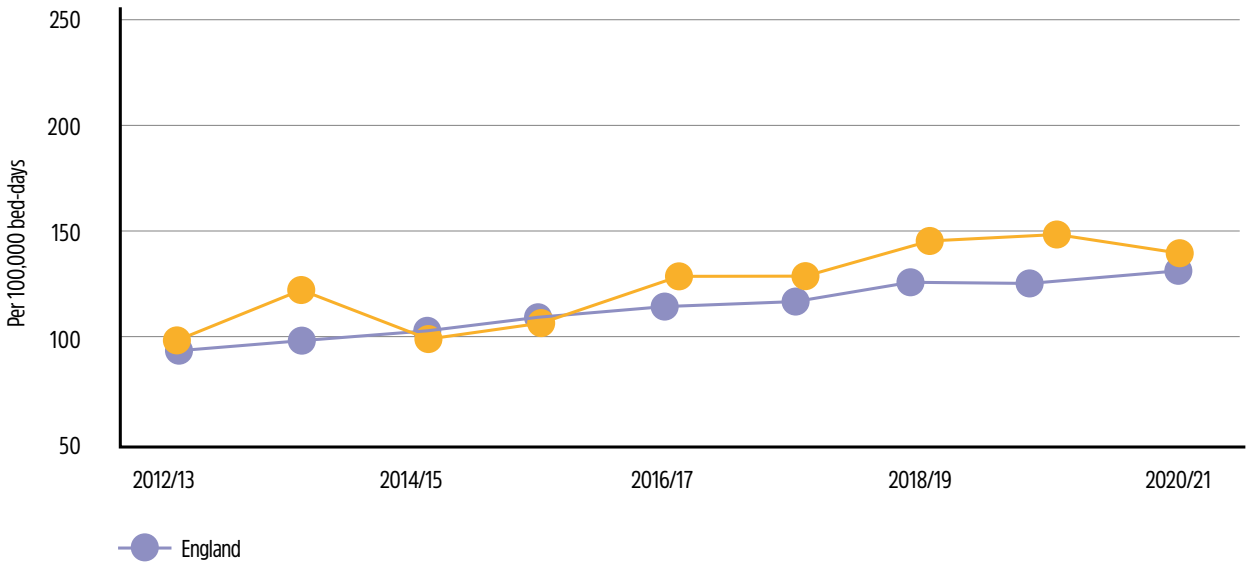


Figure 4. E.coli BSI rates in England 2012 – 2021 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips

E.coli Bacteraemia - Hull University Teaching Hospitals NHS Trust starting 01/04/20

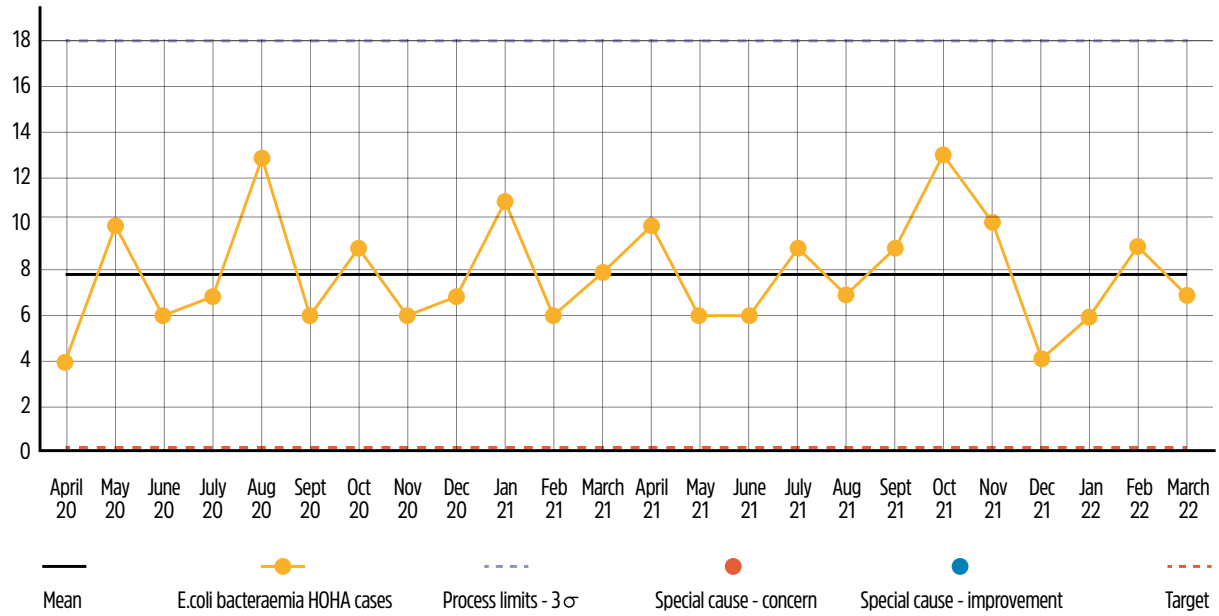


Table 4. E. coli bloodstream infection diagnosed in HUTHT 2020-22

Klebsiella and Pseudomonas Aeruginosa bacteraemia

For the operational period 1st April 2021 to 31st March 2022, UKHSA (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 2021, nationally there was a 33.3% increase in the count of all reported Klebsiella spp. bacteraemia cases from 2,348 to 3,131 and a 30.1% increase in the incidence rate from 16.9 to 22.0 cases per 100,000 population, the highest levels seen since surveillance began.

Counts and rates of hospital-onset Klebsiella spp. peaked between July to September 2020 and January to March 2021. Since the start of the pandemic, both counts and rates hospital-onset cases increased to levels which were the highest observed since the inception of Klebsiella spp. surveillance. The hospital-onset incidence rate peaked at 15.5 cases per 100,000 bed-days during January to March 2021.The specific drivers of this increase are still being investigated by UKHSA (PHE), but do know these trends coincided with increased incidence of COVID-19.

In October to December 2021, the number of hospital-onset Klebsiella spp. bacteraemia cases increased by 4.0% and the incidence rate decreased by 6.5%, when compared with the same quarter in the previous year (October to December 2020). Compared to the same period in 2019 (October to December 2019), a more typical year prior to the pandemic, the counts and the incidence rate of hospital-onset cases increased by 24.3% and 30.9% respectively.

During October to December 2021, 71.6% (2,241 of 3,131) of all reported Klebsiella spp. bacteraemia were caused by Klebsiella pneumoniae, a decrease from 72.3% in the same quarter in the previous year (October to December 2020).

Over the same period, the percentage of cases identified as Klebsiella oxytoca was 17.5% (548 of 3,131) in October to December 2021, which is similar to what was reported in October to December 2020 (17.2%). The incidence rate of all species increased approximately proportionally, broadly following the same overall trend. The exception to this was the incidence rate of K. oxytoca, which increased within hospital-onset cases around the start of the pandemic and subsequently stabilised at 1.9 to 2.1 per 100,000 bed days.

There is evidence of seasonality in the incidence trends of all-reported Klebsiella spp. bacteraemia cases, with the highest rates normally observed in July to September of each year, although it is important to evaluate financial year April 2020 to March 2021 and financial year April 2021 to March 2022 with caution.

Pseudomonas aeruginosa bacteraemia

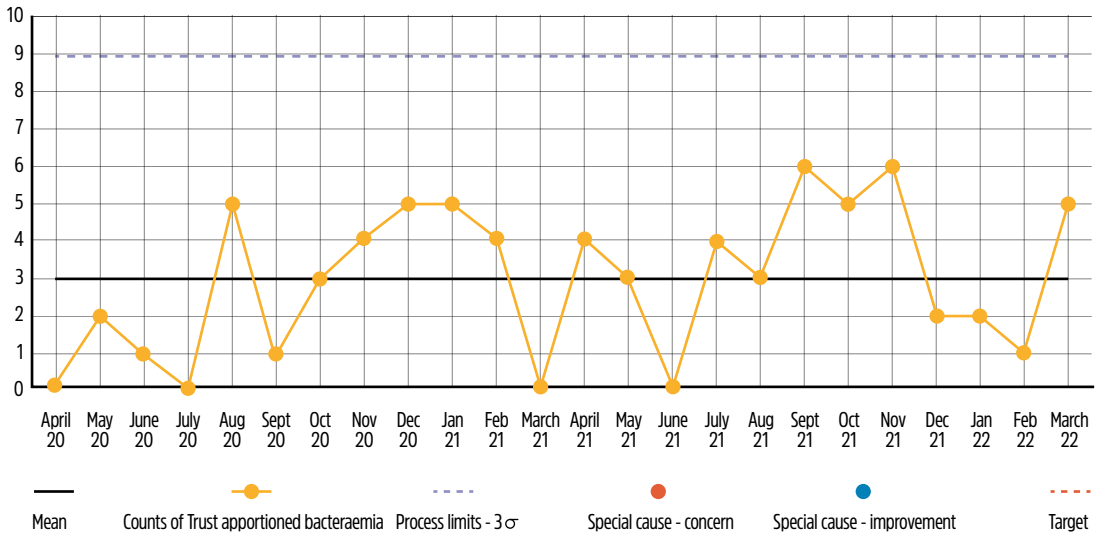
Between April to June 2017 and October to December 2021, there was a 10.1% increase in the count of all reported P. aeruginosa bacteraemia cases from 1,015 to 1,118, and a 7.5% increase in the incidence rate from 7.3 to 7.9 cases per 100,000 population.

The count and the incidence rate of community-onset cases increased by 6.1% from 639 to 678 cases and by 3.5% from 4.6 to 4.8 cases per 100,000 population respectively. Over the same period, the count and the incidence rate of hospital-onset cases increased by 17.0% from 376 to 440 cases and by 19.9% from 4.3 to 5.2 cases per 100,000 bed-days respectively.

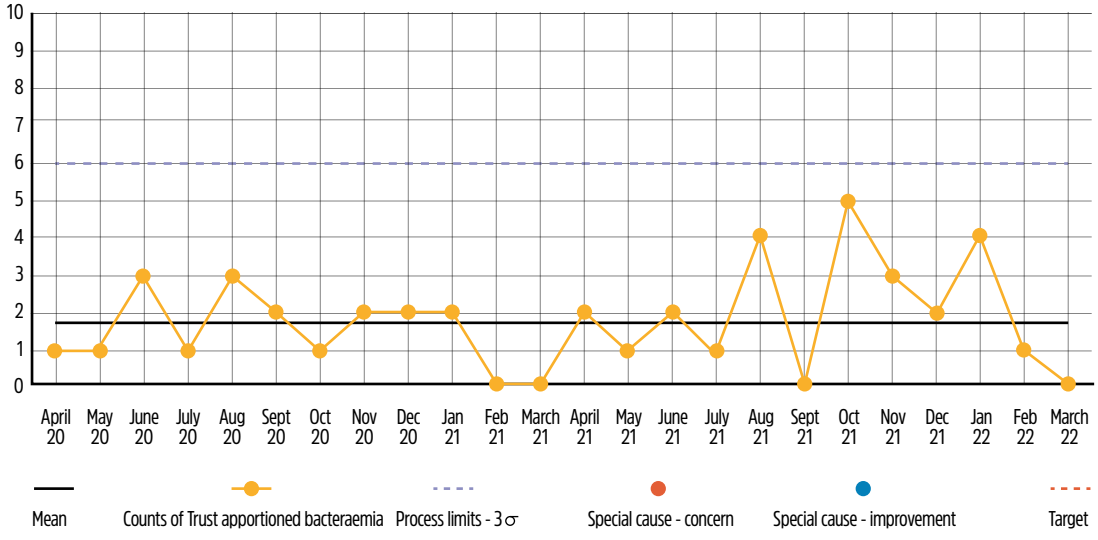
Like Klebsiella spp. cases, increases in counts and rates of hospital-onset P. aeruginosa were also observed during the second wave of the pandemic. The counts and rates of hospital-onset P. aeruginosa increased between July to September 2020 and January to March 2021. During this period, both the counts and rates of hospital-onset cases increased to levels not seen since the initiation of mandatory surveillance of P. aeruginosa bacteraemia. The incidence rate of hospital-onset cases peaked at 7.0 cases per 100,000 bed-days in January to March 2021. The reasons for this increase have been investigated and it was observed that this increase coincided with a rise in the percentage of hospital-onset bacteraemia cases who were also positive for COVID-19.

Care should be taken when comparing October to December 2021 with the same period in the previous year (October to December 2020) which was largely affected by the COVID-19 pandemic. Both the total reported and community -onset counts and rates remained broadly the same.

Klebciella bacteaemia - Hull University Teaching Hospitals NHS Trust starting 01/04/20



Pseudomonas bacteaemia - Hull University Teaching Hospitals NHS Trust starting 01/04/20



Tables 5&6. Klebsiella and Pseudomonas aeruginosa bloodstream infections diagnosed in HUTHT 2020-2022

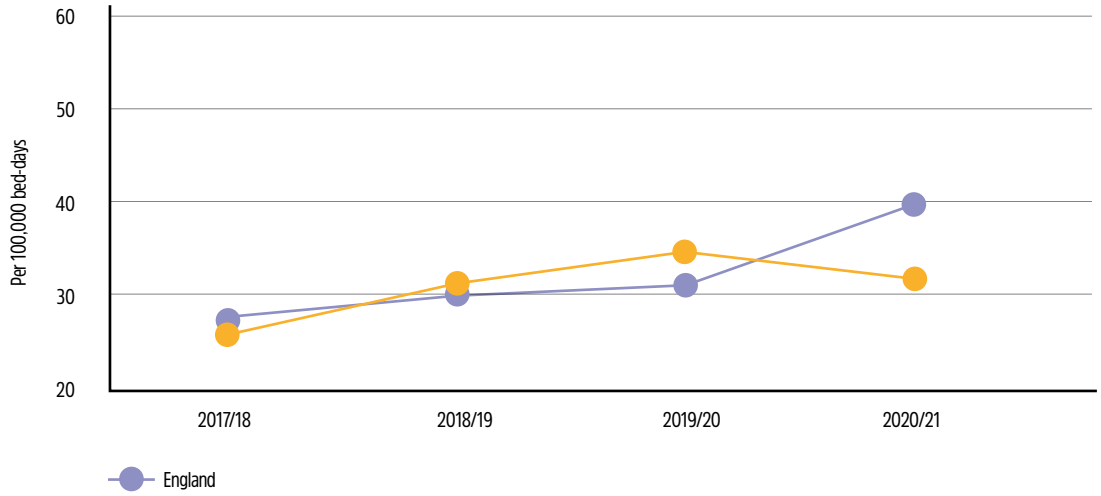


Figure 4. Klebsiella BSI rates in England 2017 - 2021 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

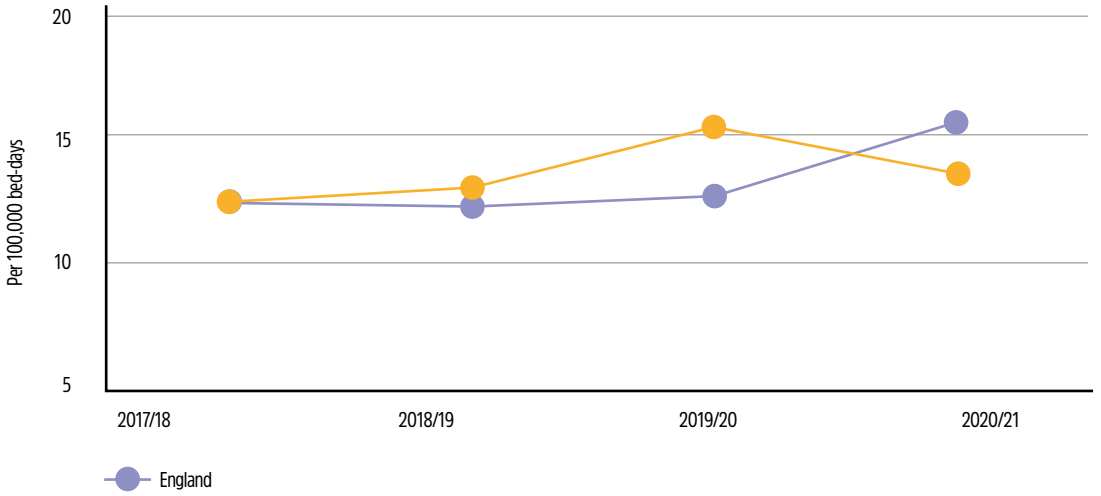


Figure 5. Pseudomonas aeruginosa BSI rates in England 2017 - 2021 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

Surgical Site Surveillance

The Trust continues to participate in both mandatory and voluntary surveillance of surgical site infection: in 2021/22 this included orthopaedic surveillance (fractured neck of femurs) and was commenced during January 2022 – March 2022, providing the opportunity to compare year on year figures.

With regards repair of neck of femur fracture surveillance completed during January – March 2022, one hundred and thirty four repair of fractured neck of femur operations were surveyed, provisional data suggests one 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 2021. At the time of drafting the report, the surveillance is awaiting sign off and ratification by the PHE Surgical Site Surveillance Service (SSISS).

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 2021-22, there were very few incidences and/or outbreaks of Norovirus reported.

Although during February & March 2022 there were 3 outbreaks caused by Norovirus which resulted in ward closures, including wards C16, H200 & H5. The outbreaks were promptly identified but affected both patients and staff, they were short lived in duration with incident meetings held to discuss control measures. All wards were cleaned and reopened following advice taken from the IPCT.

During 2021-22, 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, closures was short-lived.

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

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 2021-22 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 2021-22 worked on meeting the requirements of the toolkit e.g. identifying, screening and managing at risk patients and those with active infection. During 2021-22 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.

Influenza

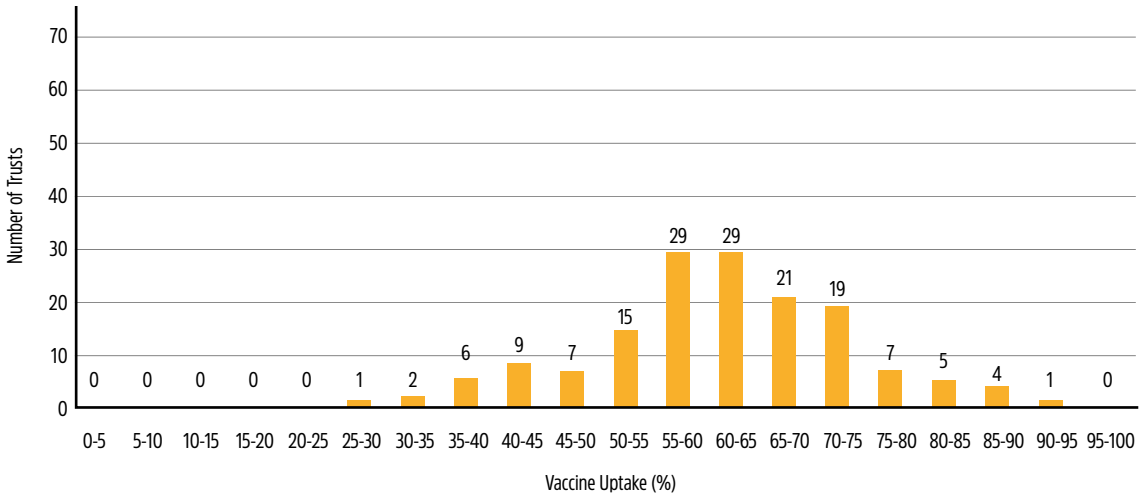
Cases of Influenza were reported from October 2021 onwards and continued to be reported up to and including April 2022.

The majority of cases were reported on admission to the Trust and were identified as Influenza A as the predominant circulating strain.

During March 2022, a noted increase was reported in the identification of Influenza A cases amongst patients due in part to the frequency of asymptomatic PCR testing for COVID-19 which incidentally identified Influenza A. Managing patients as contacts again identified asymptomatic Influenza A cases on repeat screening who were managed separately to any COVID-19 positive patients.

The influenza vaccination campaign for 2021-22 commenced on the 14th September 2021 for healthcare staff and at year end, 71% of Trust staff involved in providing direct patient care had taken up the influenza vaccine a decrease from previous campaigns but comparably higher than other acute Trusts across Yorkshire and the Humber. This was due in part to clinical staff prioritizing COVID-19 vaccination.

Influenza Vaccine Uptake (%) in HCWs, in NHS England Trusts

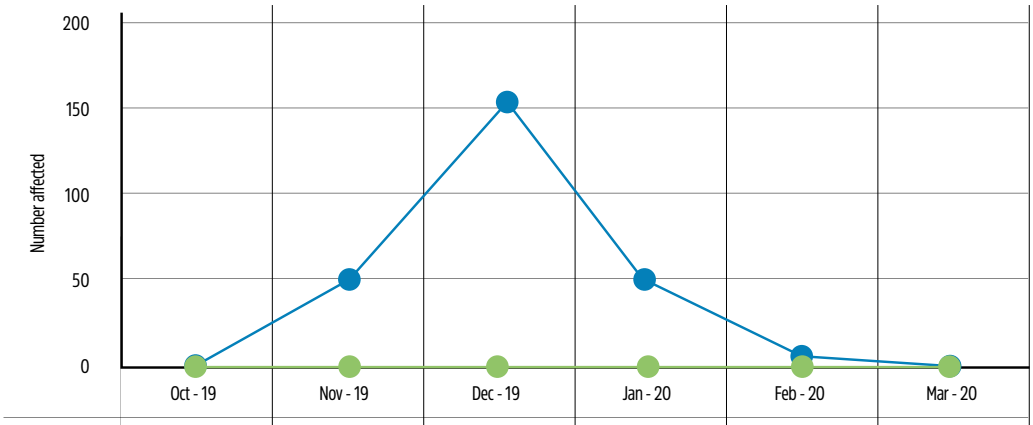


(Source: UKHSA: Seasonal flu and COVID-19 vaccine uptake in frontline healthcare workers: monthly data, 2021 to 2022)

During 2021-22, 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 2021-22, this included COVID-19 as standard.

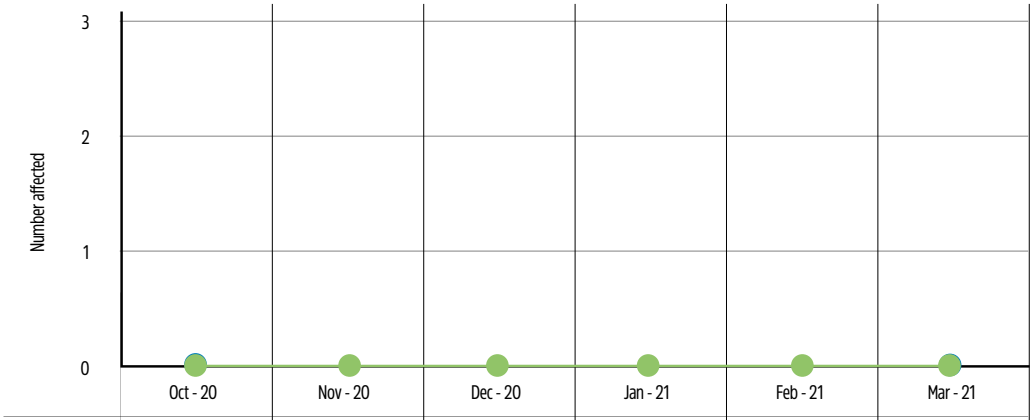
Patients were proactively screened for influenza, along with COVID-19, during admission and/or treatment when presenting with flu-like symptoms which is to be commended and encouraged, ensuring patient and staff safety. The following three graphs show the distribution of Influenza strains for FY 2019-20, 2020-21 & 2021-22.

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

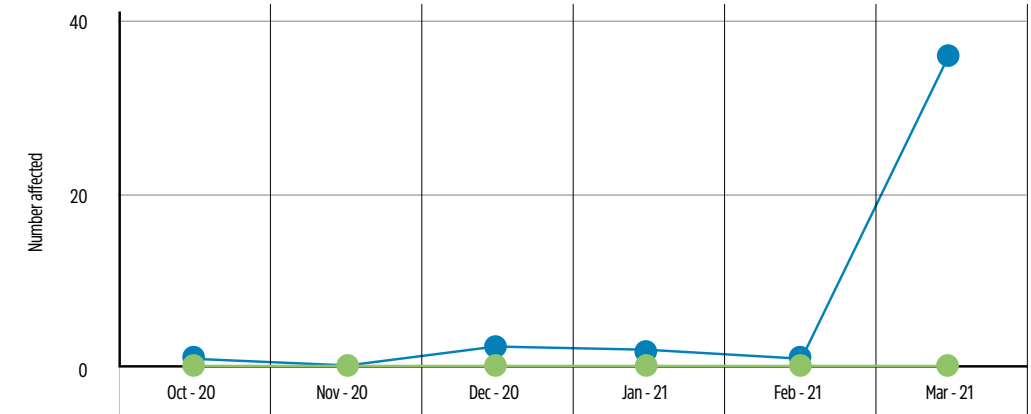
Influenza Activity 2020/21 at Hull University Teaching Hospitals NHS Trust



	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21
Flu A	0	0	0	0	0	0
Flu B	0	0	0	0	0	0

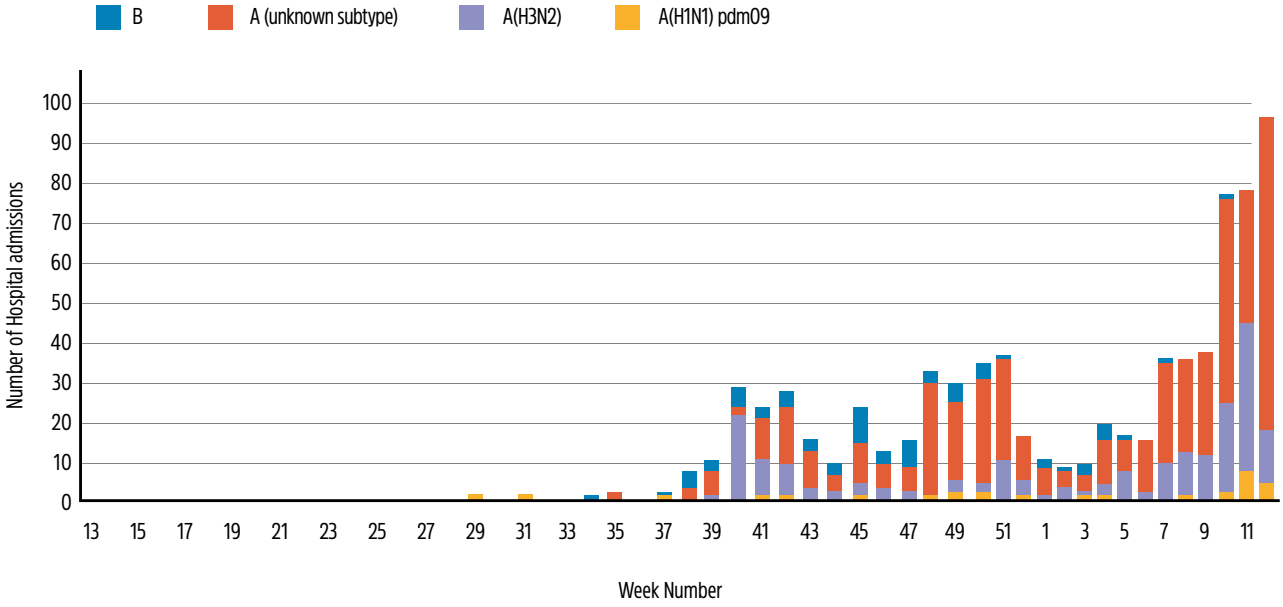
Table 9. Represents influenza activity at the Trust since October 2020 until the end of March 2021

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



	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21
Flu A	2	0	6	5	4	31
Flu B	0	0	0	0	0	0

This next graph demonstrates weekly influenza hospital admissions by influenza type in Engalnd and reflects the rise in cases in March 2022 as reflected by the Trust.



(Source: UKHSA: Weekly national Influenza and COVID-19 surveillance report)

COVID-19

The Trust adopted a Command Structure to manage the pandemic and the subsequent Trust COVID-19 Surge Plan and this continued during 2021-22.

During 2021-22, COVID-19 remained the largest challenge for the organisation in addition to the volume of patients whom medically fit for discharge had subsequently no criteria to reside, resulting in a number of wards dedicated to their care.

The pandemic during 2021-22 was punctured with different COVID-19 variants which resulted in peaks and troughs of reported COVID-19 cases. Mostly notably Delta and Omicron variants, both of which resulted in high prevalence and incidence within the community and subsequently an increase in hospital admissions and resulting outbreaks of infection.

From April to September 2021, 1,867 COVID19 cases screened positive for COVID-19; the majority were patients screened with a decision to admit and/or in OPD settings, of the 1,867 cases 21 were hospital onset probable cases (8-14days) and a further 17 were hospital onset definite cases (>15 days). Representing a 1.1% and 0.9% infection rate in this time period. These hospital onset cases were linked to reported outbreaks where community onset cases were admitted and nursed in bays resulting in contacts and subsequent positive cases. By way of context, in January 2021 at the peak of hospital onset outbreaks experienced by the Trust there were 1,428 cases reported in January 2021 alone with 258 hospital onset cases reported representing an 18% infection rate.

During October 2021, a decrease in reported cases was noted and there were no significant outbreaks of COVID19, whereas during November 2021 cases increased resulting in a number of outbreaks affecting wards at CHH and HRI. The Omicron variant was first noted within the community in December 2021 which resulted in an increase in COVID-19 cases and subsequently became the dominant strain in January 2022. During December 2021, in light of the Omicron variant updated COVID19 guidance was published including the additional need to wear RPE (FPP3 facemasks) when hierarchy of control assessments suggests other measures would be insufficient to protect both staff and patients.

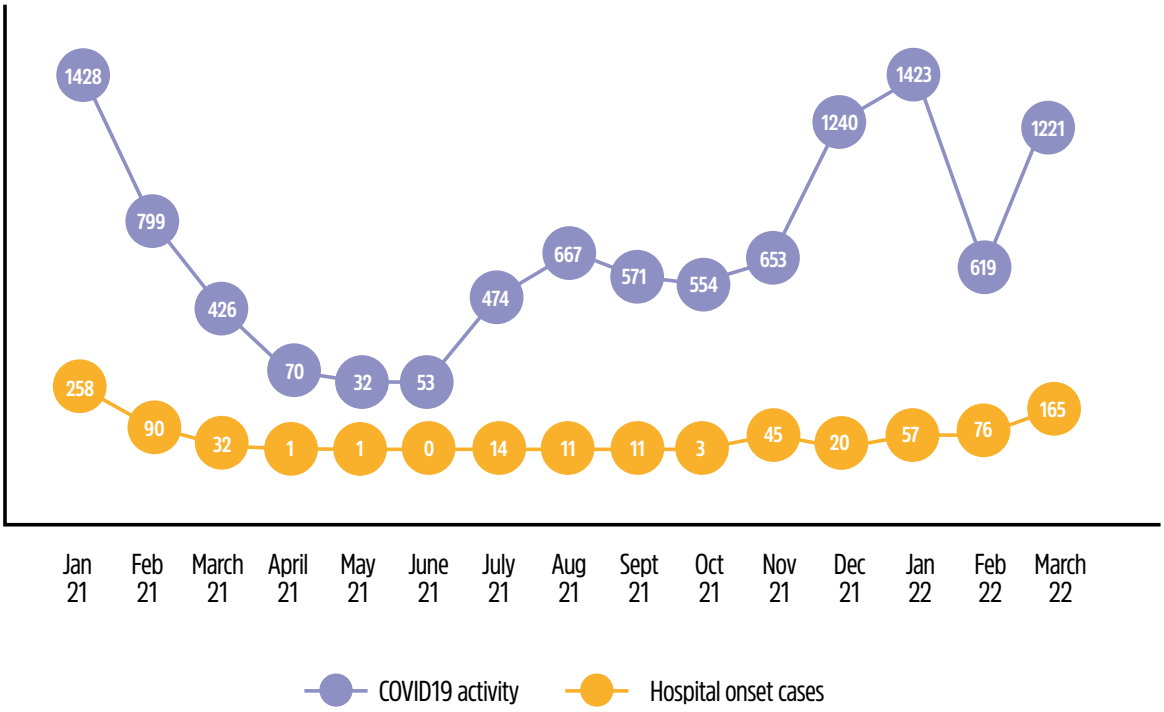
A reduction of COVID19 cases were reported during February 2022 but a marked rise in cases were noted during March 2022, in line with other organisations across Yorkshire & the Humber and due in part to the Omicron variant which was markedly more transmissible. This resulted in a number of outbreaks across the Trust resulting in bay and ward closures. Patients and staff were affected but notably patients did not require escalation of care nor were noted to be symptomatic, however, those patients who were unvaccinated and/or immunocompromised remained particularly at risk.

The impact of COVID-19 vaccination including a third dose resulted in patients being affected by COVID-19 differently, patients did not require an escalation of treatment requiring level 2 or 3 care as previously seen in the first waves of the pandemic.

Outbreaks of COVID-19 resulted in convened multidisciplinary incident meetings and to improve decision making and communication further a daily IPC report was drafted and circulated to ensure clinical and site teams were apprised of IPC recommendations with regards bay and ward closures along with IPC advice.

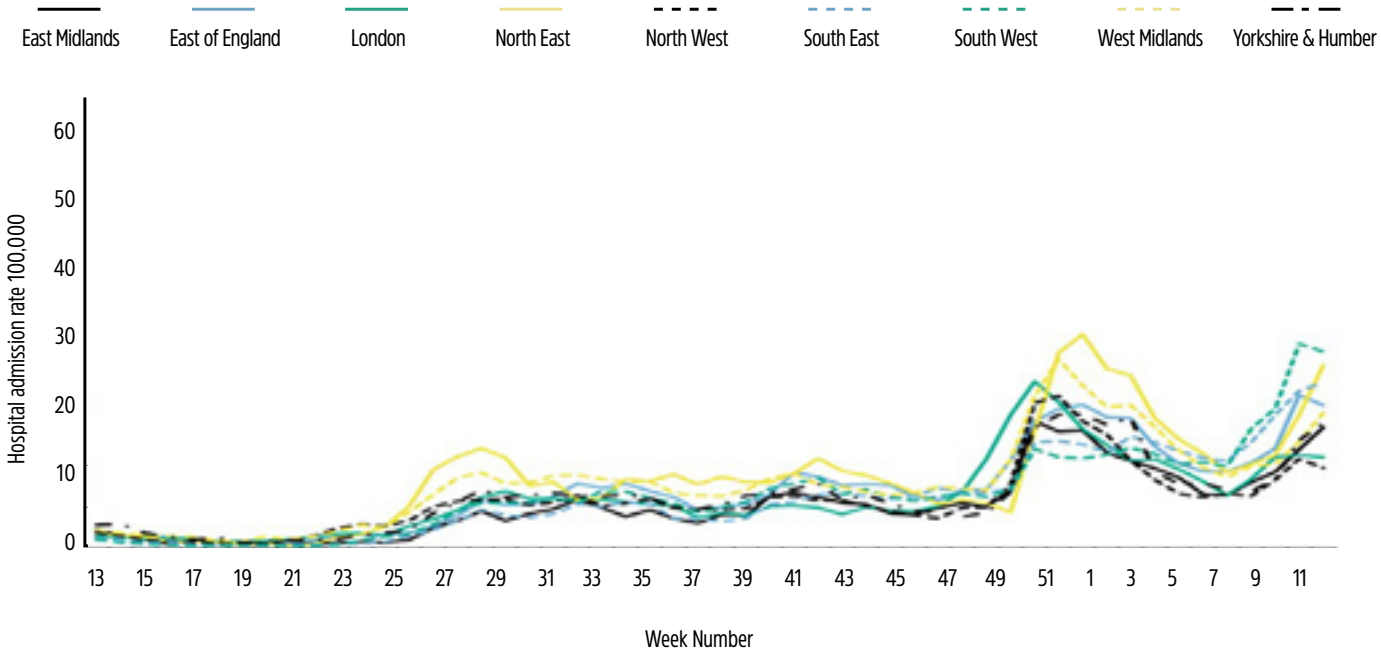
During 2021- 22, updates to national guidance and changes to the IPC board assurance framework were communicated and escalated to Trust Board as and when necessary with both the ICD and DIPC delivering Board Development sessions.

Trust COVID19 Activity



The graph demonstrates COVID19 activity at the Trust and the number of hospital onset cases.

Weekly hospital admission rate by UKHSA Centre for new COVID-19 positive cases.



(Source: UKHSA: Weekly national Influenza and COVID-19 surveillance report)

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.

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. The ward also forms part of a network of high consequence infectious disease facilities across the UK which can be utilised as and when required.

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 again significantly reduced during 2021/22 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 2021-22, 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. Although the scheme has been delayed due to the COVID-19 pandemic and the demand on inpatient facilities, it is scheduled to start during 2022.

The Neonatal Intensive Care Unit (NICU), 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. This is due in part to changes expected once the paediatric scheme commences, allowing NICU to review parental accommodation and reconfigure the unit accordingly.

During 2021-22, the COVID-19 pandemic continued to provide 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. Wards H36, H37 & H38 were utilised 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. Suite 36, an administration block closed and from December 2021 has been reconfigured to become a further inpatient area, again providing further isolation capacity on the HRI site, this is scheduled to open by June 2022.

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. Although the scheme was initially delayed the new unit opened during December 2021, providing fully compliant ICU facilities including isolation cubicles with negative pressure ventilation. Additional capacity to future proof the unit will be made available on the third floor of the scheme during 2022 which will also include additional theatre areas, all of which will improve care for patients requiring intensive care.

ANTIMICROBIAL STEWARDSHIP

Increasing emphasis is being placed nationally on the importance of antimicrobial stewardship as part of infection prevention and control plan.

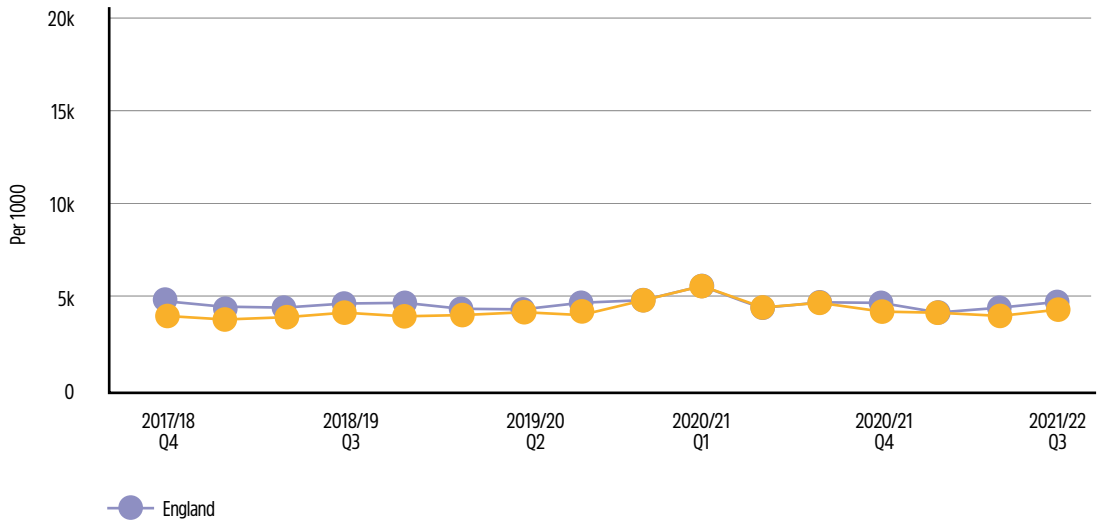
This is useful in reducing the development of C difficile infection, but is even more important in limiting the emergence of bacterial resistance. The Trust has for many years had a good record in antimicrobial stewardship.

The World Health Organisation created the Access, Watch and Reserve antibiotic categories to assist antimicrobial stewardship and to reduce antimicrobial resistance.

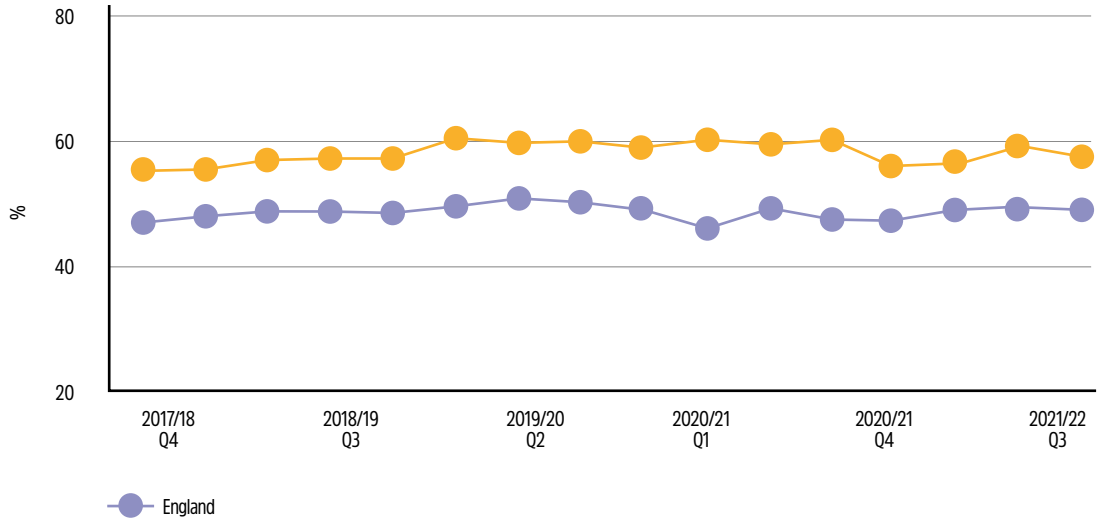
The three AWaRe categories divide antibiotics as follows:

- 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.

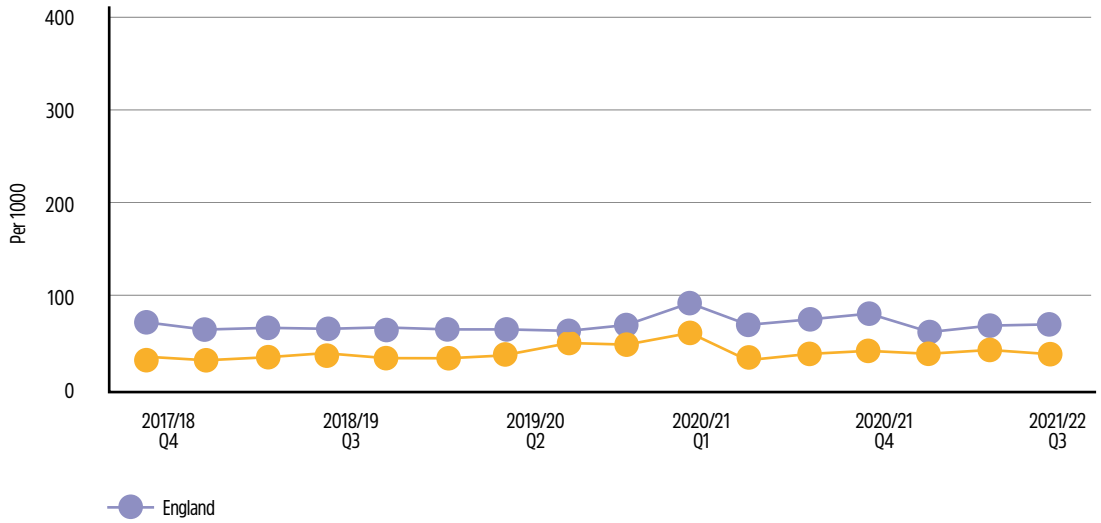
During 2021-22 CQUINS associated with use of antimicrobials and stewardship were not published because of the focused attention on the COVID-19 pandemic. Although the CQUINs were paused the Trust continued to monitor Carbapenem usage throughout 2021-22 and the proportion of ACCESS agents.



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



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 specialty has their own section and they are currently being updated. Closer links with the specialties concerned is integral to the development of the updates which will hopefully encourage guideline adherence. During 2021-22, 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 2021-22 with the addition of new charts to accompany previously published versions 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. During 2021-22, funding was secured to purchase the Microguide application, suitable for mobile device use, enabling clinical teams to access in real time Trust antibiotic guidelines, enabling greater compliance and improved antimicrobial stewardship. This will go live for use from July 2022 onwards. 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 specialty reports.

During 2021-22 electronic prescribing and medicines administration (EPMA) continued across the Clinical Support Health Group but was expanded to include other wards and departments on the Castle Hill Hospital (CHH) site, predominantly across the Surgery 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. These improvements were recognized when extending the EPMA reach across the CHH site, with the Hull Royal Infirmary (HRI) site to follow from June 2022.

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

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. During 2021-22 the OPAT service worked in close unison with City Health Care Partnership (CHCP) in delivering an OPAT service from Marfleet Community Centre, improving patient's experiences living in and around the Hull area. This was partly funded by CHCP over a six month period and at the time of writing this report is subject to a further business case to continue with this OPAT model.

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 during 2020-21 but unfortunately delayed due to the pandemic, reduction in COVID-19 activity provided the opportunity to re-explore this service for patients with Sepsis with the team anticipating a further improvement in the care and patient experience for patients with Sepsis once fully introduced.

The Sepsis team alongside the Infectious Diseases consultant have helped and supported clinics delivering neutralising monoclonal antibodies or antivirals for non-hospitalised patients with COVID-19 (nMABs).

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 initially short-lived, although improving as COVID-19 numbers reduce.

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). Clinical teams complete DATIX reports should sterile equipment fall short of the required standards and investigated by CSSD accordingly. 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. Emergency and trauma activity continued unabated.

During the last quarter of the financial year an increase in theatre activity coupled with a reduction in COVID-19 cases has been noted.

During 2021-22 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.

WATER SAFETY

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, although reliance on paper records is reducing.

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 2021-22, 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 to eradicate contamination. 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 2021-22, the Estates team continue a consistent and comprehensive regime of water testing especially in augmented care areas and areas managing immunocompromised patients.

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 2021-22, 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 2021-22 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 and continued during 2021-22 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 2021-22, 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 once COVID-19 activity permitted. Additional monitoring via audit completed by the IPCT, Senior Matrons and dedicated CENSUS audits during 2021-22 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.

National Standards of Healthcare Cleanliness 2021 were published in April 2021 and apply to all healthcare environments and replace the National specifications for cleanliness in the NHS 2007 (and amendments) published by the National Patient Safety Agency. To encourage continuous improvement they combine mandates, guidance, recommendations and good practice. The standards incorporate significant changes such as the "percentage scoring" system which was not clear to patients/visitors, replaced with cleanliness ratings from zero – 5, similar as seen in the hospitality industry. A zero star rating equates to "urgent improvement necessary" while a 5 star rating confirms the cleanliness in the area concerned as "very good".

The Facilities team convened a Task & Finish Group with an experienced project manager during 2021 to progress through the standards and understand the changes required. At the time of drafting the report the Trust are on track with meeting the requirements of the standards within the given timeframes provided by NHS England & NHS Improvement.

Following a tendering process, Synergy Linen Management Services became the linen contractor for the Trust from the 1st August 2021, prior to that Elis UK Ltd held the contract. The IPCT continue to work closely with facilities and the linen contractor to ensure that the contract meets the requirements of the HTM 01-04 and reduces the risk of hospital linen being a source of infection transmission and that adequate safe linen supplies are maintained.

PLACE INSPECTIONS

The annual Patient Led Assessment of the Environment (PLACE) inspection of the Trust did not take place during 2021-22 due to the COVID-19 pandemic but work has continued to address and/or monitor the issues previously raised, utilising the national PLACE-lite assessment forms.

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 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 2022-22 audits were presented to the respective Infection Reduction Committees by the reporting Health Group, summarising all of the audit activity and high level findings. Due to the demands placed on the IPC team with regards COVID-19 and the frequency of audit requirements dependent upon score, completion within the allocated timeframe was not always achievable, resulting in the IPC team developing an action plan to focus on key areas requiring attention. In addition, during 2021-22 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. weekly COVID-19 compliance and 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 2021-22, ongoing compliance with audit requirements was 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.

During 2021/22, a review of IPC audits completed at ward / departmental level was undertaken to ensure ownership of and compliance with IPC practice. The review resulted in an updated audit format, audit schedule and process utilising MyAssurance being developed and going live in February 2022. At the time of drafting the annual report a live dashboard was under development and due to go live in May 2022, thereby allowing Health Groups and the IPCT identify trends and required action to improve compliance and practice. It is anticipated the live dashboard will be scrutinised and challenged at OIRC and escalation as required to SIRC, acknowledging areas for improvement and good practice.

POLICIES

The Trust has a programme for review and revision of core IPC 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 2021-22 as and when national guidance was published and/or updated with a dedicated COVID-19 PATTIE page.

A review of all IPC policies was undertaken during 2021/22 following an external audit facilitated by RSM and commissioned by the Trust on a recommendation from NHS improvement following visits during 2021 and 2022.

TRAINING AND EDUCATION

Education and training are essential to improve healthcare workers knowledge and understanding of measures to improve infection prevention and control and 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 previously 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.

The COVID-19 pandemic provided the opportunity for the IPCT to deliver bespoke training on donning and doffing of personal protective equipment and undertake fit test training to staff required to wear FFP3 masks. This continued throughout 2021-22 with training underpinned by visual cues such as posters and guidance available to staff on Pattie and auditing of compliance.

Department of Health & Social Care (DHSC) in June 2021, wrote to Chief Executives, Medical Directors & Directors of Nursing of all NHS trusts and foundation trusts with a request to strengthen FFP3 resilience in the acute hospital setting. This entailed the need to fit test staff to at least two different FFP3 facemasks, ideally three with FFP3 facemasks being rationalised to include UK make versions. This ask was particularly onerous for the IPCT to conduct in isolation and therefore the responsibility to ensure staff were fit tested was transferred to the Trust's Health & Safety Team. In addition, DHSC offered Trusts the option of accessing further support to conduct fit testing due to the time and investment involved, the DIPC accepted the offer and the National fit test team supported the Trust with additional training resource working alongside the Health & Safety Team. During 2020-21 fit test training compliance was recorded by the IPCT, but the system was not robust as locally delivered sessions although delivered and the staff member provided with a certificate was not always captured. A centrally held database and a robust system of recording fit testing training compliance for clinically facing staff was commenced during 2021-22 and forms part of the staff members appraisal process and is now recorded via HEY24/7 with two yearly updates required.

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 with the exception of resuscitation training which continued face to face, albeit at smaller numbers and following advice from the DIPC & IPCT. 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 6620 clinical staff completed level 1 & 2 ELearning during 2021-22, a marked increase from the year before. Compliance with IPC mandatory training during 2021-22 for clinical and non-clinical staff is reported at 87%.

OTHER ACHIEVEMENTS IN 2021-22

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 2021-22, this has been vital and the ongoing COVID-19 pandemic has further enhanced Trust collaboration with NHS Improvement, UK Health Service Agency, formally 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 2021-22 successful collaboration continued with regards COVID-19, nosocomial case numbers and investigation of HCAIs and notifiable diseases.

The Trust contributed at regional NHS Improvement meetings with presentations on the challenges posed by the COVID-19 pandemic, nosocomial infections and the associated learning.

OTHER RISKS IN 2021-22

During 2021-22, 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 2021-22, cases of Pseudomonas Aeruginosa colonisation were detected in neonates nursed on the Neonatal Intensive Care Unit found on twice weekly screening. Reported cases were less than in previous years. No bacteraemia cases have been detected on the unit since August 2018. Extensive investigation regarding a possible source related to the environment had previously taken place with no known source found. Measures to improve water safety and mitigate environmental contamination have taken place during 2021-22 although hampered by the COVID-19 pandemic.

Prudent communication with Public Health England and local commissioners 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 2021-22.

From the 15th March 2022, the use of a novel sink drain cleaning product was commenced on NICU with all hand wash basins and showers being cleaned with the product. A previous small scale pilot using the product on the unit had demonstrated a significant decrease in environmental contamination rates of Pseudomonas Aeruginosa, further evaluation will be undertaken during 2022/23.

During 2021-22, 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 2021-22 three cardiac perfusion machines were found to culture Mycobacteria chimaera or Mycobacteria chelonae 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.

Nationally, the risk of delaying cardiothoracic surgery now far outweighs the risk of developing Mycobacteria chimaera but until a change in national guidance is published the Trust will continue to respond accordingly when positive results are reported.

During 2021-22, the COVID-19 pandemic continued to highlight the increased need for robust digital systems not only within the Trust but also for the IPCT. This need was 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. A paper was tabled at the Trust Digital Board by the Department of Infection in March 2021 and an associated risk raised. This risk remains both on the Corporate and IPC risk registers. During 2021-22, the need for a robust digital IPC reporting system was identified by NHS Improvement as a key driver for improved reactive and proactive work undertaken by the IPCT, with current systems outdated. To date, although the Trust has scoped the use of 'off the shelf' digital IPC systems, used by other Trusts, with funding available, unfortunately current digital systems used by the Trust e.g. Lorenzo would not support any integration. For 2022-23, this remains a significant risk for the Trust and IPCT.

EXTERNAL INSPECTIONS

The Trust during 2021-22 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, NHSEI 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.

Following this visit, an offer of additional support was given by the NHSEI national IPC team who further visited the Trust during June 2021. The visits included both Trust sites at HRI and CHH along with attendance at SIRC and OIRC. Following the visit, a letter with recommendations on the reporting and governance of IPC, defining Trust wide IPC roles and responsibilities including that of the DIPC and ownership of the IPC Board Assurance Framework (BAF) was forwarded to the DIPC and Chief Nurse for consideration.

During August & September 2021, as a result of the visit and a recommendation from the national team, the Trust commissioned an audit of IPC reporting and governance processes through RSM, an external audit and assurance service. This involved a number of fact finding meetings with key members of staff along with requests for information to validate results and findings. A report was forwarded to the DIPC and Chief Nurse for consideration.

Respective action plans were drafted, monitored via SIRC & OIRC and approved as a result of all the visits and service reviews. In addition, an IPC Task & Finish Group was formed in September 2021 and chaired by the Associate Director of Quality to progress actions and ensure the BAF remained the responsibility of the Trust and Health Groups rather than the sole responsibility of the DIPC, ICD & IPCT. Significant progress was made with the last IPC Task & Finish meeting being held on the 6th April 2022. Ongoing monitoring continues via current Trust meeting structures.

PATIENT EXPERIENCE

Responsive

Single Oversight Framework (SOF) indicators 2021/22

Indicator	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	21/22
Diagnostic Waiting Times: 6 Weeks	<=1%	39.80%	38.10%	36.90%	37.10%	40.10%	39.30%	38.30%	36.30%	39.20%	37.90%	30.50%	32.96%	37.10%
Referral to Treatment Incomplete pathway	0	53.40%	56.40%	57.40%	57.10%	57.50%	57.70%	59.00%	59.20%	58.20%	57.60%	57.30%	57.25%	-
Referral to Treatment Incomplete 52+ Week Waiters	0	10,750	9,268	8,066	7,409	6,912	6,740	6,422	5,558	5,171	5,292	5,311	5,077	-
Proportion of patients not treated within 28 days of last minute cancellation	95%	8	16	11	2	6	9	9	10	7	12	15	12	-
A&E Waiting Times: Patients seen within 4 hours	0	69.80%	68.40%	70.90%	62.80%	56.70%	55.60%	55.80%	53.90%	53.00%	49.60%	50.50%	48.50%	58.4%
Ambulance turn around - number over 30 mins	0	12.40%	15.40%	16.20%	24.60%	22.90%	23.20%	24.50%	23.00%	18.60%	20.80%	20.70%	21.10%	-
Ambulance turn around - number over 60 mins	reduction	3.60%	5.90%	5.10%	11.30%	17.70%	18.40%	15.90%	19.70%	12.70%	15.30%	21.70%	26.20%	-
Stranded Patients (21 days)	>=93%	84	108	108	98	106	117	132	163	149	159	187	208	-
Two Week Wait Standard	>=93%	79.30%	74.10%	74.60%	82.90%	82.60%	87.10%	77.00%	69.50%	74.20%	81.30%	83.10%	not yet published	78.58%
Breast Symptom Two Week Wait Standard	>=96%	9.90%	9.40%	3.10%	10.00%	16.10%	48.20%	20.90%	7.40%	14.50%	17.30%	32.80%	not yet published	16.43%
31 Day Standard	>=98%	87.90%	91.70%	94.10%	93.30%	89.80%	90.30%	88.90%	91.80%	94.30%	85.00%	89.90%	not yet published	90.70%
31 Day Subsequent Drug Standard	>=98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.40%	100.00%	93.50%	100.00%	not yet published	99.14%
31 Day Subsequent Radiotherapy Standard	>=94%	100.00%	98.00%	99.30%	100.00%	98.70%	96.30%	98.10%	98.90%	96.90%	92.30%	98.20%	not yet published	97.86%
31 Day Subsequent Surgery Standard	>=94%	72.90%	74.20%	77.60%	77.40%	77.80%	78.50%	75.80%	66.70%	63.50%	54.40%	69.40%	not yet published	67.14%
Cancer: 62 Day Standard	>=85%	56.70%	62.40%	64.50%	65.00%	55.80%	56.80%	55.70%	65.40%	66.90%	54.80%	56.70%	not yet published	60.07%
Cancer: 62 Day Screening Standard	>=90%	56.90%	50.00%	44.30%	58.70%	57.60%	62.00%	61.80%	68.80%	73.90%	49.30%	33.30%	not yet published	57.21%
Cancer: 28 Day Faster Diagnosis	>=75%	66.80%	71.70%	68.90%	73.60%	76.10%	77.70%	75.10%	78.10%	78.60%	70.00%	75.30%	not yet published	73.76%

The Trust's position on 'responsive' remained affected in 2021/22, following national directives to cancel elective procedures and outpatient clinics in order to create capacity for Covid-19 patients in 2020/21. Previous to the start of the pandemic, 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 agreed recovery plans in order to return to pre-pandemic levels.

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.

Effective

Single Oversight Framework (SOF) indicators 2020/21

Indicator	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	21/22
HSMR	< 100	102.35	86.8	87.88	92.55	105.42	103.05	97.89	126.64	112.12	120.6	not yet published	not yet published	117.34
HSMR Weekend	< 100	123.3	109.33	139.19	132.25	134.27	137.99	109.2	155.74	167.73	153.43	not yet published	not yet published	151.78
SHMI	< 100	117.25	117.28	115.74	114.83	115.37	115.09	115.05	not yet published	not yet published	not yet published	not yet published	not yet published	115.2
Theatre Utilisation	90%	83.40%	82.20%	80.90%	75.40%	69.80%	74.30%	67.40%	79.30%	68.00%	64.70%	81.90%	82.60%	75.90%
30 Day Readmissions	<=8.1%	7.60%	7.30%	7.60%	7.10%	7.00%	7.00%	7.20%	6.90%	7.90%	7.60%	5.90%	not yet published	7.00%

The Trust has in place a Mortality and Morbidity Committee, which is a multi-agency Committee across the Trust's Health Groups and Corporate functions including Quality Governance and the Medical Examiner Service and primary care colleagues. The Committee undertakes more detailed analysis of the factors affecting mortality and how improvements can be made against the end of life care and bereavement services. The Committee is improvement focused with presentations on key improvement work received from Health Group Medical Directors, the Quality Governance Team, and the Deputy Chief Medical Officer and from other key projects that take place as a result of actions agreed at this meeting.

The quarterly and annual Learning from Deaths Report are reviewed at the Mortality and Morbidity Committee, Quality Committee and Trust Board. Mortality and Learning from Deaths information is now also presented to the Health Group Specialty Governance Meetings, Health Group Governance Committees and work is ongoing to improve the information available to further enhance the discussions and learning at Mortality and Morbidity Meetings across all Specialties.

In 2021, the Mortality and Morbidity Committee established a Task and Finish Group to address the Trust's current Dr Foster Hospital Standardised Mortality Ratio (HSMR) outlier status as identified in the CQC Insight Report from May 2021 and to undertake some more in-depth mortality improvement work. The group is led by the Deputy Chief Medical Officer and is MDT with representation from Hull CCG and it continues to meet twice per month. The Task and Finish Group has undertaken a significant amount of work to fully understand the Trust's mortality status and how this can be improved, sustained with improved clinical outcome evidential. The Task and Finish Group has identified its priority clinical conditions to focus on initially as Sepsis, Pneumonia, Stroke, Lung Cancer. This work is ongoing.

Safe

Single Oversight Framework (SOF) indicators 2021/22

Indicator	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	21/22
Occurrence of any Never Event	0	0	0	1	1	0	1	1	0	0	1	0	0	5
VTE Risk Assessment	95%	-	-	81.54%	-	-	85.84%	-	-	86.03%	-	-	not yet published	84.49%
Patient Safety Alerts Outstanding (CAS)	0	0	0	0	0	0	0	0	1	1	1	1	1	1
MRSA Bacteraemias	0	0	1	0	0	0	0	0	0	1	0	0	0	2
Clostridium Difficile	<=80 (21/22)	0	5	1	9	3	3	1	3	3	2	4	4	38
Emergency C-section rate	<=12.1%	18.20%	19.60%	18.30%	18.80%	16.10%	17.80%	18.00%	18.80%	16.90%	20.30%	17.30%	not yet published	18.19%
Stroke - % of patients spending at least 90% of their time on a Stroke Ward (Best Practice Tarrif)	≥80%	78.95%	75.82%	64.47%	71.23%	72.22%	77.78%	83.64%	82.02%	84.81%	86.96%	62.79%	not yet published	76.87%
Stroke - % of patients admitted to a Stroke Ward within 4 hours via A&E	≥90%	76.90%	75.30%	68.70%	63.30%	61.80%	60.70%	66.70%	56.30%	78.30%	69.10%	61.20%	not yet published	66.60%
Stroke - TIA Service: % scanned within 1 hour (Best Practice Tariff)	improvement	90.79%	92.31%	96.05%	89.04%	88.89%	92.59%	92.73%	96.63%	93.67%	91.30%	79.07%	not yet published	91.79%
Stroke - TIA Service: % scanned within 12 hours (Best Practice Tarrif)	improvement	52.63%	43.96%	44.74%	49.32%	45.83%	48.15%	52.73%	53.93%	55.70%	49.28%	41.86%	not yet published	49.13%

The Trust has reported five Never Events this year; 3 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 November 2021, this alert remains outstanding. This alert relates to 'Eliminating the risk of inadvertent connection to medical air via a flow meter'. The Trust failed to meet the stroke measures as reported in Best Practice Tariff.

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%.

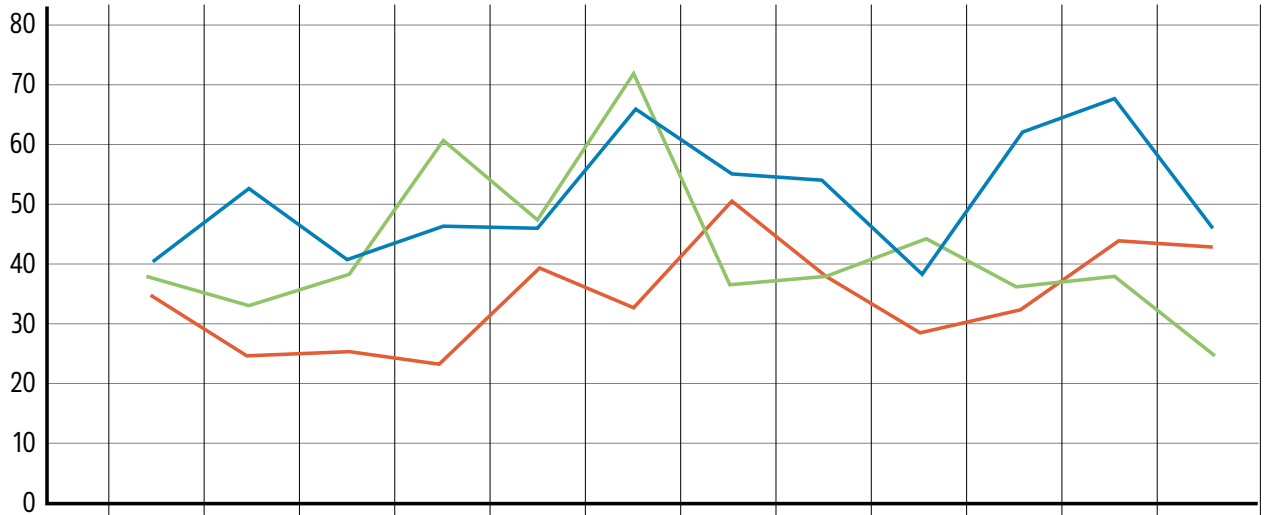
Caring

Single Oversight Framework (SOF) indicators 2021/22

Indicator	Standard	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	21/22
Inpatient Scores from Friends and Family Test - % positive	-	not yet published	98.00%	99.00%	99.00%	100.00%	99.00%	99.00%	99.00%	98.90%	85.40%	89.00%	not yet published	95.2%
A&E Scores from Friends and Family Test - % positive	-	not yet published	82.00%	79.00%	76.00%	70.00%	70.00%	71.00%	79.00%	70.60%	71.80%	67.70%	not yet published	73.3%
Maternity Scores from Friends and Family Test - % Positive	-	not yet published	96.00%	100.00%	100.00%	100.00%	96.00%	100.00%	100.00%	100.00%	100.00%	100.00%	not yet published	99.3%
Staff Surveys: FFT recommend the Trust as a place to work	-	-	-	not yet published	-	-	not yet published	-	-	not yet published	-	-	not yet published	not yet published
Staff Surveys: FFT recommend the Trust as a place for care/ treatment	-	-	-	82.3%	-	-	82.3%	-	-	not yet published	-	-	not yet published	82.3%
Written Complaints Rate	Reduction	2.02	0.72	1.34	2.33	1.6	1.91	1.21	1.65	1.27	1.27	1.07	1.24	1.46
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Complaints

Complaints Received by Month and Year



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2019/20	40	53	41	46	46	66	55	54	38	62	68	46
2020/21	35	25	25	23	39	33	51	38	28	32	44	43
2021/22	38	33	38	61	47	72	36	38	44	36	38	25

This graph sets out comparative complaints data from 2019-22 to date. During the period 1 April 2021 to 31 March 2022, the Surgery Health Group (HG) received 106 complaints (21%), Medicine HG 112 (22%), Family and Women's HG 115 (22%), Emergency HG 65 (13%) and Cancer and Clinical Support HG 48 (9%) complaints. Six 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. Complaint numbers over the past two years have fluctuated due to the Covid-19 pandemic.

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, 439 formal complaints were closed. The Trust aims to close complaints within 40 working days and 46% 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 (105), with outcome of treatment (53) outcome of surgery (35) being the top 3 sub-subjects within complaints.

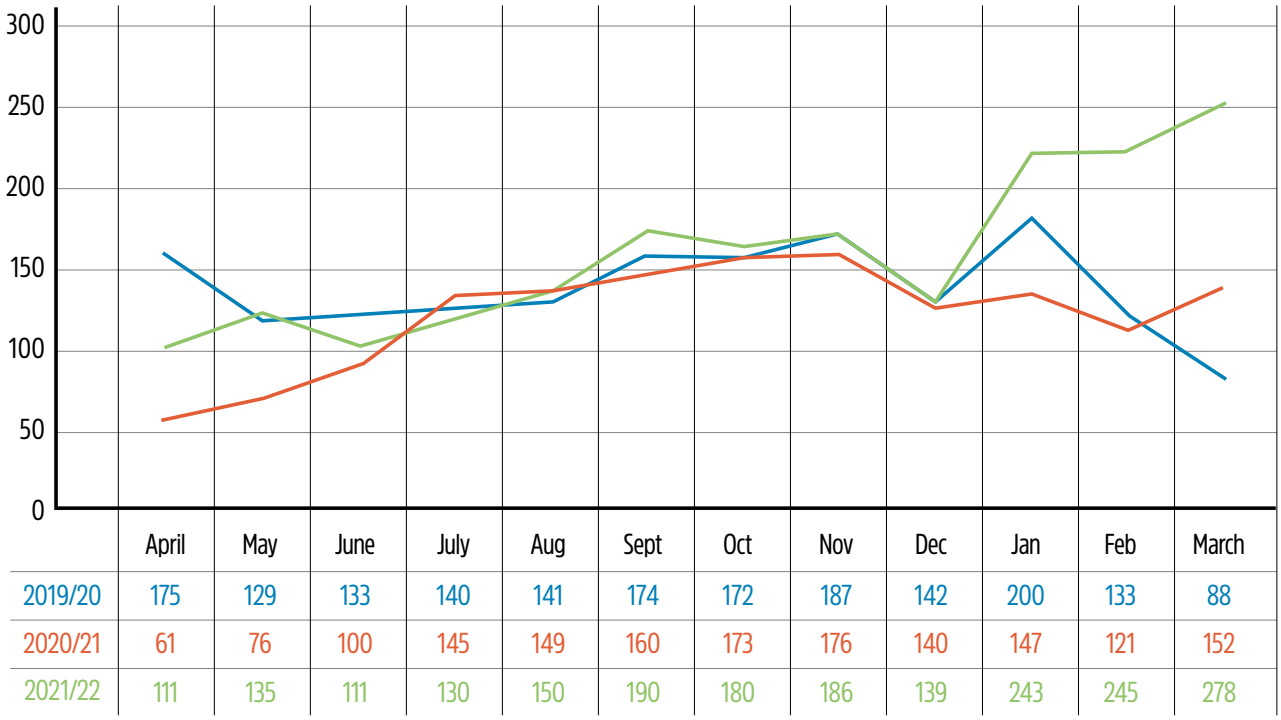
64 complaints were not investigated for varying reasons, including the complainant had requested that it not be progressed, consent not received, the complaint was escalated for a serious incident investigation, or de-escalated to PALS. 118 complaints were not upheld, 252 partly upheld and 64 upheld.

Complaints closed within 40 working days 2021/22 (whole Trust):

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
54%	60.7%	73.6%	73.6%	**53%**	**38%**	**56.6%**	**44.7%**	**42%**	**46%**	**18%**	39%

Patient Advice and Liaison Service

PALS Concerns Received by Month and Year



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2019/20	175	129	133	140	141	174	172	187	142	200	133	88
2020/21	61	76	100	145	149	160	173	176	140	147	121	152
2021/22	111	135	111	130	150	190	180	186	139	243	245	278

The graph indicated the total number of concerns, compliments, comments and general advice contacts received by the PALS team for April 2021 – March 2022 was 2507, an increase of 25.1% from the previous financial year (1946). The team have during the last few months of 2021/22 seen a significant increase in the number of PALS enquiries and this is expected to continue as services are reinstated following the pandemic.

PALS by Type	2018/19	2019/20	2020/21	2021/22
Comment and suggestions	15	**21**	**25**	10
Complaints	**150**	**142**	**185**	**247**
Concerns	**2253**	**1813**	**1567**	**2098**
General advice	**467**	**296**	**169**	**152**
Totals	**2885**	**2273**	**1946**	**2507**

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 (164)
- Waiting time for an outpatient appointment, including follow-up appointment (142)
- Delay, notification of results (108)

Parliamentary and Health Service Ombudsman

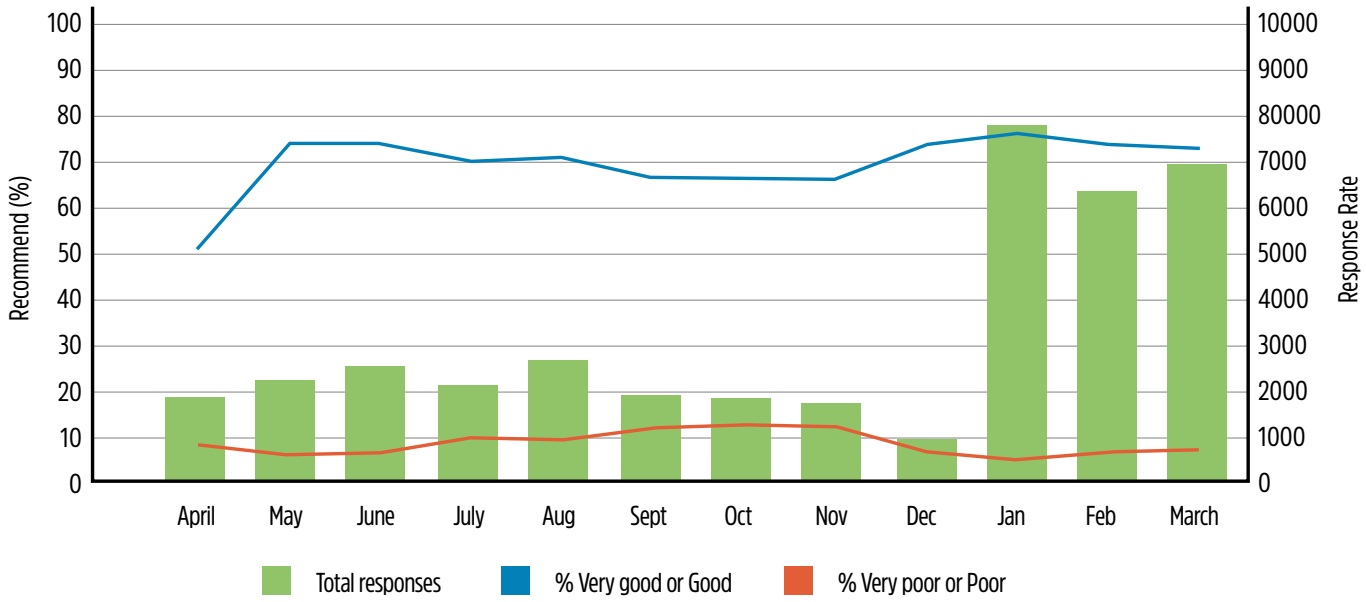
Should the complainant remain dissatisfied with the response received from the Trust into the complaint raised, they can ask the Parliamentary and Health Service Ombudsman to independently review their complaint.

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.

During 2021/22, there were 3 complaints referred to the PHSO and the outcome of each of these investigations is expected during the next few months. The PHSO reviewed 8 other cases during 2021/22 4 of which were not investigated, 3 partly upheld and 1 not upheld. Actions were recommended on the 3 partly upheld complaints, which have been completed to the satisfaction of the PHSO. Actions included discussion of the cases at the relevant Governance Meetings and staff meetings for learning and awareness. One investigation identified the lack of suitable provision for endoscopy procedures under general anaesthetic, which will be resolved with the construction of the new Allam Endoscopy Centre at Castle Hill Hospital, this will include the introduction of weekly endoscopy lists under general anaesthetic.

Friends and Family Test (FFT)

Trust Total Recommendation % v Response Rate



Hull University Teaching Hospitals NHS Trust offers patients the opportunity to feedback from all areas of the Trust. This includes inpatients, outpatients, Emergency Department, Day Surgery, paediatric services, Maternity services as well as specialist nurses, Bereavement services, radiology, audiology and Therapy Services.

The Trust has received 45,681 pieces of individual feedback between April 2021 and March 2022 from patients and their relatives. This is supporting the learning of lessons and making improvements to patient services throughout the Trust. All feedback is cascaded back through the Trust to wards and department and to the Trusts multi-disciplinary teams.

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

- 85.17% of patients have said that they would be likely to recommend HUTH if they needed to receive care in the future
- 8.08% of patients have said that they would be unlikely to recommend HUTH.

VOLUNTEER SERVICES

The Trust has 247 adult volunteers and 254 Young Health Champions volunteers across the Trust and is continuing to recruit every month.

The volunteers have dedicated 22,043 hours to the Trust between April 2021 and March 2022. Each shift for a volunteer is for a minimum of four hours. Volunteers can claim for their travelling expenses or a car-parking pass and are provided with a uniform.

The Voluntary Service's team continues to provide pastoral care to volunteers and check on them weekly if they are unwell or have not been able to volunteer. This contact is really appreciated by all volunteers, especially those who live alone or feel isolated.

Some volunteers have returned to their previous roles before the pandemic whilst others are now involved in new initiatives such as the ward communicator role, where a volunteer answers the ward or department telephones. The Activity Dementia Companions is also a new initiative and currently consists of a pool of eleven volunteers who support the Dementia lead within the Trust. Pharmacy volunteers assist the Pharmacy team with day to day duties, enabling patients to get there medication on time on discharge.

The Trust is supporting 254 Young Health Champions aged sixteen and upwards across all hospital sites. Through the Young Health Champions volunteering programme, the Trust is offering 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 and was awarded a grant of £79,520 towards the development of young volunteer opportunities; this was over a 2-year period. The funding is 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 hub will be available to all young adults in the Trust for pastoral care, a place where the team can help with training modules, apprenticeship and university applications as well as a place to meet new people and find out more about what the NHS has to offer.

The Trust is engaging with over 40 Trusts learning and sharing best practice and helping to inspire the young people of the future.

QUALITY ACCOUNTS 2021/22

Each year the Trust publishes its Quality Accounts.

These contain the details of the quality and safety priorities for the previous year and how we performed against them. It also sets out what we aim to improve during the next financial year and how we aim to do it. The Quality Accounts are published on the Hull University Teaching Hospitals NHS Trust website by 30 June each year and this Annual Report should be read in conjunction with the Quality Accounts.

CARE QUALITY COMMISSION

Care Quality Commission Inspection

The Trust was not inspected during 2021/22 by the Care Quality Commission.

The Care Quality Commission undertook an inspection of a selection of the Trust's core services in March 2020 but due to Covid-19, was not able to complete the scheduled Well-led assessment. 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.

Overall rating	Inadequate	Requires improvement	Good	Outstanding
Are Services				
Safe?		Requires improvement		
Effective?			Good	
Caring?			Good	
Responsive?		Requires improvement		
Well led?			Good	

Hull Royal Infirmary

Overall rating	Inadequate	Requires improvement	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Requires improvement	Good	Good	Good	Good	Good
Services for children & young people	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Requires improvement	Good
End of life care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Urgent and emergency	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Requires improvement	Good	Good

Castle Hill Hospital

Overall rating	Inadequate	Requires improvement	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Requires improvement	Good
End of life care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Requires improvement	Good	Good

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. The Trust has implemented an 'Internal Assurance Plan' which ensures all core services and Fundamental Standards across the organization and continually reviewed, monitored and supported to celebrate their successes and where staff are going above and beyond to provide outstanding care and to make any required improvements to ensure patients and relatives are receiving the high quality care which is safe, effective, caring, responsive and well-led.

The Trust continues to closely engage with the CQC on a regular basis, with a minimum of quarterly Engagement Meetings taking place. Updates from all core services, risks and improvements are discussed and monitored with the CQC in an open and transparent way.

SUSTAINABILITY ANNUAL REPORT

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.

GREEN PLAN

The Trust is aware of the significant impact it has on the environment and to the threat climate change poses to human health.

To this end the Trust declared a climate emergency in 2002/21 and last year the Trust board approved our green plan, titled Zero30, Becoming net zero by 2030.

This is an ambitious target and sets out a path to achieve this goal ahead of the NHS target. Hull has the second highest risk of flooding in urban area after London in England, rising sea levels in future years mean we must do all we can to mitigate climate change.

The Trust as a major employer in the local region has a responsibility to set an example in our response to climate change.

Our green plan includes objectives to:

- Reduce building emissions by 50% by 2028
- Reduce anaesthetic gas emissions by 50% by 2025
- 25% of Trust vehicles to be zero emissions by 2024
- A minimum of 10% of the award criteria for all procurement to be attributed to sustainability by 2022

The Trust has created its own website which gives further details on the Trusts objectives, a copy of the green plan can be downloaded from the front page. www.zero30.uk.

WORK COMPLETED OVER THE LAST YEAR

Last year the Trust bid for and was successful in gaining a grant for £12.6M from the department of Business, Energy, Industry and Strategy (BEIS) to decarbonise our sites.

The work 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 air source heat pumps to replace and supplement existing gas fired boilers. There was also a large project to install a 5MW photo voltaic solar farm to generate renewable power for the Castle Hill Hospital. This scheme was completed at the end of March and will provide all of the daytime power requirements of the Castle Hill Hospital meaning no power is taken from the National grid. The PV scheme will generate over 4,000,000 kWh per year, approximately a third of the power requirements of the Castle Hill Hospital. This will also increase resilience and save the Trust over £1,000,000 next year while reducing demand on the National Grid and providing 100% renewable power. The Trust continues to explore opportunities for the installation of more renewable technologies on site.

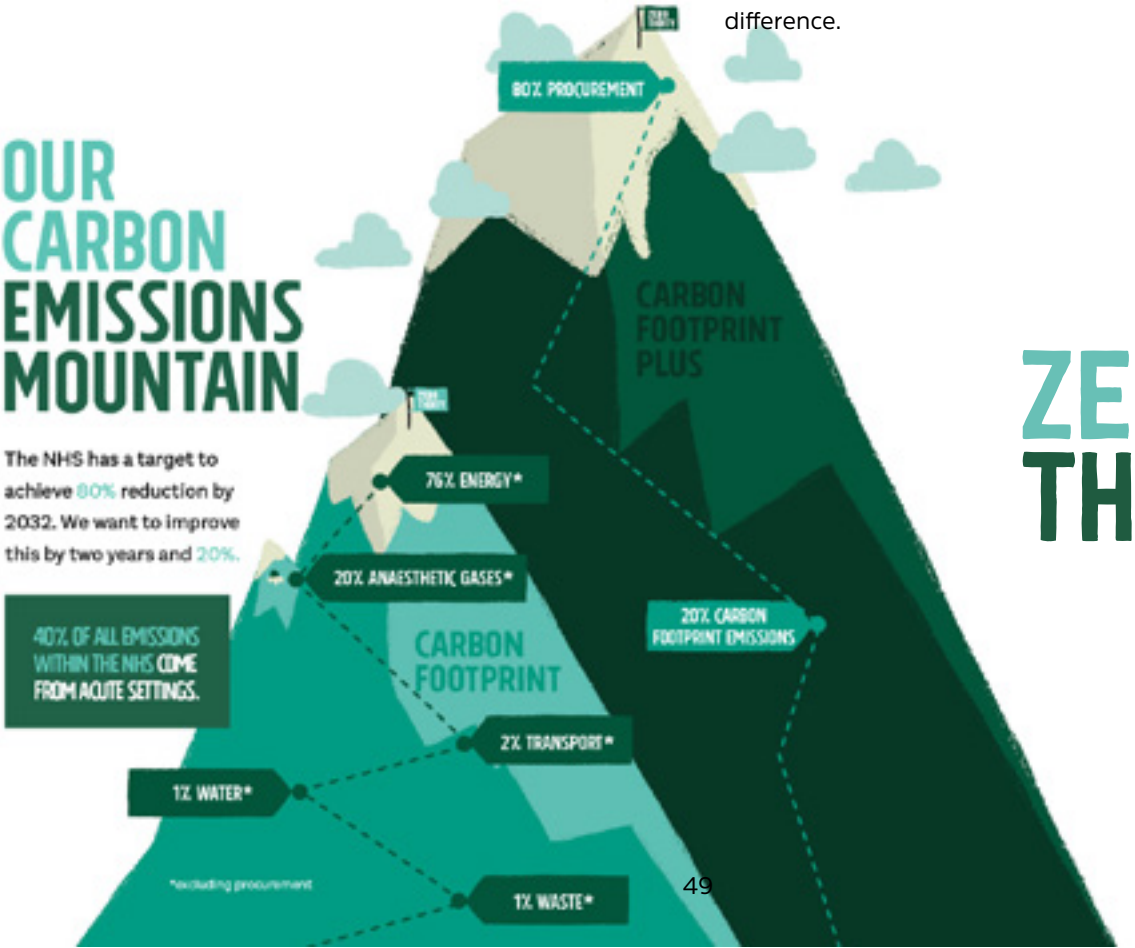
As a result of the grant, the work completed is forecast to reduce carbon emissions by approximately 1,500 tonnes CO2e. To achieve the Trusts ambitious target similar ongoing levels of investment into the Trust estate are required. Key areas of focus are the improvement of existing building fabric by increasing insulation, replacement windows and reducing air leakage combined with a move away from fossil fuel heating sources.

A piece of work to reduce the usage of Entonox delivered a significant reduction in carbon emissions. Entonox is a gas made up of 50% Nitrous oxide and 50% Oxygen, its primary usage is pain relief. Due to the nature of Nitrous oxide it is 296 times more harmful to the environment than carbon dioxide. The area of greatest use in HUTH was in the Women and Children's Hospital, following initial investigation into the usage a multi-disciplinary team was set up to check for potential leakage. The work resulted in the replacement of seals in the bed head units and a change of process in the department to ensure breathing valves were only plugged in to the system when in use. The effect of this was to reduce emissions by 87%. Not only has this contributed to a reduction in overall Trust footprint emissions of over 10% but will save over 3,500 tonnes of CO2e per year and over £40k. Additional benefits include the reduced number of deliveries to site and savings in staff time no longer changing cylinders.

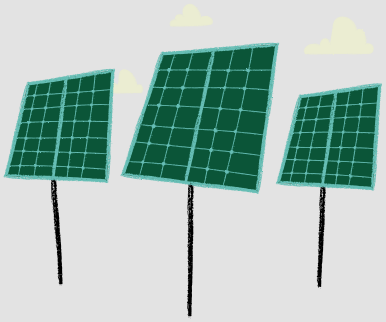
Over the year work has continued to improve the facilities for active travel and promote its adoption by staff and visitors. In partnership with the East Riding of Yorkshire Council an extra 60 cycle stands have been installed onto the Castle Hill site together with a bicycle maintenance station. To help cycle access to site a new cycle and pedestrian access point from the A164 cycle path has been created to allow users to access the facilities in the North West corner of the site more easily.

Improvements to HRI have been limited due to the significant construction works but plans are in place for the new financial year.

To promote the Zero30 plan and engage with staff a communications plan has started encouraging staff to make pledges of how they will support and make changes to reduce their impact on the environment. There is more work to do with engaging staff and shifting the culture but there is a real interest from our staff and a desire to make a difference.



ZERO THIRTY



To support the move towards zero emissions vehicles the Trust has installed 31 electric vehicle (EV) chargers. These are split into areas for patients and visitors and general areas for staff use. The staff areas hope to support those staff who don't have access to off street parking at home the option to consider an EV and be able to charge while at work.

The work of the Trust was recognised in October when the Capital team won the IHEEM award for Sustainable achievement.

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 in partnership with our contractors and suppliers to ensure they to embrace our ethos.

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.

However working with NHS forest the Trust received 1,000 native trees that it planted on the Castle Hill site. This planting was carried out with the assistance of three local primary schools whose pupils attended on the day to plant trees and was for all of them the first external school trip they had had since the pandemic.

These trees will help to offset carbon emission by sequestering carbon as they grow as well as expanding a woodland habitat that will support many other species of flora and fauna in the years to come.

ENERGY

In the last year the Trust has had a significant investment in the estate to reduce the use of energy and carbon emissions.

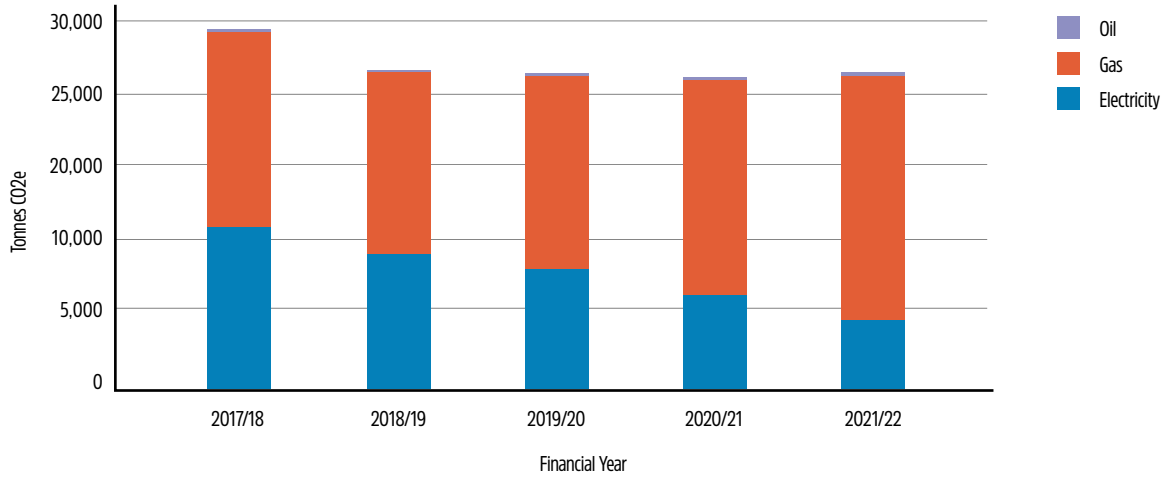
This has come from external funding in the form of £12.6M from BEIS and additional Trust capital funding. The Trust has spent £6,248,170 on energy in 2021/22, this was an increase from last years cost due to the impact of rising prices on the energy markets and the need to install a new supply to CHH to enable the PV and CHP to be connected. The impact of this is an increase to the average cost per kWh of 0.4p.

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

Energy Consumption	2017/18	2018/19	2019/20	2020/21	2021/22
Electicity Use (kWh)	27,497,952	29,045,520	28,530,717	25,137,847	19,176,384
Gas Use (kWh)	72,563,655	67,254,657	72,996,079	79,769,461	90,028,622
Oil Use (kWh)	258,110	633,914	657,859	689,436	300,565
Total kHh	100,319,717	96,934,091	102,184,655	105,596,744	109,504,571
Total Energy spend (£)	4,925,625	5,540,173	5,687,804	5,627,062	6,248,170

Carbon emissions have increased slightly this year. This is due in part to the additional CHP installed at CHH site. The reductions forecast from the BEIS funded investments have not yet started to come through as many where completed towards the end of the financial year such as the PV that only became fully operational in March. The contribution of the CHP's and solar PV in the generation of electricity can be seen in the reduction of kWh consumed and emissions from electricity

Carbon Emissions from Energy CO2e



WATER

There has been an increase in the consumption of water at the Trust, this has been from a combination of increased water use from construction together with a number of leaks on the HRI site. These leaks have now been repaired.

Although consumption has increased the cost of the utility has also increased during the last year. There has been a notable increase in cost compared to previous years. Last year saw a 6% increase in the cost of water the year previous was 2%. Sewerage costs increased by 8% this year compared to 5% the year previous.

Water Consumption	2017/18	2018/19	2019/20	2020/21	2021/22
Mains m3	303,304	316,929	348,674	309,451	327,438
Waste water m3	242,643	252,366	278,939	247,561	288,149
Water & Sewage Spend (£)	655,861	656,471	750,431	714,883	781,658

WASTE

The Trust produced a combined total of 1,837 tonnes of waste during the 2021/22 period.

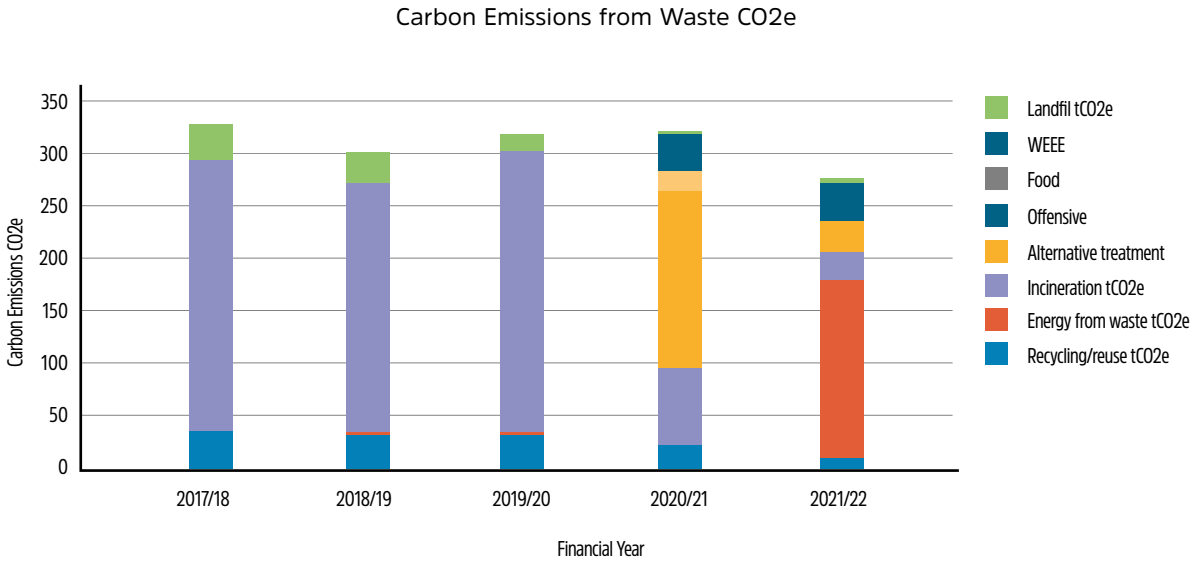
There has been a reduction in the volume of waste sent to recycling due to change with our contractors off site treatment facility. This has resulted in an increased volume of waste being sent to energy from waste facilities.

The impact of covid has significantly reduced the volume of waste generated due to reductions in the number of clinics and procedures carried out. There has been continuing work 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. They continue to educate and advise staff on the correct disposal routes. This education has changed the split in the disposal routes of the waste generated from clinical areas, greater percentages now being sent into the alternative and offensive disposal routes.

Waste Tonnes	2017/18	2018/19	2019/20	2020/21	2021/22
Recycling / reuse (tonnes)	1,745	1,641	1,615	1,254	599
Energy from waste (tonnes)	11	27	127	-	791
Incineration (tonnes)	1,165	1,087	1,208	304	109
Alternative treatment (tonnes)	-	-	-	694	119
Offensive (tonnes)	-	-	-	221	154
Food (tonnes)	-	-	-	20	26
WEEE (tonnes)	-	-	-	32	32
Landfill (tonnes)	102	87	45	7	7
Total Waste (tonnes)	3,023	2,833	2,995	2,532	1,837

The carbon emissions from waste have reduced from 321 to 277 tonnes. The change to energy from waste has had a notable negative impact on our emissions. We will continue to explore alternative usage and disposal routes of all waste streams to reduce their carbon impact. The increase in recycling both on site and off site through any future contracts will be a key focus in the coming years.



ANAESTHETIC GASES

Acute Trusts are the largest contributors to anaesthetic gas use within the NHS.

These gases have a significant impact on the environment many times higher than carbon dioxide (CO2). One, desflurane has a global warming potential of over 3,000 times that of CO2 so me must ensure we use these gases responsibly. 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.

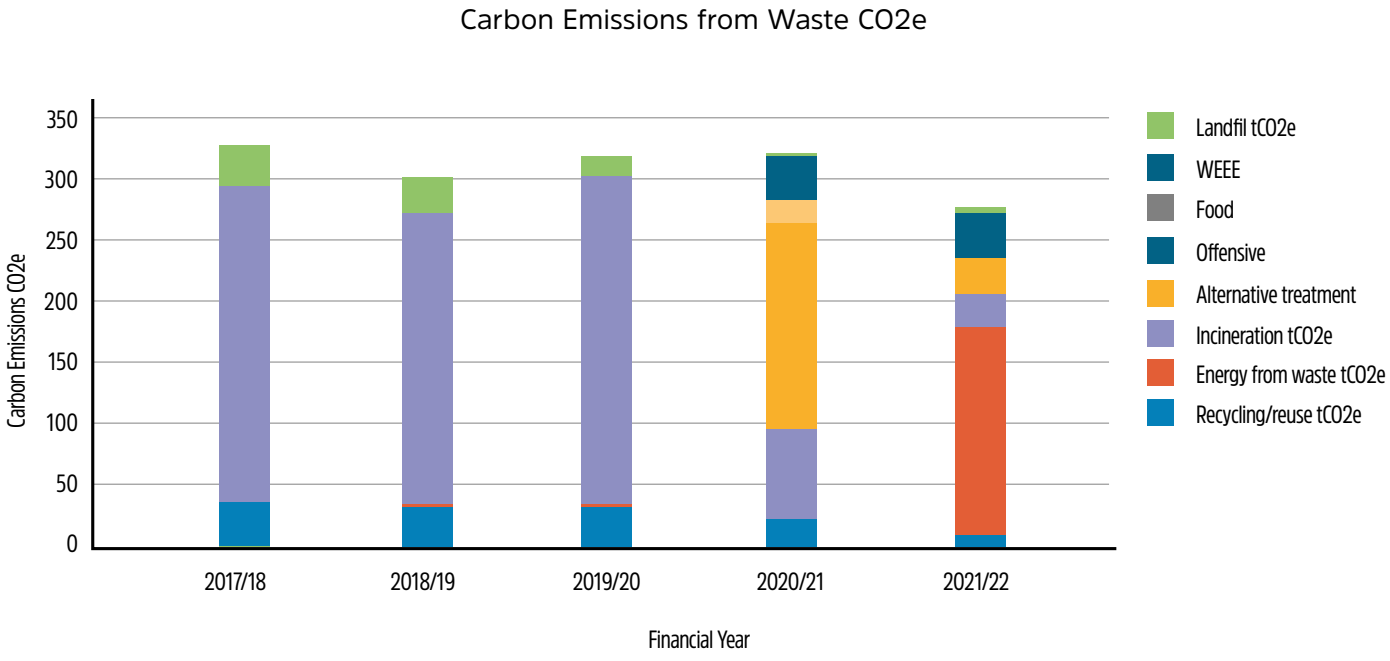
As the table below shows we have continued to reduce the use of the most environmentally damaging of the anaesthetic gases, desflurane by switching to other gases were possible.

From the 31st March the Trust will no longer be purchasing any more desflurane, the remaining product will be registered as a sign out drug.

The last year has seen an increase in sevoflurane and isoflurane back to levels seen pre covid. The work mentioned previously around Entonox reduction has resulted in the significant fall in usage seen in the graph. By reducing leakage and changing the processes in the Women and Children's Hospital to ensure the demand valves are not left plugged in. Last year the Trust reduced its emissions by almost 2,000 tonnes a saving of 47% of the levels seen pre covid.

There is more work to do but the Trust has made great progress towards lowering its emissions from anaesthetic gases. The engagement and support of both the anaesthetic teams, support services and midwives have been instrumental in bringing about these changes.

Anaesthetic Gases Volume	2017/18	2018/19	2019/20	2020/21	2021/22
Desflurane - liquid (liters)	234	232	112	39	19
Isoflurane - liquid (liters)	46	57	72	11	53
Sevoflurane - Gas (liters)	620	644	701	322	550
Nitrous oxide - gas (liters)	1,764,000	1,103,400	1,735,200	1,312,200	1,962,000
Portable nitrous oxide ar (liters)	569,000	460,600	492,800	331,100	426,300
Maternity Manifold nitrous (liters)	12,225,000	14,535,000	15,960,000	14,640,000	6,645,000



ELIMINATING MIXED-SEX ACCOMMODATION (EMSA)

Declaration Of Compliance 2021/22

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 2021/22, 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 2021/22.

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: hyp-tr.pals.mailbox@nhs.net if you have any comments or concerns about single gender accommodation. Thank you.

Signed:
May 2022

Sean Lyons,
Chairman

Chris Long,
Chief Executive

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 Cady.

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 c 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 a more inclusive organisation.

RESEARCH AND INNOVATION

The ambitious HUTH R&I Strategy seeks the creation of a well-led 'research active and aware' workforce enabling high quality care for every patient through research opportunities.

To achieve this, it is fundamental that there are mechanisms to increase our capacity and capability for research in order to recruit and retain remarkable staff and high-quality researchers and develop the research potential further in all professional groups, service users and carers.

The opportunity to seize the momentum for engagement and growth in research among senior clinical colleagues is ongoing. Underpinning this aim is the requirement for investment in people to deliver research that will translate into the provision of safe, high quality care with greater clinical outcomes than those organisations that do not support research investment.

CLINICAL RESEARCH NETWORK

National Institute for Health Research portfolio:

A national programme of 'managed recovery' has been implemented to ensure that non-COVID 19 research activity resumes to pre-pandemic levels as rapidly as possible.

7,350 participants were recruited into 142 NIHR portfolio adopted studies. Specifically, we would like to highlight the following:

- The Trust has achieved 166% of its 2021-22 'NIHR portfolio' participant recruitment target **with over 7,000 accruals** and so represents notable value for money and impact on the local community.
- A strategic focus on the restart and recovery of commercially-led research and a commitment to delivering for the Life Sciences Industry post-pandemic has seen the Trust's **commercial activity ranked 3rd highest in the network as well as 2nd highest number of recruiting commercial studies for commercial activity.**
- Population and Mental Health feature amongst the top recruiting studies in HUTH's portfolio with the 'Hull Lung Health' and 'Faster Access to Alcohol Treatment' work, with both also focussing on collaboration with the wider community population within the region and neighbouring Trusts such as NLAG.
- HUTH continues to deliver a broad research portfolio with **142 active and open portfolio studies – again, ranked 3rd highest in the network.**
- Notable activity areas to highlight include Oncology and Haematology, Respiratory, Metabolic & Endocrine (top recruiter in the network and nationally), Renal, Paediatrics, Gastroenterology, Hepatology and Trauma and Emergencies.
- **Almost 60,000 participants have been recruited into research over the last 12 years.**
- There has been a significant step-wise increase in Trust-led research undertaken nationally (NIHR grants awarded), which is providing the catalyst for the Trust's planned expansion of research capability and capacity. In conjunction with our some of our academic colleagues **we have hosted over £10m of NIHR grants in the last 10 years.**

We feel sure that the ongoing delivery of our Research and Innovation Strategy (and continued pursuit of this throughout the pandemic) has contributed to this notably strong performance.

In collaboration, we have now delivered four Covid-19 Vaccine Trials. This has done much to enhance the reputation of the RDI Team as well as operational and support staff. Individual researchers continue to attain national prominence, the most recent being Dr Lynsey Corless who is to be appointed NIHR Hepatology National Speciality Group Lead.

Following the Trust's tremendous contribution to COVID-19 research over the past two years, is it critical that it can build on this momentum and champion research as a treatment option for those who have to use our services within both our acute setting and the wider Humber Coast and Vale ICS.

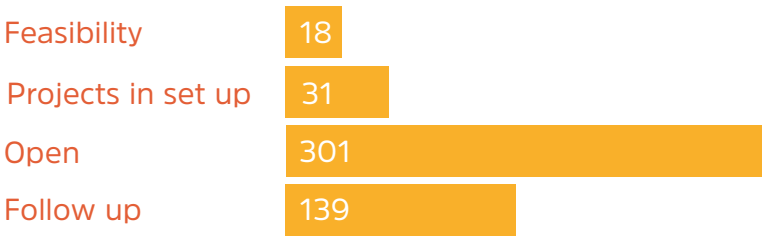
R&D SUMMARY DASHBOARD (AS AT 31/03/2022)

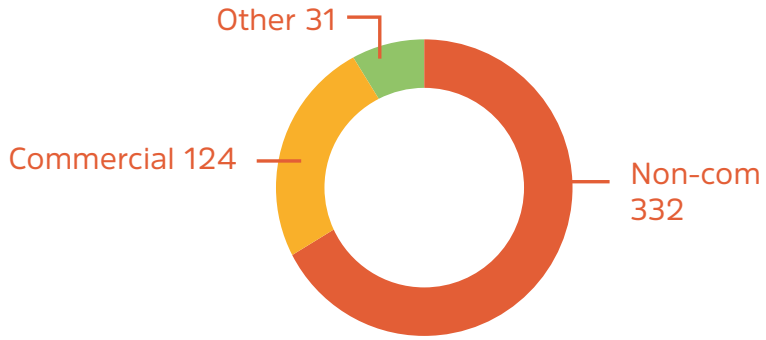
8174 patients were recruited in **2021/22**

Top 5 Contributors

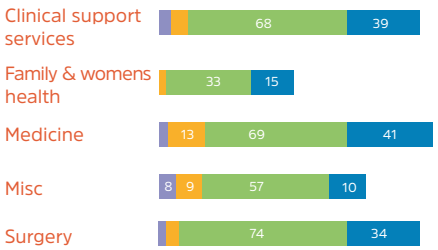
- Respiratory **4.37K**
- Infectious Diseases **1.33K**
- Emergency Medicine **430**
- Diabetes **336**
- Oncology **240**

489 Projects are currently being assessed for feasibility,set up, open, or in follow up.

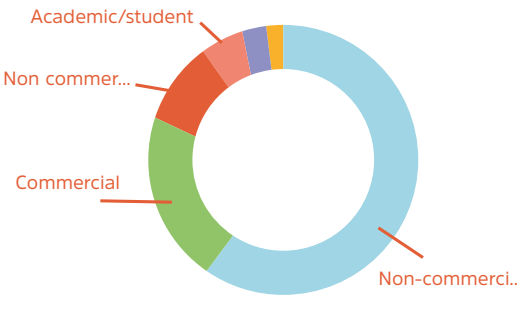




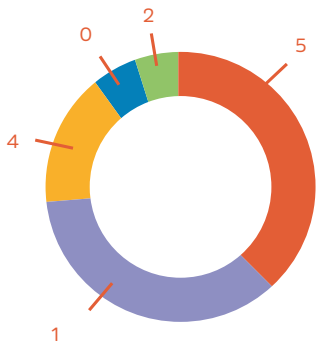
What is the status of our projects by clinical area?



What is the split of our projects by type?



What is the split of our projects by IRAS category?



Project status

Feasibility	18
Projects in set up	31
Open	301
Follow up	139

Project Type

(Blank)	10
Academic/student	21
Commercial non-portfolio	6
Commercial portfolio	120
Non-commercial non-portfolio	58
Non-commercial portfolio	274

IRAS Category

0	33
1	168
2	22
4	67
5	199

PROGRESS ON KEY STRATEGIC PRIORITIES IN 2021-22

2021-22 saw the deployment of a number of initiatives that continue to underpin the delivery of the R&I Strategy:

- ## Significantly increasing Trust-led research undertaken nationally

  as our research activity and workforce capacity incrementally expand, our success in securing externally funded grant income from the NIHR continues. We can now boast to lead multi-centre national research in the areas of Vascular Surgery, Gastroenterology (IBD and Hepatology), Renal, Orthopaedics, Respiratory, Infection and Haematology (a £2.3m NIHR Grant secured in 2021-22).

- ## Expanding our research capability

  Continuing from the vital COVID-19 vaccine research, the Infection Research Group secured a Genetically Modified Organisms (GMO - Contained Use) license from the Health and Safety Executive. This will initially support the delivery of a specific Hepatitis-B commercial trial but will open up the possibility of further work seen as critical to the ability of the Trust to participate in this emerging field across both Infection and Oncology.

- ## Establishing research programmes with the potential to positively impact our key performance and quality indicators

  The Hull Lung Health Study builds on the fantastic work of the HCV ICS Hull Lung Health Checks. This data collection study will generate a highly valuable cohort dataset that can help determine future research and influence the direction of service provision in this area. To date, almost 5,000 patients have consented to this important study. The Respiratory and Therapies teams are working with colleagues across the patch in a major new research consortium, which will inform medium and longer-term policy and health system responses to Long COVID. Our Trust will continue to support the delivery of an important 'Long-COVID' study 'STIMULATE-ICP'.

- ## Exploiting our research potential

  A concerted effort in 2021-22 by our local partners (HYMS, UoH) to bring together all key stakeholders to embed a pipeline of PET-CT research is gathering momentum with one study in the advance stages of negotiation with an international commercial company.

- ## Exploiting our research potential

  The Trust is currently in early feasibility discussions with two commercial companies including projects to use Artificial Intelligence (AI) technology in breast screening (supported by NHSx) and improved detection of abnormal chest x-rays. Academically, partnerships between clinicians and staff at the University of Hull are beginning to explore the use of large datasets with AI technology. Additionally, five potential AI projects have been chosen to be taken forward in collaboration with MSc students at the University of Hull's Faculty of Science and Engineering. This is the first time such a collaboration has been attempted and it is hoped this can create a mutually beneficial mechanism to unify the clinical and academic skills on our doorstep.

- ## Humber and North Yorkshire Health and Care Partnership

  The Trust wishes to play an active role the establishment of a Humber and North Yorkshire Health and Care Partnership 'Research Collaborative' initially of the Acute Providers in the patch; Harrogate, HUTH, NLAG and York. Several meetings with the ICS and acute Trusts were held in 2021-22 and established a blueprint for a formal governance pathway for research and innovation activities. In the second half of 2021-22, plans to cement our research relationships with our immediate neighbours (NLAG and Humber) have taken shape, culminating in an agreed pathway for a 'Memorandum of Understanding'.

- ## Cancer Data Network (IQVIA)

  Throughout 21-22, the R&D Office has been working with IT colleagues and the commercial company IQVIA to explore the possibility of implementing the infrastructure to host the 'Cancer Data Network'. This is multi-faceted with a focus on (1) advanced on-site cancer data analytics and benchmarking to identify variations in pathways and (2) research services and trial matching solutions to optimise research as a treatment option for these patients. Fundamentally, this is aimed at increasing treatment options of cancer patients. The implementation would drive efficiencies in viewing data and making clinical decisions to reduce variations in practice but also from a research perspective, would save valuable hours of pre-screening that is currently done manually.

- ## Building research accommodation

  The latest building to open on the Hull Royal Infirmary site has been generously supported by local businessman and philanthropist, Dr Assem Allam, with a donation of £3m. The Allam family donation has facilitated a significant increase in research accommodation within this building. This has resulted in purpose-designed, spacious and modern accommodation in which to undertake diabetes and endocrinology research, and the new centre is now helping to reaffirm Hull's reputation as a global leader in research too. The entire first floor has been given over to diabetes and endocrinology research and the staff supporting this work, which seems fitting given this team is the most successful recruiter into endocrine studies in the whole country.

  Their cutting-edge research facilities now include dedicated laboratories, a sports science laboratory, ultrasound, ECG and consulting rooms plus day-case facilities for complex clinical trials. The team currently has over 200 people involved in 12 active clinical trials, the findings of which will go on to benefit people with long-term conditions by significantly advancing treatment options and medical knowledge.

NHS
Hull University
Teaching Hospitals
NHS Trust

ACCOUNTABILITY REPORT

ANNUAL REPORT 2021/22

CORPORATE GOVERNANCE REPORT

DIRECTORS REPORT

There have been 3 Chairs of the Trust in 2021/22 and these were Terry Moran CB until August 2021, Stuart Hall (Acting chair) took over temporarily whilst a recruitment process was undertaken and Sean Lyons from February 2022 to date. Sean is joint Chair with Northern Lincolnshire and Goole Hospitals NHS Foundation Trust.

The Trust Board comprises the Chairman, six voting Non-Executive Directors, 2 non-voting Non-Executive Directors, 5 voting directors and 3 non-voting directors. The directors with voting rights are the Chief Executive, Chief Nurse, Chief Financial Officer, Chief Medical Officer and Chief Operating Officer.

The 3 non-voting members of the Executive Team are the Director of Workforce and OD, the Director of Strategy and Planning and the Director of Quality Governance. In 2022/23 a Joint Chief Information Officer has been added to the Board.

Four Board members have a clinically related background. These are the Chief Nurse, the Chief Medical Officer and 2 Non-Executive Directors.

TERMS OF OFFICE OF NON-EXECUTIVE DIRECTORS

The Non-Executive Directors were appointed to the Board by NHS England/Improvement.

Non-Executive Directors can be appoint for a maximum of 3 terms (up to 9 years). There is one exception as the Trust is a NHS organisation with a significant teaching commitment it appoints one Non-Executive Director from the University of Hull.

Terms of office, Non-Executive Directors

Name	Title	Term 1	Term 2	Term 3
Sean Lyons	Chair	1 February 2022 and end on 31 January 2025		
Stuart Hall	Vice Chair/ NED	01.01.15 to 31.12.16 Extended to 30.06.17	01.07.17 to 30.09.19	01.10.19 to 30.09.23
Tracey Christmas	NED/SID	06.07.15 to 31.07.17	06.07.17 to 30.09.18 Extended to 30.09.19	01.10.19 to 30.09.21 Extended 31.07.23
Tony Curry	A/NED NED	01.04.19 to 31.03.21 01.10.19 to 30.09.21	01.10.21 to 30.09.23	
Mike Robson	NED	01.04.20 – 31.03.22	31.03.22 to 31.03.25	
Una McLeod	NED	01.04.20 – 31.03.21	01.04.21 – 31.03.23	
Linda Jackson	A/NED	01.04.20 – 31.03.22	31.03.22 to	
Ashok Pathak	A/NED	01.04.21 – 31.03.23		
David Hughes	NED	02.02.22 – 01.02.24		

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

CHAIRMAN AND NON-EXECUTIVE DIRECTORS

Mr Sean Lyons, Chairman (Joint Chair with NLAG)

Sean joined us from Lincolnshire CCG, where he was Chairman until 2021.

Prior to this he was Chairman at Sherwood Forest Hospitals NHS Foundation Trust steering the organisation out of special measures and helping to oversee improvements to its CQC rating.

Sean left school before A-levels and went straight into an apprenticeship in the steel industry which he says was hugely enjoyable and gave him a real appreciation for the shop floor .He went on to complete a degree in Mechanical Engineering and an MBA and then made a move to British Steel Stainless in Sheffield. This company merged with a Swedish company and Sean worked his way up to Senior Vice President before a return to Scunthorpe where he took up a Director post running the plates and sections businesses, ultimately becoming Director of the Scunthorpe Steelworks in 2007. He retired from the steel industry in 2011 and then in 2013 made the move to the NHS. Sean is also Chairman of the West Nottinghamshire college in Mansfield, a role he will continue with.

Mr Stuart Hall, Vice Chair

He has spent a large part of his career working with FTSE 100 company, Santander.

A fellow of the Chartered Institute of Bankers, Stuart is experienced in a range of areas from governance and HR to strategy development, and a Director of a Community Interest Company. He has experience as a Director of Community Interest Companies specialising in vocational training and end of life care.

Mrs Tracey Christmas

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.

Mr Tony Curry

Tony was appointed in April 2019 and has held senior appointments in higher education, financial services and manufacturing and also as a director with PricewaterhouseCoopers.

He has over 40 years' information technology experience working in 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.

Dr David Hughes

Dr David Hughes was employed by the Trust in February 2022 as a Non-Executive Director and Quality Committee Chair.

Prior to this Dr David Hughes was the Medical Director at Sheffield Teaching Hospitals NHS Trust. Dr Hughes, who is a nationally renowned Consultant Histopathologist, was the Deputy Medical Director at Sheffield from 2013 and prior to that he was Associate Medical Director for Cancer for many years. David began his Consultant career in 1998 before moving to STH in 2005. Dr Hughes is a specialist sarcoma pathologist who trained in Sheffield, Edinburgh and San Antonio, Texas and has worked as a consultant in the sarcoma teams at the Royal Orthopaedic Hospital, Birmingham, the Robert Jones and Agnes Hunt Orthopaedic Hospital as well as Sheffield Teaching Hospitals.

Professor Una MacLeod

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 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.

Mike Robson

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.

Linda Jackson

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.

Dr Ashok Pathak

Dr Pathak is an Orthopaedic Surgeon who retired from the National Health Service after 34 years' service, having worked primarily for the Hull and East Yorkshire Hospitals Trust.

Previously he was the Chairman of the Negotiating Committee for the British Medical Association. Dr Pathak was involved with the International Doctors Forum and was a Trustee of BMA Charities. In addition he was an overseas doctor's mentor for many years, involved in the recruitment and retention of overseas doctors with the Trust.

Currently, Dr Pathak is a member of Her Majesty's Court Service in the capacity of Medically Qualified Tribunal Member.

He is a former first-class cricketer who played at County level in India (Ranji Trophy) and was an expert cricket analyst for the World Cup in 1996. Currently, he is a Trustee of Cricket Beyond Boundaries, a charity which supports the development of underprivileged cricketers from India.

He was also a Governor at Hymers College and is currently an Ambassador for Hymers College.

Dr Pathak was awarded an MBE in 2010 for his lifetime contribution to medicine in Yorkshire and India.

Mr Christopher Long, Chief Executive

Chris served for 12 years in the Army as an infantry officer before coming into NHS management in 1991.

He worked in a variety of roles before being appointed Chief Executive of one of the first primary care trusts (PCTs) in 2002. He moved to Hull PCT as Chief Executive in 2004, where he stayed until PCTs were abolished in 2013. Following a brief spell in NHS England he was appointed as Chief Executive of our Trust in October 2014.

EXECUTIVE TEAM

Dr Makani Purva, Chief Medical Officer

Professor Makani Purva is Chief Medical Officer, Consultant Anaesthetist and Director of Simulation at the Hull Institute of Learning and Simulation.

Mrs Ellen Ryabov, Chief Operating Officer

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 Foundation Trust, latterly as their Interim Chief Operating Officer. Her previous substantive NHS role was Chief Operating Officer at Heart of England NHS Foundation Trust, 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

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Mr Lee Bond, Chief Financial Officer

Lee was appointed in March 2013. In 2020 Lee was appointed as Joint Chief Financial Officer for HUTH and Northern Lincolnshire and Goole NHS Foundation Trust.

Prior to this he was a Director of Business Delivery within Hull University Teaching Hospitals NHS Trust and before that, Director of Finance at Central Manchester University Hospitals NHS Foundation Trust.

His previous financial posts include Sherwood Forest Hospitals NHS Foundation Trust and Sheffield Children's NHS Foundation Trust.

Mrs 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.

Beverley left the Trust in March 2022.

Mrs Jo Ledger, Interim Chief Nurse

Jo was appointed Interim Chief Nurse in March 2022 and her substantive role is Deputy Chief Nurse.

Jo has worked in the Trust for over 20 years in a variety of nursing roles.

DIRECTORS

Mr Simon Nearney, Director of Workforce

Simon joined the Trust in September 2012 from his previous post as Director of Human Resources at Leicestershire County Council.

He has held several senior Human Resources 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.

Michelle Kemp, Director of Strategy and Planning

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

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.

Mr Duncan Taylor, Director of Estates and Facilities

Duncan was appointed in July 2013. Before that he was Director of Estates Development covering the Infrastructure and Development Directorate.

He has worked for Hull University Teaching Hospitals NHS Trust since 1985, and has been closely involved in the majority of the capital projects across the Trust from small upgrades up to the major projects at Castle Hill Hospital.

He is the Project Director for the Tower Block Encapsulation and Emergency Department Upgrade. He has a passion for the redesign of health care facilities and the use of innovative products and design techniques to improve the facilities and experience for patients, visitors and staff.

STATEMENT OF DIRECTORS RESPONSIBILITIES

Name	Job Title	Key areas of responsibility
Chris Long	Chief Executive	Accountable Officer
Lee Bond	Joint Chief Financial Officer	• Financial Management • Estates, Facilities and Development
Beverley Geary/Jo Ledger	Chief Nurse/Interim Chief Nurse	• Professional lead for nursing and midwifery Patient Experience • Safeguarding
Ellen Ryabov	Chief Operating Officer	• Performance • Clinical Service delivery
Michelle Cady	Director of Strategy and Planning	• Operational and business planning Trust Strategy • Improvement • Emergency Preparedness
Michelle Cady	Director of Strategy and Planning	• Operational and business planning Trust Strategy • Improvement • Emergency Preparedness
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
Suzanne Rostron	Director of Quality Governance	• Quality Governance Corporate Governance Patient Safety Compliance • CQC

STATEMENT OF NON-EXECUTIVE DIRECTOR'S ROLES

Name	Title	Committee Membership	Other Trust Roles
Sean Lyons	Chair		
Stuart Hall	Vice Chair/ NED	Remuneration	• Lead for RTT • Deputy Lead ICS
Tracey Christmas	NED/SID	Remuneration Audit (Chair) Performance and Finance	• Speaking Up/Whistleblowing Champion • Transition child/adult lead • Champion for Safeguarding
Tony Curry	A/NED NED	Remuneration Performance and Finance Charitable Funds (Chair)	• Lead for Digital & IT • Non-Executive Champion for Scan4Safety
Mike Robson	NED	Remuneration Audit Performance and Finance (Chair) Charitable Funds Committee	• Non-Executive Champion for GIRFT
Una McLeod	NED	Remuneration Quality Workforce, Education and Culture Committee (Chair)	• Lead for Hull University partnership • Champion for End of Life Care
Linda Jackson	A/NED	Attends: Remuneration Quality	
Ashok Pathak	A/NED	Attends: Remuneration Quality	
David Hughes	NED	Quality (Chair) Remuneration	

TRUST BOARD MEETINGS

The Trust Board met on 6 occasions during 2021/22, including an extraordinary Trust Board meeting in June 2021 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	11/5	10/6	13/7	14/9	9/11	11/1	8/3	Total
Sean Lyons	-	-	-	-	-	Stood down	✔	1/1
T Moran	✔	✔	✘	-	-	Stood down	-	2/3
S Hall	✔	✔	✔	✔	✔	Stood down	✔	6/6
T Christmas	✔	✔	✔	✘	✔	Stood down	✘	5/6
T Curry	✔	✔	✔	✔	✔	Stood down	✔	6/6
U MacLeod	✔	✔	✔	✔	✔	Stood down	✔	6/6
M Robson	✔	✔	✔	✔	✔	Stood down	✔	6/6
L Jackson	✔	✘	✘	✔	✔	Stood down	✔	4/6
A Pathak	✔	✘	✔	✔	✔	Stood down	✔	5/6
David Hughes	-	-	-	-	-	Stood down	✔	1/1
C Long	✔	✔	✔	✘	✔	Stood down	✔	5/6
L Bond	✔	✔	✔	✔	✔	Stood down	✔	6/6
M Purva	✔	✘	✔	✔	✔	Stood down	✔	5/6
B Geary	✔	✔	✔	✔	✔	Stood down	✔	6/6
S Nearney	✔	✔	✔	✔	✔	Stood down	✔	6/6
E Ryabov	✔	✔	✔	✔	✔	Stood down	✔	6/6
M Cady	✔	✘	✔	✔	✔	Stood down	✔	5/6
S Rostron	✔	✔	✔	✔	✔	Stood down	✔	6/6
R Thompson	✔	✔	✔	✔	✔	Stood down	✔	6/6

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 and the Director of Quality Governance.

The Audit Committee provides assurance on the Trust's systems of internal control, integrated governance and risk management. A tracking system of agreed actions is in place and the internal auditors follow up recommendations to provide assurance to the Audit Committee that the issues raised have been addressed. There were 5 meetings of the Audit Committee in 2021/22 which included 1 extraordinary meeting to consider the Annual Accounts and Report. All meetings were quorate.

Members	Attendance
T Christmas	5/5
M Robson	5/5
T Curry	5/5

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

The internal audit programme for 2021/22 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 Director of Audit Opinion and Annual Report 2021/22 gave an overall opinion of positive assurance with an amber/green rating, which is that the Trust has ar 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 12 planned internal audit reports for the Trust, 2 of which resulted in substantial assurance opinions, 4 received reasonable assurance and 6 received partial or minimal assurance. The key findings, recommendations and agreed management actions have all been and accepted by the Audit Committee from all internal audit reports.

In 2021/22, the internal audits receiving substantial assurance was the Board Assurance Framework and Contract Management.Reasonable assurance was given to Clinical Harm Review, Workforce, Race Equality Standard, Theatre Utilisation and Follow up actions.

Partial/Minimal assurance was given to Doctor's Leave, 18 Weeks RTT, Infection Prevention, New Starters and Junior Doctor Rotas, Accounts Payable and Credit Cards and Asset Management.

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 3 times during 2021/22. 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 Head of Corporate Affairs also attend the Committee. Non-Executive Director members' attendance is detailed below:

Name	May 2021	November 2021	February 2022
Sean Lyons	-	-	✔
Stuart Hall	✔	✔	✔
Mike Robson	✔	✔	✔
David Huges	-	-	✔
Tracey Christmas	✔	✔	✘
Tony Curry	✔	✔	✔
Una Macleod	✘	✘	✘

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.

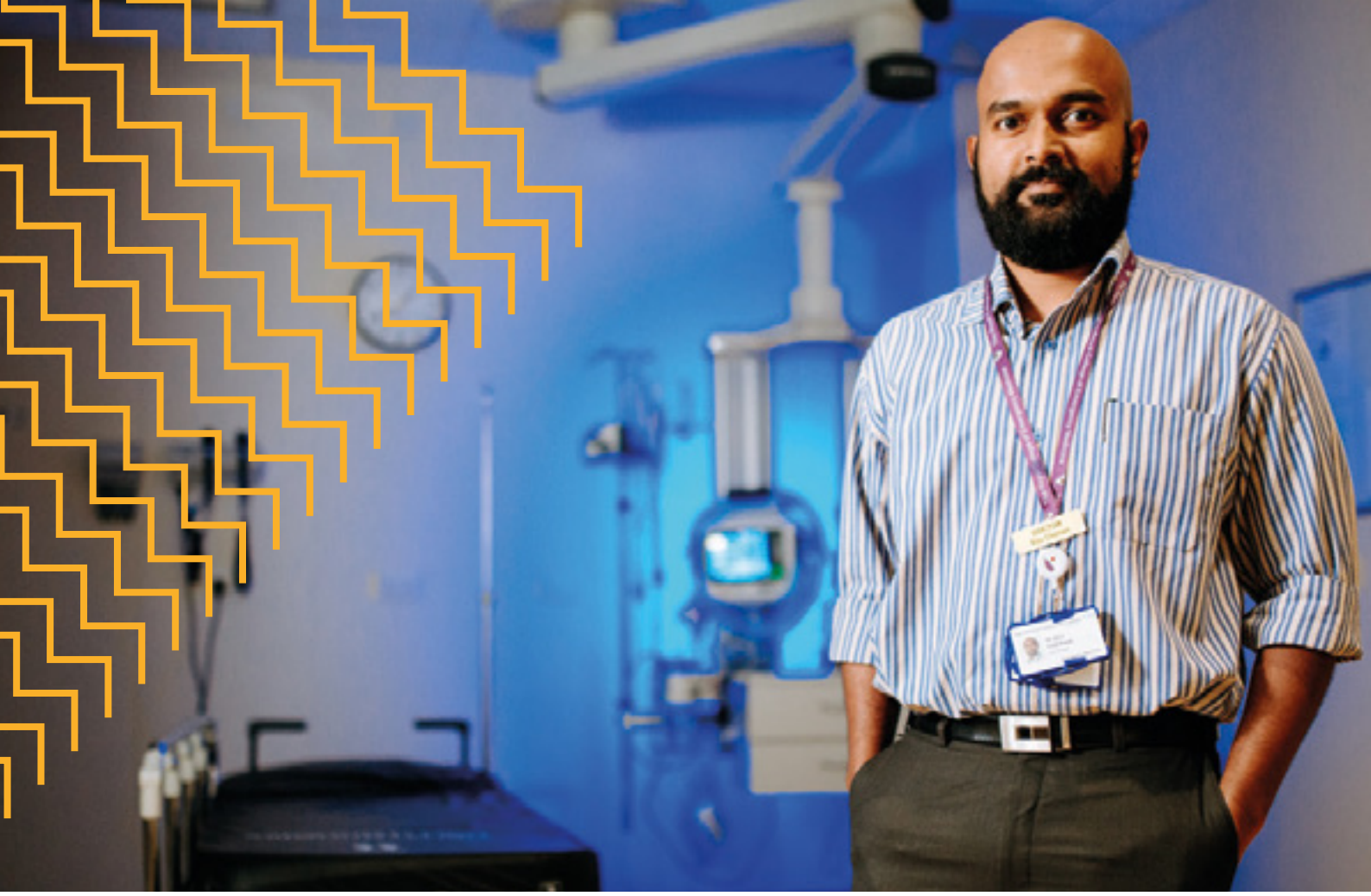
Key items discussed by the Committee during the year included annual performance reviews for Executive Directors, information on the top earners in the Trust and sector salary benchmarking.A Remuneration Committee summary of issues of internal control is received every 6 months at the Audit Committee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

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 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 2021/22 was published as: Standards Not Fully Met (Plan Agreed), and The DSP Toolkit was audited and assessed as achieving Substantial Assurance. The submission date for the DSP Toolkit has been changed to 30th June 2022 and the 2021/22 result and audit result will only be available after this date.

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 4 Data Security and Protection Breaches in 2021/2022 to the ICO as classified in the DSP Toolkit Incident Reporting Guidelines. The ICO closed all 3 cases, and no further recommendations were made. One case is still being worked through in liaison with the ICO. None have resulted in regulatory action being taken against the Trust at this stage.

Incident Description	ICO Response	Nature of Incident	People Affected	Subjects Informed
A staff member's family member went to our COVID testing and the contact details that he had provided were not updated within his electronic patient record. When the data pulled through to the National Test and trace system they had an incorrect mobile number for the person. The Test & Trace system then sent a text message to the incorrect number with full details of the patient including DoB, NHS Number,test result. The person who received the text then found the patient on social media and sent him a message to notify him of the incident. The text message has since been deleted.	No further action	Disclosed in error	1	Verbally
A staff member accessed their ex-partner's patient record while the ex-partner was undergoing treatment with the trust. The details of the treatment and diagnosis were shared wider.	No further action	Unauthorised Access/ Disclosure	1	Verbally and letter
After being notified by a patient, further investigation revealed there are 40 patients who had previously requested that their clinic letters containing their diagnosis (a protected status) not be sent to their GP had been automatically sent in error following an alteration to our electronic patient record system to allow letters to be automatically be sent to the GP if generated within the system. There was some confusion from staff meant that they hadn't realised the letters from this particular clinic were included. This has now been rectified and those patients who request the information from this clinic not to go to their GP will have their request recorded and adhered to.	In liaison with the ICO	Disclosed in error	40	Verbally and letter
45 mammogram images were found on the streets of Kidderminster by a member of the public. The images are from Hull University Teaching Hospitals NHS Trust (HUTH), (Castle Hill Hospital) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Upon further investigation these were old imaged on route for destruction by our contracted waste management company who had sub-contracted a transport company. The sub-contractor had not realised that the curtain-sided vehicle had lost some of the cargo. The trust are confident that all the images that were released have been returned.	No further action	Disclosed in error	Under 45 (not clear due to images not having a patient identifier)	No

The table below shows a breakdown of all IG incidents that have been reported each month by Health Group and Corporate Function. The highest reporting months were November and December 2021.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Corporate Functions	8	3	3	7	3	3	5	7	4	7	3	6	59
Clinical Support - Health Group	1	4	6	4	1	4	5	7	7	3	2	2	46
Emergency Medicine - Health Group	3	0	5	3	3	3	3	2	1	3	1	2	29
Family and Women's Health - Health Group	6	9	4	5	2	5	1	6	7	2	3	4	54
Medicine - Health Group	2	8	5	1	5	5	7	9	6	2	3	5	58
Surgery - Health Group	3	2	3	4	6	2	3	5	7	2	6	3	46
Total	23	26	26	24	20	22	24	36	32	19	18	22	292

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 2021 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 2022 and up to the date of approval of the annual report and accounts.

CAPACITY TO HANDLE RISK

The Trust Board approved the Risk Management Strategy 2022-2025 in March 2022 and sets the Risk Management Policy for the organisation. This was also reviewed and updated in March 2022.

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 on the following pages.

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 inherent, 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 and the central Risk Team are available to support.

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's Operational Risk and Compliance Sub-committee (clinical risks) and the Non-Clinical Quality Sub-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 and reviewed weekly at the Serious Incident Oversight and Review Group. 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 with all investigation panels having at least one trained member. The Trust's Mortality and Morbidity 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.

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, daily updates and 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 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. During the pandemic the fundamental audits were stood down but the assurance process re-started in November 2021 with core service reviews. These are monitored by the Operational Risk and Compliance Sub-Committee.

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 provided its 'baseline' submission to the Data Security and Protection Toolkit in February 2022 and the final submission is due by the end of June 2022. 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 Institute for Health Research (NIHR) 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 November 2021.

The Trust Board reviewed its governance framework in January 2022 as a result of the Covid-19 pandemic and the Omicron variant. Meetings were stood down to allow key members of staff to work operationally to manage the patient pathways. The effects of these 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 2022.

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 Sub-committee reviews clinical risks and the Non-Clinical Quality Sub-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 risks are considered and linked to 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.

OPERATIONAL RISK REGISTER:

There were 174 operational risks on the risk register at the end of March 2022, as follows:

Operational Risks by HG and Current Risk Rating	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic	Total
Corporate Functions	0	1	19	5	1	26
Clinical Support - Health Group	0	2	16	14	10	42
Emergency Medicine - Health Group	1	1	2	2	0	6
Family and Women's Health - Health Group	0	4	33	9	3	49
Medicine - Health Group	0	1	11	4	0	16
Surgery - Health Group	1	3	19	9	1	33
Trust wide risk managed by Falls prevention committee	0	0	1	0	0	1
Trustwide	0	0	0	1	0	1
Total	2	12	101	44	15	174

This compares to 33 low risks, 117 moderate and 52 risks rated as high, and a total 204 risks at the end of March 2021. There has been an overall decrease in the number of risks on the operational risk register. The Trust's Corporate Risk Register has also seen a decrease in the number of open risks 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. This had increased to 39 at the end of March 2021 and demonstrated the Trusts continued efforts to identify risks in response to the ongoing pandemic. At the end of March 2022 this has decreased to 23 demonstrating that the trust has continued to actively manage these risks by ensuring steps are taken to mitigate the risks to a safe level allowing for closure.

Covid Risks by HG and Current Risk Rating	1 Negligible	2 Minor	3 Moderate	4 Major	Total
Clinical Support - Health Group	0	0	0	1	1
Family and Women's Health - Health Group	0	2	6	1	9
Medicine - Health Group	0	0	2	2	4
Surgery - Health Group	0	0	0	2	2
Trust wide COVID-19 Risk	1	1	2	3	7
Total	1	3	10	9	23

CORPORATE RISK REGISTER:

The Corporate Risk Register was last reviewed in March 2022 at the Non-Clinical Quality Sub-committee (NCQSC) and Operational Risk and Compliance Sub-committee (ORCSC).

A high level overview of all high-rated corporate risks and all other open corporate risks is presented to ORCSC on a bi-monthly basis. Each meeting ORCSC is 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 13 corporate risks on the risk register at the end of March 2022, as follows:

	High	Low	Moderate	Total
Corporate Functions	0	0	1	1
Clinical Support - Health Group	0	0	1	1
Emergency Medicine - Health Group	1	0	0	1
Family and Women's Health - Health Group	4	1	2	7
Medicine - Health Group	1	0	1	2
Surgery - Health Group	1	0	0	1
Total	7	1	5	13

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 ten risks on the Board Assurance Framework at the start of 2021/22 against Trust's ten strategic aims from the Trust Strategy. The highest-rated risks at the end of 2021/22 on the Board Assurance Framework related to the Trust's underlying financial position, quality of care and performance standards.

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, 6 risk areas received made sufficient progress to reach the target risk ratings, which was the Trust's ability to meet its financial plan in 2021/22 and to meet its Capital plan in 2021/22, good progress was made towards quality improvements, the Research and Innovation risk target was met and vacancy levels have reduced enough to meet the workforce target. There were 10 risk areas on the Board Assurance Framework for 2021/22. 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 2021/22 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 Board Development sessions 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.

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. During 2021/22, the Board Assurance Framework has been subject to quarterly reviews at the Board Committees and then approval at the Trust Board. Internal Audit carried out an extensive review of the Board Assurance Framework in 2021/22 and substantial assurance was reported with no management actions raised.

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 2021/22, 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 two 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 takes 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 Workforce, Education and Culture Committee and the Trust is working towards embedding the additional requirements of the Developing Workforce Safeguards. 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.

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 4 Serious Incidents Requiring Reporting (SIRIs) in 2021/20222 to the Information Commissioner's Office (ICO).

The ICO has closed all of these 3 of the 4 cases, with no further action required. The ICO has had further questions around the 4th incident which are being worked through. 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.

The Patient Safety and Clinical Effectiveness Committee agreed that the proposed priorities for 2022/23 will be:

1) COVID-19 Recovery Plans – **SAFETY, EFFECTIVE AND LEARNING**
2) Learning from Patient Experience – **LEARNING**
3) Care for older people/dementia – **FOCUSED**
4) Mental Health Triage in the Emergency Department – **FOCUSED**
5) Mortality and morbidity – **EFFECTIVE AND LEARNING**

The 2022/23 Quality and Safety Priorities will be aligned to the Trust's Quality Strategy priorities of Safety, Effective, Learning and Focused (SELF). The Quality Accounts, and the process that accompanies them is a key tool for delivering the Quality Strategy as well as maintaining stakeholder involvement. The Quality and Safety Priorities will be delivered using the Continuous Quality Improvement Framework and progress will be reported to the Patient Safety and Clinical Effectiveness Sub-committee and to the Quality Committee.

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 seven occasions during 2021/22 and was quorate at all meetings. The attendance of each individual Board 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 2021/22, which is the required number as set by its Terms of Reference and was quorate for all meetings.

Its work plan for 2021/22 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 2021/22 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 2021/22 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 Head of Audit Opinion suggests that the Trust should consider reporting on the partial/minimal assurance reports referred to in the Internal Audit Annual Report together with progress made since undertaking the audit.

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 2021/22.

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 10 occasions which was not in line with its Terms of Reference and was stood down on 2 occasions 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 Quality Improvement and identifying quality improvements for next financial year. Each meeting also received a report from each of the Quality Committee Sub-Committees which included any point of escalation. The Board was advised of any escalation issues following each meeting by the Non-Executive Quality Committee Chair.

The Remuneration Committee met 3 times during 2021/22, which included 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 and minutes from the Trust Pay Terms and Conditions Group.

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 22 (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. The Trust Board also received a Nursing and Midwifery staffing update 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 2021/22, the Trust declared 5 Never Events. 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.

The Quality Committee structure and reporting sub-committees has been reviewed and strengthened in 2021/22 by adding an Operational Risk and Compliance sub-committee.

The Quality and Risk Management Strategies were reviewed by the Quality Committee and approved by the Board.

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 2021/22 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 2021/22 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 2021/22, harm reviews, Workforce Race Equality Standard, Doctor's Annual Leave, 18 week referral to treatment, Quality and Safety Improvement, Theatre Utilisation, waiting list initiatives, Data Security and Protection Tooolkit, Board Assurance Framework, infection prevention and control, new starters and financial systems.

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.

ED attendances and flow throughout the Emergency Department has continued to be significantly compromised in 2021/22 with some excessive waits being due to an increase in the length of time patients are in the ED waiting for 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 2021/22. 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 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.

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 Humber Acute Services Review and Integrated Care System.

The Trust has received its Staff Survey results for 2021/22. The results reflect the last 2 challenging years of the pandemic and the staff redeployment and burn out that has occurred.

HEALTH AND SAFETY OF STAFF

While the Trust maintained its excellent record with the Health and Safety regulator during 2020/2021, however, the Trust did receive a visit by the HSE following a dangerous occurrence that occurred in a containment level 2 laboratory within the Pathology building.

This occurred on the 01/10/2021 but because York and Scarborough Teaching Hospitals took charge of Pathology services 01/11/2021 the enforcement letter and consequent actions went with the service to York and Scarborough.

The enforcement letter included actions to mitigate any similar incidents, which have been actioned and dealt with and acknowledged as being satisfactory by the HSE.

This year 2021/2022 (22) saw no increase or decrease to the previous year 2020/2021 (22) with the overall trend of reduction over the last 11 years being maintained.

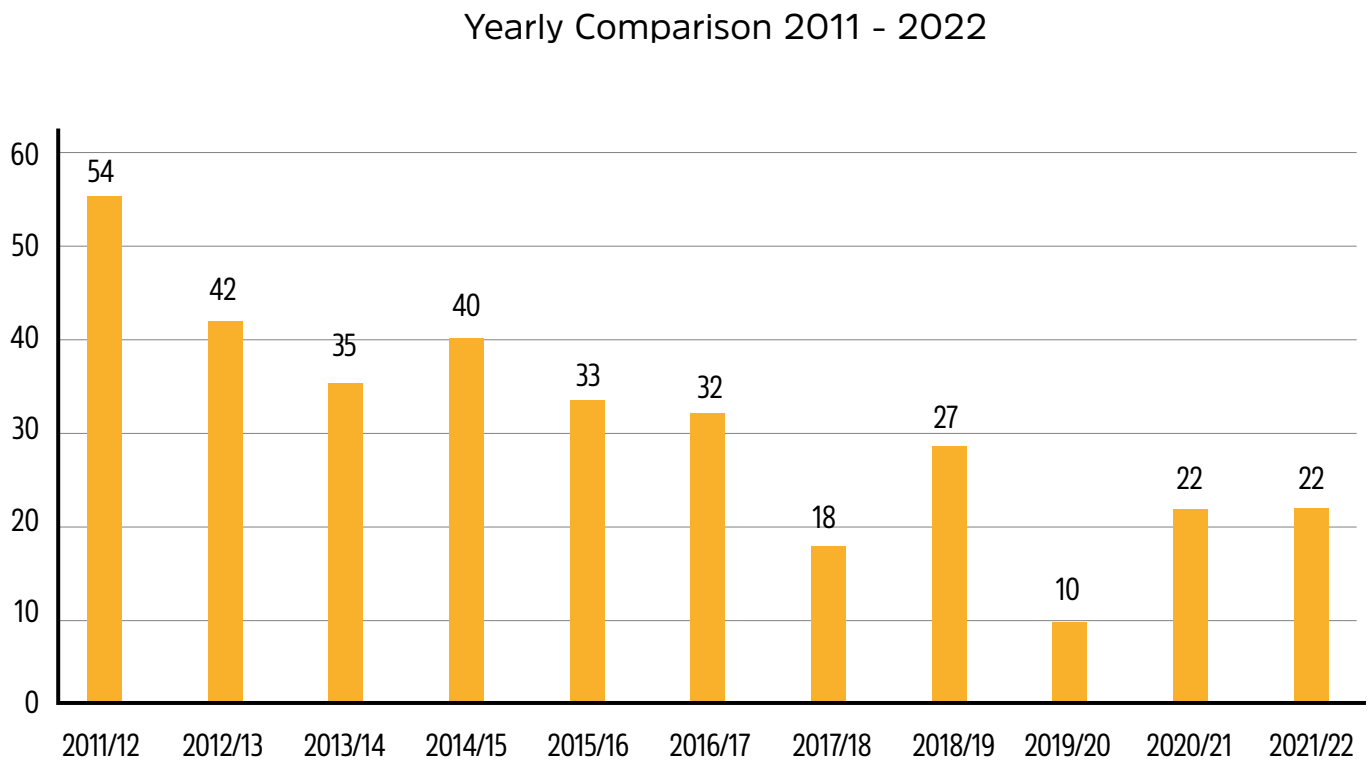


Figure 1: The main cause of RIDDOR reportable incident over the last year were 'slips, trips and falls' (12) actions for improvement are underway, including the removal of trip through infrastructure improvements and quarterly inspections.

Moving and handling has seen a whole time low when looking at reportable incidents, with only one reported during 2021/2022.

Since October 2021, the management of face fit testing was given to the Safety department to take charge of and since then it has been the subject of much focus and will remain as such for the near future.

This has included competently training staff in the methods of carrying out Qualitative (34) and Quantitative (5) testing, which was invaluable when first setting up the face fit test program.

To bolster this the Safety department also purchased two new Portacount machines to bring the total to three. These are used when carrying out quantitative testing and is the most accurate test method for face fit testing.

The Trust has also seen the introduction of the HEY 24/7 online booking system for staff to use when wanting a face fit test and is mandatory for most clinical staff.

The Trust have been successful in securing the assistance of four external face fit testers supplied by Ashfields Healthcare. This service is free to the Trust until April 2023, which has allowed the flexibility to have two persons covering the daily bookings across HRI and CHH with the remaining two other placed and testing in key areas across the Trust such as ICU, Theatres, Wards and Therapies etc.

At the point of writing this report, the total number of staff tested since November 2021 stands at 3,029 with an estimated further 4,500 remaining to be tested.

MANUAL HANDLING

Equipment reviews and provision remained a focus with a slide sheet standardisation project winning a Health Business Award in the Patient Safety category.

Older beds were also replaced with ergonomically designed electric profiling frames to help with safer patient handling and promote patient independence. New equipment was provided in trail areas to 'flat-lift' patients from the floor following a fall using an inflatable device aiming to improve patient comfort and safety when possible significant injury has been identified.

With face-to-face training still restricted, staff updates continued via virtual and on-line learning supported by the large network of Link Trainers to monitor practical skills. Due to the positive feedback, plans are being put into place to expand the video resources and deliver future training built on a blended learning approach.

The number of manual handling RIDDOR reportable incidents has reduced significantly from last year. Those that were reported were due to non-patient handling activities.

COVID-19

Due to the ongoing pandemic situation the Trust Board has continued the following governance arrangements in 2021/22:

- That the Board meets virtually either by video conference bi-monthly
- The Board meeting is held in public with all welcome to attend
- 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.

The Trust 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.

GREEN PLAN, BECOMING NET ZERO BY 2030

Whilst our recent focus has been very much about protecting patients, staff and the public in the face of a global pandemic, the NHS must not lose sight of the imminent health emergency that climate change could bring.

That means more intense storms and floods, more frequent heat waves, and the wider spread of infectious diseases.

Only the strongest and most determined response will impact on this, bringing with it direct improvements for public health and health equity

we will continue with our commitments to reduce carbon emissions, build resilience to the effects of climate change, minimise waste and pollution, and make the very best use of scarce resources.

Projects

- Lighting 20,000 light fittings at Hull Royal Infirmary and Castle Hill Hospital as well as smaller hospital sites around the city are to be replaced with SMART LED lighting after the trust was awarded a £12.6m grant to support its major green agenda.
- We have secured funding for a ground breaking solar panel scheme at Castle Hill Hospital that will transform our carbon footprint.
- A major project insulating buildings across the trust will massively reduce heat loss.
- Replacing our localised gas fired boilers throughout the trust with Air Source Heat Pumps.
- Wind farm - We will contract with a renewable energy supplier in the medium term to supply our offsite electricity.
- We will start installing a district heating system around our sites to enable us to switch to renewable sources of heating.
- We will reduce the emission of anaesthetic gases by 50% by 2025

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 2021/22, 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
- Securing capital funding to address all critical and long-term infrastructure requirements
- The Trust's patient safety culture requires further development and embedding in all clinical areas
- The Trust to address patients waiting 104 weeks or more as part of the elective recovery plan
- The Trust to address the issues patients with no criteria to reside, working with health partners to ensure patients are treated in the most appropriate setting.

The Trust Board acknowledges that 2022-23 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 2022/23.

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 2021/22 and will need to continue to implement the robust recovery plan in place to ensure high quality patient care.
- The Trust will need to make sustained improvement in Emergency Department performance
- The Trust met its financial plan in 2021/22 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 2022

REMUNERATION AND STAFF REPORT/PENSION TABLES/ PAY MULTIPLES FAIR PAY DISCLOSURES

(subject to audit)

	Current year 2021/22						Prior year 2020/21					
	(a)	(b)	(c)	(d)	(e)	Total	(a)	(b)	(c)	(d)	(e)	Total
	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (£5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension - related benefits (bands of £2,500)	(a to e) (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (£5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension - related benefits (bands of £2,500)	(a to e) (bands of £5,000)
	£000	£'s	£000	£000	£000	£000	£000	£'s	£000	£000	£000	£000
Sean Lyons: Chairman (started 1/2/2022)	5-10	0	0	0	0	5-10	-	-	-	-	-	-
Terrv Moran: Chairman (left 31/07/2021)	10-15	0	0	0	0	10-15	35-40	0	0	0	0	35-40
Stuart Hall: Non Executive Director and Vice Chair (started 01/01/2015)	30-35	0	0	0	0	30-35	15-20	0	0	0	0	15-20
Tracey Christmas: Non Executive Director (started 06/07/2015)	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Anton Currv: Non Executive Director (started 01/04/2019)	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Mike Robson: Non Executive Director (started 01/04/2020)	10-15	0	0	0	0	10-15	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	10-15	0	0	0	0	10-15
Dr David Hughes: Non Executive Director (started 02/02/2022)	0-5	0	0	0	0	0-5	-	-	-	-	-	-
Linda Jackson: Associate Non Executive Director (01/04/2020)	5-10	0	0	0	0	5-10	10-15	0	0	0	0	10-15
Dr Ashok Pathak: Associate Non Executive Director (Started 01/04/2021)	10-15	0	0	0	0	10-15	-	-	-	-	-	-
Julie Bolus: Non Executive Director (left 01/04/21)	0	0	0	0	0	0	0-5	0	0	0	0	0-5
Martin Veysey: Non Executive Director (left 30/11/2020)	0	0	0	0	0	0	5-10	0	0	0	0	5-10
Chris Long: Non Executive Director (started 29/09/14)	205-210	0	0	0	0	205-210	200-205	0	0	0	0	200-205
Lee Bond: Chief Financial Officer (started 01/03/13)	95-100	0	0	0	77.5-80	170-175	125-130	0	0	0	125-127.5	250-255
Makani Purva: Chief Medical Officer (started 01/08/2018)	185-190	0	0	0	35-37.5	225-230	200-205	0	0	0	50-52.5	250-255
Beverley Geary: Chief Nurse (01/03/2019)	150-155	0	0	0	27.5-30	180-185	150-155	0	0	0	42.5-45	195-200
Ellen Ryabov: Chief Operating Officer (started 01/11/2020)	150-155	0	0	0	0	150-155	50-55	0	0	0	0	50-55
Simon Nearney: Director of Workforce & Organisational Development	125-130	0	0	0	27.5-30	150-155	130-135	0	0	0	30-32.5	160-165
Michelle Cady: Director of Strategy and Planning (started 01/01/2021)	135-140	0	0	0	120-122.5	255-260	30-35	0	0	0	77.5-80	110-115
Suzanne Rostron: Director of Quality Governance (started 01/03/2021)	115-120	0	0	0	32.5-35	150-155	5-10	0	0	0	40-42.5	50-55
Teresa Cope: Chief Operating Officer (left 30/11/2020)	0	0	0	0	0	0	100-105	0	0	0	47.5-50	150-155
Jacqueline Myers: Director of Strategy and Planning (left 31/12/2020)	0	0	0	0	0	0	85-90	0	0	0	130-132.5	220-225
Carla Ramsay: Director of Corporate Affairs (left 30/09/2020)	0	0	0	0	0	0	35-40	0	0	0	32.5-35	70-75

Notes

Sean Lyons replaced Terry Moran as Chair of both Hull University Teaching Hospitals NHS Trust and North Lincolnshire and Goole NHS Foundation Trust on 1/2/22.

The salary banding 5-10 in the table above represents Mr Lyons' remuneration relating to Hull University Teaching Hospitals NHS Trust only.

Terry Moran was Chair of both Hull University Teaching Hospitals NHS Trust and North Lincolnshire and Goole NHS Foundation Trust until 31/7/21.

The salary banding 10-15 in the table above represents Mr Moran's remuneration relating to Hull University Teaching Hospitals NHS Trust only.

Stuart Hall is a Non-Executive Director and 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 30-35 in the table above represents Mr Hall's remuneration relating to Hull University Teaching Hospitals NHS Trust only.

Linda Jackson is an Associate Non-Executive Director of Hull University Teaching Hospitals NHS Trust and Non-Executive Director and Vice Chair of North Lincolnshire and Goole NHS Foundation Trust.

The salary banding 5-10 in the table above represents Ms Jackson's remuneration relating to Hull University Teaching Hospitals NHS Trust only.

Lee Bond is Chief Financial Officer of both Hull University Teaching Hospitals NHS Trust and North Lincolnshire and Goole NHS Foundation Trust and his time is shared equally between both organisations.

The salary banding 95-100 in the table above represents M Bond's remuneration relating to Hull University Teaching Hospitals NHS Trust only.

Dr Makani Purva's remuneration includes £36,192 in relation to a clinical excellence award.

Ellen Ryabov has already claimed her NHS pension

REMUNERATION AND STAFF REPORT/PENSION TABLES/ PAY MULTIPLES FAIR PAY DISCLOSURES

(subject to audit)

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real increase in pension at pension age(bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31/03/2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31/03/22 (bands of £5,000)	Cash Equivalent Transfer Value at 01/04/21 (£000)	Real increase in Cash Equivalent Transfer Value (£000)	Cash Equivalent Transfer Value at 31/03/22 (£000)	Employer's contributions to stakeholder pension
Chris Long: Chief Executive Officer (started 29/09/2014)	0	0	50-55	155-160	0	0	0	0
Lee Bond: Chief Financial Officer (started 01/03/2013)	5-7.5	2.5-5	65-75	140-145	1123	73	1228	0
Makani Purva: Chief Medical Officer (started 01/08/2018)	2.5-5	0	50-55	90-95	937	35	1002	0
Simon Nearney: Director of Workforce & Organisational Development (started 01/06/2014)	0-2.5	0	20-25	0	239	15	274	0
Beverley Geary: Chief Nurse (01/03/2019)	2.5-5	0	55-60	140-145	1064	33	1124	0
Michelle Cady: Director of Strategy and Planning (started 01/01/2021)	5-7.5	10-12.5	35-40	70-75	588	112	723	0
Suzanne Rostron: Director of Quality Governance (started 01/03/2021)	2.5-5	0-2.5	25-30	50-55	418	25	461	0
Ellen Ryabov: Chief Operating Officer (started 01/11/2020)	-	-	-	-	-	-	-	-

Notes

The Chairman and Non-Executive Directors do not receive pensionable remuneration, therefore there are no entries in respect of pensions for the Chairman and Non -Executive Directors.

Lee Bond is Chief Financial Officer, this a joint role with North Lincolshire and Goole NHS Foundation Trust. The table above represents the total pension benefits for Mr Bond in this joint role.

Ellen Ryabov has already claimed her NHS pension.

A CETV calculation is not applicable where members are over NRA in the existing scheme.

Real Increase in CETV

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

The CETV calculations are based in the Department of Work and Pensions regulations which came into force on 13th October 2008.

Cash Equivalent Transfer Values

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

PAY MULTIPLES – FAIR-PAY DISCLOSURES

(subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of total remuneration of the organisation's workforce.

Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in Hull University Teaching Hospitals NHS Trust in the financial year 2021-22 was the Chief Executive Officer at £207,500 (2020-21, £202,500). The relationship to the remuneration of the organisation's workforce is disclosed in the below tables.

	21/22 (£)	20/21 (£)	19/20 (£)
Median Pay	31,534	30,615	30,112
Pay Multiple*	6.58	6.61	6.60
Average Pay	39,263	37,467	36,155
Highest paid Director – Actual remuneration	207,959	204,081	197,477
Highest paid Director (mid-point of the £5k band)	207,500	202,500	197,500
Change in median pay	3.00%	1.67%	4.34%
Change in pay multiple*	-0.52%	0.85%	0.95%
Change in average pay	4.79%	3.63%	3.14%
Change in highest paid Director pay	2.47%	3.34%	6.49%
Range of staff remuneration	8,408 – 254,145	8,115 - 250,922	7,626 - 290,499
Highest paid employee	254,145	250,922	290,499

*2020/21 figures restated following application of new methodology.

Pay ratio information table	2021/2022			2020/2021		
	25th percentile	**Median**	**75th** percentile	**25th** percentile	**Median**	**75th percentile**
Total remuneration (£)	21,885	31,534	43,013	21,142	30,615	41,051
Salary component of total remuneration (£)	21,885	31,534	43,013	21,142	30,615	41,051
Performance pay and bonuses (£)	-	-	-	-	-	-
Pay ratio information (multiple)	9.5	6.6	4.8	9.6	6.6	4.9

The Trust's highest paid director's remuneration is 6.58 times the median remuneration of the workforce (2020/21: 6.61 times), which is £31,534 (2020/21 - £30,615).

The median level of remuneration has increased by 3.00% and the remuneration of the highest paid Director has increased by 2.47%. The median salary has increased primarily as a result of the 3% pay award uplift.

In 2021/22, 9 employees (2020/21 – 7) received remuneration in excess of the highest paid director / member. The remuneration for these employees was in the range of £210,000 to £255,000 (2020/21 - £205,000 to £255,000). All nine 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.

REMUNERATION AND STAFF REPORT

Staff Costs

			2021/22	2020/21
	Permanent £000	Other £000	Total £000	Total £000
Salaries and wages	346,365	0	**346,365**	336,817
Social security costs	33,265	0	**33,265**	30,877
Apprenticeship levy	1,664	0	**1,664**	1,575
Employer's contributions to NHS pensions *	54,153	0	**54,153**	51,941
Pension cost - other	170	0	**170**	143
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff (including agency)	0	10,595	**10,595**	8,575
Total gross staff costs**	435,617	10,595	**446,211**	429,928
Of which: Costs capitalised as part of assets	1382	7	**1389**	1304

*** The employer's contribution to NHS pensions figure includes the additional 6.3% (£16.554m) for which there is a corresponding entry on income.**

Average number of employees (WTE basis)

The figures tabled below are subject to audit.

			2021/22	2020/21
	Permanent £000	Other £000	Total £000	Total £000
Medical and dental	1,260	176	**1,436**	1,344
Ambulance staff	-	-	**-**	-
Administration and estates	1,664	3	**1,667**	1,647
Healthcare assistants and other support staff	5532	37	**569**	586
Nursing, midwifery and health visiting staff	3,055	60	**3,115**	3,090
Nursing, midwifery and health visiting learners	43	-	**43**	33
Scientific, therapeutic and technical staff	1,123	24	**1,147**	1,110
Healthcare science staff	378	-	**378**	454
Social care staff	-	-	**-**	-
Other	**1**	**-**	**1**	**1**
Total average numbers	8,056	300	**8,356**	8,265
Of which: Number of employees (WTE) engaged on capital projects	38	-	**38**	41

MODERNISING POLICY, PRACTICE AND TECHNOLOGY WITHIN WORKFORCE AND OD

Throughout 2021/22, in the context of the continuing pandemic, the Workforce and Organisational Development Team continued to work towards delivering a supportive culture designed to flex to the needs of the workforce.

EMPLOYEE SERVICE CENTRE

Five years after its 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.

Over the last year, the ESC has received and dealt with just under 121,000 call/emails via the Helpdesk. This is a significant increase compared to 2020/21 figures, where there were 88,000 calls/emails.

The past year has seen the ESC continue to play a pivotal role in supporting the Trust response to the COVID-19 pandemic.

As a 7 days a week/365 days per year service, the ESC Helpdesk continued to be the first point of contact for COVID-19 related queries, including booking COVID-19 tests for staff and family members and working with clinical nursing colleagues to enable staff to get tested in a safe and timely manner. The ESC Helpdesk worked closely with the E-Roster Team who ensured absences and returns to work were input into the roster system in real-time. The information collated by both teams supported relevant command groups.

At the height of the Omicron variant, the Medical Staffing Team was extended to a 7 day a week service to support the Trust in filling as many rota gaps as possible. They also supported significant rota changes to meet service requirements.

Between April 2021 to March 2022, 2,438 new starters were recruited, either as permanent, casual workers or on an honorary contract basis. This is very similar to the 2020/2021 figures, where 2,346 new starters were recruited.

New starters continued to have 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) which were developed to replace the large monthly induction events. These continue to facilitate a more flexible approach to start dates for new employees.

As a key function for the Trust, the Payroll Team continued to work flexibly, with a combination of home and office working, to ensure that in the event of any significant outbreak of COVID-19 within the department, the capacity of the team would not be adversely impacted and ensure staff continued to be paid.

The ESC have continued to show true professionalism and adaptability with the ever changing COVID landscape and will continue to play a pivotal role in supporting the Trust as staff and patients learn to live with COVID.

HUMAN RESOURCES ADVISORY SERVICE

Following the first year of the pandemic the service resumed normal employee relations activities.

There has been an increase in the number of conduct cases managed via accepted responsibility from 60% (2021) to 72% 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. The Bullying and Harassment Policy was revised with a change of focus and is now the Staff Conflict Resolution and Professionalism Policy.

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 supporting the process for implementing government legislation in relation to the vaccination of staff.

Frequently Asked Questions for staff and managers were updated regularly and communicated widely following rapidly changing national advice and guidance. These supplemented numerous person specific management and staff queries.

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

The Nurse and Staff Bank, e-Rostering (electronic roster) and e-Medical Workforce Teams have continued to respond proactively to the ongoing COVID-19 pandemic over the last financial year.

As the lead employer for the COVID-19 Vaccination Programme across the integrated care system, a bank of 500 vaccinators, support and administration staff has been developed and deployed to 42 sites across the Humber, Coast and Vale. The team has worked dynamically with Primary Care Networks, community pharmacies and large scale vaccination providers to enable the successful roll out of the vaccination programme.

In addition to the above, the roll out of the implementation of HealthRoster across all Trust services, whilst previously being delayed due to COVID-19, recommenced and continues to be pivotal in supporting the Trust to provide safe and effective patient services.

RESERVE FORCES TRAINING AND MOBILISATION

Hull University Teaching Hospitals NHS Trust is recognised for its commitment to supporting the Armed Forces.

In 2020, under the Employer Recognition Scheme, the Trust proudly received the Gold Award. The Trust is currently revalidating this award to ensure the work continues.

Armed Forces Champions across the Trust continue to actively increase awareness of the Armed Forces community and available training amongst colleagues, which includes training for staff to raise awareness of the needs and issues that veterans may face. Several leads within the Trust have been identified who proactively advocate and support defence through the provision of information regarding relevant internal policies and external services, including Citizens Advice and the Veterans Gateway. This information is passed on to reservists and veterans who currently work for, or who wish to work for, the Trust.

The support provided by the Trust does not only extend to staff but also to patients. Processes to identify patients who are veterans when they are admitted to the Trust have been created to enable individuals to be offered relevant support and to signpost them to the extra help / information available to them.

EQUALITY, DIVERSITY AND INCLUSION

The Trust remains committed to the equality, diversity and inclusion agenda and to developing an organisational culture that encourages every member of staff, whatever their role or background, to succeed.

This is embedded within the Trust's refreshed strategy from 2022 to 2025 whereby at the centre of the strategy is outstanding care, safety and quality for patients, delivered by a skilled and diverse workforce in a culture of equality, inclusion and civility.

EQUALITY, DIVERSITY AND INCLUSION STEERING GROUP

During 2021, the Equality, Diversity and Inclusion Steering Group was reinvigorated and relaunched.

The Steering Group will have the responsibility for the development and overview of the Trust's Equality, Diversity and Inclusion Strategy and priorities and ensure the Trust meets Public Sector Equality Duties, NHSE/I and CQC requirements from a workforce perspective, as well as monitoring progress against relevant action plans.

The Group will promote its general and specific equality duties as prescribed by the Equality Act 2010.

The Group will focus on a wide range of topics, including:

- Role modelling inclusive and compassionate leadership of the EDI agenda and support the Trust to deliver an inclusive and compassionate culture at all levels.
- Support engagement with staff to understand their lived experiences to inform a review and update of the Trust's Equality, Diversity and Inclusion Strategy.
- Develop the Equality Objectives for the Trust and monitor progress.
- Ensure interconnectivity between national guidance and staff network work plans whilst being cognisant of the intersectionality of protected characteristics in line with the Trust's duty of care as an employer.
- Support, guide, influence and embed equality, diversity and inclusion into training and development opportunities for all Trust staff across the wide range of subjects.
- Reduce inequalities in employment by ensuring clear routes to allow staff to speak up when they face discrimination due to one of their protected characteristics. Ensure robust monitoring arrangements are in place to identify themes to support evidence base for change.

LGBTQ+ NETWORK

The changing culture within the Trust has enabled the LGBTQ+ Network and its members to raise their profile at an individual, departmental and Trust wide level.

Part of the Network's ongoing work was to highlight how staff can add pronouns to their email signatures as well as having their pronouns on ID badges. The Network are focussing on mental health issues and looking at how staff across the organisation can be educated about this. The Network are also exploring how to support managers and colleagues who have LGBTQ+ staff members.

ENABLED STAFF SUPPORT NETWORK

The Enabled Staff Support Network has recently celebrated its first full year since its launch in Spring 2021.

The Network, provides support for all HUTH staff members who identify as having a disability, long term condition or impairment and their allies.

Over the past year the Network has focused on awareness raising of disabilities across the Trust.

Key achievements include:

- The Network made two vlogs relating to access issues at Castle Hill and Hull Royal and has now developed strong links with the Capital Project Team which provides a real opportunity to influence the initial design and/or refurbishment of new buildings, wards and departments from a disability perspective, which in turn provides the opportunity to positively influence the experience of staff, patients and visitors.
- The first Enabled Staff Support Network conference took place on the 25 June 2021, with over 60 delegates attending.
- Network members have submitted a number of blogs on Pattie to raise awareness of issues facing staff with a disability or impairment.
- An Educational Hub has been created on Pattie containing information on disability awareness.
- The Network has raised the visibility and voice of HUTH staff members with a disability or impairment within the Trust, in a bid to raise issues regarding equity and to stamp out discrimination for staff with a disability.
- A key achievement of the Network was introducing peer to peer support for Network members, enabling them to grow in confidence and be able to bring their authentic selves to work.
- Disability education modules for line managers are being created in partnership with the Network.

BAME LEADERSHIP NETWORK

Over the past year, the BAME Leadership Network has continued to meet virtually, with a focus on key areas including addressing bullying and harassment and ensuring diversity in recruitment for BAME colleagues.

The Network held its annual conference on Friday, 21 May 2021, at which over 80 people dialled in to the virtual event. Keynote speakers at the conference included Workforce Race Equality Standard (WRES) expert, Bo Escritt, Lead Pharmacist with Yorkshire Ambulance Service, Usha Kaushal, and Steve Russell, Chief Executive of NHS Nightingale (Yorkshire and the Humber) and of Harrogate and District NHS Foundation Trust.

Chief Executive, Chris Long, also spoke about the importance of the equality, diversity and inclusion agenda to the future success of HUTH, whilst Director of Workforce, Simon Nearney, spoke about the hospitals' race equality programme. Delegates were able to explore issues such as unconscious bias and equality of opportunity for career progression through a series of breakout sessions.

The network is currently planning its next annual conference, which will take place in June 2022 at which it plans to launch a Zero Tolerance to Racism Framework. The conference will take place as a hybrid of in-person and virtual attendance.

ZERO TOLERANCE TO RACISM FRAMEWORK AND REPORTING SYSTEM

Insights from the 'Rooting out racism' focus groups and online questionnaire were used to inform the creation of a Zero Tolerance to Racism Charter, Framework and reporting system.

The Charter will clearly outline actions and behaviours constituting to racism. The Framework will support any member of staff (recipient or a bystander witnessing racism) to become aware of the routes available to report racism and to access support for themselves or for colleagues. The online reporting system will enable any staff member to submit a report describing the racist behaviour they have witnessed or experienced.

WELLBEING CONVERSATIONS

In addition to the above, to focus on the wellbeing of staff, a new version of MyAppraisal was launched in July 2021, which includes a prompt for managers to ensure they have a comprehensive wellbeing conversation with their staff.

Whilst managers are encouraged to have regular wellbeing conversations with their staff, this tool ensures that conversations to support staff happen on a yearly basis and encourages managers to continue this practice. The new version also provides a training session to support managers to have effective and meaningful wellbeing conversations.

EDUCATION AND LEARNING OPPORTUNITIES

To support the inclusion agenda, additional education and learning opportunities have been created, to support 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.

Key EDI training includes:

- 'Let's talk about discrimination – Become an Ally' sessions were provided for staff across the Trust in October 2020 during Black History Month and continued throughout 2021. These sessions focused on the importance of fostering an inclusive culture, where all staff feel they belong and can progress at work, regardless of their race. The sessions focused on self-reflection and how to take active action to support colleagues. The sessions were also delivered externally to support neighbouring organisations across the Humber, Coast and Vale region, with approximately 140 participants in attendance.
- 'Becoming an excellent disability ally' and 'Access to work and reasonable adjustments' have been piloted and further sessions will continue throughout 2022 to educate staff and line managers on how to support staff with a disability or long term condition.
- The Equality, Diversity and Inclusion mandatory training was redesigned and relaunched with new content. The training includes new concepts, models, strategies relating to becoming an ally in the workplace and challenging discrimination. The Equality, Diversity and Inclusion training offer is now more in-depth and informative. The taught EDI training is being adapted to self-directed E-learning in order to enable more staff to access in-depth information.
- The Executive Team and Health Group Directors have participated in Inclusive Leadership modules (2021–2022).

GENDER PAY REPORTING

Regulations that took effect on 31 March 2017 (The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information.

These form part of the Trust's public sector equality duty under the Equality Act 2010. The Equality and Human

Rights Commission has the power to enforce any failure to comply with the regulations.

The Trust published its fifth Gender Pay Gap report by 30 March 2022, to meet statutory timescales.

The Trust's data, 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 Trust's mean gender pay gap at 29.50% and median gender pay gap at 19.85% have increased marginally since the previous reporting period, and are above the national averages of 14.9% (mean) and 15.4% (median). Excluding medical and dental staff the Trust figures would be 3.68% and 0.72% respectively.

For full details, the Trust's Gender Pay Gap report is available on the Trust's website.

DISABILITY EQUALITY

The Trust's Workforce Disability Equality Standard (WDES) report.

Covering the period 1 April 2020 to March 2021, 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.

The WDES Action Plan, developed in partnership with the Enabled Network Chair provides an overview of work to support this important agenda.

The full WDES submission and Action Plan is available on the Trust's website.

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.

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

LEARNING AND ORGANISATIONAL DEVELOPMENT

LEARNING ENVIRONMENT

The Learning Team continue to build on the success of last year and offer a hybrid learning environment, with both face to face and virtual classroom spaces available, to ensure that we have a responsive and inclusive training environment.

Our virtual classroom is incorporated into the current learning platform hey247.net and this method is easy to access for our staff and reduces the pressure on room capacity. Hey247.net also allows our staff to 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.

This past year the majority of our training provision has been delivered virtually via eLearning and online webinars to ensure compliance with ongoing COVID-19 restrictions/ guidance and to meet the needs of the workforce. As we can now reduce social distancing to 1 metre, we have reintroduced some classroom based teaching within the department on a phased return.

The team are investigating technologies to allow live streaming of classroom-based sessions to improve accessibility to our offering. Priority is being given to statutory and mandatory training in the first instance. All PPE and relevant IPC practices will remain in place to ensure we minimise risks for those attending face-to-face sessions.

The Education and Development Centre (located in Suite 22 at Castle Hill) is nearly 5 years old and despite being an amazing facility for staff, has undergone some improvements to keep it looking fresh and a place for a great learning experience.

Recent investments to improve the Centre's appearance / functionality within Suite 22. These include:

- Refurbishment of the admin offices - To enhance security and usability (including safe wheelchair access).
- Windows – Upgrade to double glazed – enhancing security and energy efficiency.
- Flooring – To improve safety and infection control.
- Outdoor Areas – Including outdoor seating and landscaping to enhance space for wellbeing / breakout areas.
- Review and update of I.T infrastructure within Training Rooms and Pods – To improve reliability and ease of use.
- Kitchen Facilities - Improvements to appliances for all to use.

APPRENTICESHIPS

COVID-19 continued to impact on apprenticeship delivery in the Trust.

In 2021-22 we experienced a drop in the recruitment to new apprentices but an increase in existing colleagues undertaking apprenticeship programmes.

From speaking with learning providers across the Humber region, the Apprenticeship Team note that the drop in apprentice employment is not unique to HUTH. The increase in full and part-time employment (non-apprenticeship) vacancies is one of the main reasons being cited for this.

WORK EXPERIENCE/ WIDENING PARTICIPATION

Work experience has been on hold in the Trust during the pandemic and has been hard for the schools and our staff alike.

We have continued to offer online opportunities through videos and virtual sessions. Our partnership with St Mary's School has also ensured we continued with virtual mentorship arrangements. With COVID-19 impacting on having school children on work experiences we have taken the opportunity to review our offer and as a result of this we plan to make improvements to our offer. Discussions with Hull City Council's Engagement Officer will take place, along with the wider team, to review previous activities and identify clear, workable objectives for the next academic year.

HULL INSTITUTE FOR LEARNING AND SIMULATION (HILS)

Within Simulation, face to face delivery has continued, albeit with reduced numbers and infection control measures in place due to COVID-19 social distancing guidance.

Reduced social distancing to 1 metre has allowed an increase in capacity, allowing more learners to access scenario based learning and practice clinical skills. HILS is currently reviewing its service provision to ensure that simulation training is meeting the needs of the Health Groups and that it is accessible to all, whilst planning the sustainability of the provision.

SURGICAL SKILLS CENTRE

The Surgical Skills has continued to successfully deliver face to face training.

The team are currently looking at the service provision and looking at adapting the facilities to ensure they are more user friendly and accessible to trainees. The Centre is currently working towards a Human Tissue Licence application, which has been submitted, and currently under review waiting for audit.

MEDICAL EDUCATION

Despite continuing constraints, we have continued to support and provide quality education to our Doctors in Training and Trust Doctors.

This has been mainly achieved through online teaching sessions for the majority of the training year with a slow move to more hybrid sessions to allow for more face to face interaction with peers. We have also supported a trainee led online weekly teaching session aimed at F2s, which is also accessible for F2s at NLAG and York hospitals to join.

We continue to support our trainers through educational appraisal and educational supervision accreditation and are in the process of delivering local training sessions to meet the needs of our trainers.

LEADERSHIP AND PEOPLE DEVELOPMENT

All Great Leaders Programmes have recommenced and a new modular redesign has helped to pandemic proof the programmes, avoiding large delays in completion of our programmes.

Great Leaders Bitesize has now relaunched (March 2022) and has a wide range of topics from Managing Attendance through to Manager as Coach in small easy to access modules. These are one off online short sessions with a mixture of HR training, plus non-technical and people development training such as coaching skills, ethical decision making, and managing difficult conversations. These modules repeat every quarter to ensure staff do not miss any content due to work commitments. It allows clinical colleagues to have a flexible approach to their personal leadership development.

Rise and Shine (new and less experienced leaders): In September 2021, the Rise and Shine Programme restarted, which is an 11 month programme for new and emerging leaders. The Programme is, available online and face to face, to reduce the impact of social distancing. It provides a mixture of transactional and transformational leadership content ending in work based projects. It delivers two cohorts a year with 15 people per cohort. 16 leaders completed the Programme in a year, with 15 having started in September 21.

Be Remarkable (existing leaders): This course was adapted to a hybrid modular model to make it more flexible during the pandemic. The course currently runs with 6 cohorts a year, with, on average, 10 people per cohort. The programme has 3 modules.

- Module 1: Getting to know yourself as a leader (face to face) (delivered in partnership with Trans2Performance)
- Module 2: Creating highly effective teams (online)
- Module 3: 90 day challenge (mixture of face to face and online)

15 leaders completed the programme in the year with a further 50 leaders on the programme at varying stages of the modules. The modules repeat regularly to allow the leaders maximum flexibility without compromising their development in this busy environment.

Supervisors + (new and experienced in supervisory positions): 10 people are currently on this programme with a further 10 planned for Autumn 2022.

Leading through COVID Series continued until March 2022. This was a COVID hot topic programme that replaced our usual bitesized content and covered:

- Leading remote teams
- Supporting staff through redeployment
- Introduction to coaching
- Managing beyond the policy
- Civility and inclusion

CMI Level 3 Apprenticeship – Team Leader: This was a pilot programme to test a provider approach and the impact it can have in the Trust. 14 leaders will complete the programme in June 2022. We plan to repeat the programme and explore whether we can offer Level 5 and potentially Level 7 (master's level) programmes using this approach. The provider offers a bitesize manageable approach to learning led by real leaders through coaching, webinars and online learning. We have found it fits really well with busy NHS job roles and the challenges of being released for development during the pandemic.

TALENT MANAGEMENT

A talent diagnostic, including focus groups, 1:1 interviews and an organisational survey, has taken place.

The three priority areas for 2022 are:

- Appraisals - Ensuring every staff member has a meaningful and developmental appraisal experience.
- Success Profiles - Ensuring that clear 'success profiles' are created that outline key skills, experience, knowledge and behaviours for key roles.
- Succession Planning – Ensuring leaders are supported to fairly and robustly make decisions about staff progression and development within their teams and proactively support careers.

COACHING AND MENTORING NETWORK

- 36 trained coaches (20 of whom are actively coaching)
- Monthly supervision provided
- Subjects for coaching include; professional development, career, confidence and performance.
- Two coaches currently completing Level 7 executive coaching training
- Training of 10 BAME staff in ILM 5 Coaching and Mentoring starts in Sept 2022
- One coach due to undertake Level 7 Supervisors qualification

DEVELOPMENT OF CLINICAL SUPERVISION NETWORK

- Continuation of 3 day clinical supervision training for Nurses and AHPs.
- Development of continuing professional development (CPD) and support for Supervisors and Nurses recently undertaking Professional Nurse Advocate (PNA) training.
- Development of a multi-disciplinary network of clinical supervisors to provide, restorative, formative and normative supervision to fellow health professionals.
- Team development and recovery post COVID.
- Team mission statement sessions: These help teams to identify shared team values and create a shared vision that is aligned to the Trusts vision. This builds and supports the creation of strong team identity. Achieved through 3 hour sessions, with a maximum of 12 people per session, eight clinical teams have completed this and a further three more are booked over the next year.
- Bespoke team time out sessions to aid team communication and interdependence using Insights Discovery alongside a wide range of other team development techniques.

MEDIATION

This service has been completely reinvigorated this year, with 10 new mediators trained to supplement our existing team.

We now have 13 active mediators in place creating a strong network of practitioners. Mediators have access to monthly Mediator Support Meetings, which are facilitated by the Mediation Service Leads. The purpose of these meetings is to create a community of practice where learning can be shared and discussed confidentially between peers.

During 2021/22, the Mediation Service Lead has received funding to complete the ACAS Certificate in Internal Workplace Mediation course. The Trust Mediation Service Leads, who currently deliver the successful in-house training programme 'The Manager as Mediator', will now train Trust Mediators internally. The move to in-house training will not only realise significant cost savings to the Trust, as ACAS will no longer be commissioned to train our staff, but enable us to train new aspiring Trust Mediators more frequently and in smaller cohorts. This new approach will give the Trust Mediation Service much greater autonomy and enable it to respond to service demand in a timely, efficient and cost effective manner.

STAFF PSYCHOSOCIAL SUPPORT – LIVING WITH COVID

The multidisciplinary (MDT) 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 and Spiritual Support Services.

The MDT is a fully embedded approach and works collaboratively to shape and deliver staff mental wellbeing 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)

The team offers a wide range of staff support services including:

- 24 hour hotline (staffed by our Pastoral and Spiritual Care Team).
- Staff support email for signposting and booking appointments.
- In house Staff Support Psychologists (ICU and Trust Wide) bookable 1:1 slots.
- Counselling (in-house) and via Self-referral to Focus Counselling Services.
- Bookable personal coaching 1:1s provided by a qualified coach in the OD team.
- Chaplaincy team daily in reach to wards and departments connecting with and supporting staff directly.
- Coaching/Clinical Supervision led support to Charge Nurses and ward recovery sessions.
- Wellbeing and resilience training sessions.
- 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. Four members of staff have accessed the guide.
- Our Pattie pages have been migrated to be with the UP! Health and Wellbeing pages and are signposted directly from the COVID-19 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 designed to compliment and provide extra capacity.

TEAM TIME

The staff support group intervention 'Team Time' from the Point of Care Foundation was launched with the formation of a Steering Group, including representatives of clinical and non-clinical staff across the organisation, and 15 Team Time facilitators whom were trained in the role.

Team Time sessions delivered have included topics such as 'Rudeness at work', 'Pandemic Guilt' and 'Home is where the heart is'. Approximately 50 attendees have attended sessions. Team Time will continue to be delivered alongside Schwartz Rounds, which will be launched in 2022.

PSYCHOLOGICAL DEBRIEFING SERVICE

A new service is being developed for the Trust to support staff after they may have experienced difficult events or a buildup of smaller events creating stress reactions that may need support to work through.

Over 20 Trauma Risk Incident Management Practitioners (TRIM) have completed their training. A full service roll out to the Trust will commence once all training is completed in 2022/23.

UP! HEALTH AND WELLBEING PROGRAMME

The Trust launched its Up! health and wellbeing programme in January 2020 and, although infection prevention and control measures were in place throughout the various waves of the pandemic, we have gone from strength to strength.

We now have:

- Wednesday Walkers, the walking group for Castle Hill staff
- Monday Marchers, the walking group for Hull Royal staff
- HUTH Drama, our drama club about to stage their first production in September
- HUTH Art, our WhatsApp based group
- HUTH Grow Your Own, an online support group for vegetable and fruit growers
- HUTH Woodwork – face-to-face woodwork tuition
- Gardening Club for HRI staff
- HUTH Harriers, the Trust's running group, who run four times a week
- Weekly coaching sessions at Costello Stadium for Trust runners, led by three of Up! fully qualified run leaders
- Monthly parkrun tourism events for all staff
- Yoga classes at both HRI and Castle Hill, including a 6.45am session before work and a session for clinical staff on long days
- Regular relaxation workshops on Saturday mornings at Castle Hill
- Sound baths at both HRI and CH for restorative healing
- Bike User Groups at both HRI and CH
- Cycling safety/maintenance/confidence building/route planning events every Wednesday at the Health and Wellbeing Suite from September to December and again from March to June.
- Healthy, Happy HUTH (formerly Lockdown Losers) who have lost a collective 126 stone and 13 lbs since its launch in September 2020. Our current group of 26 members have lost 14 stone collectively since January. Three individual members have lost five, seven and eight stone since the group began – and have kept it off to maintain their weight or are continuing on their journeys.

In addition, we organised a Football Tournament at Soccer Kings in Hull in May 2021 for six Trust teams with Corporate Services claiming victory. We hope to make this an annual event.

We have also worked with the Trust's gardening team at Castle Hill to create a woodland trail in the woods at the top of the grounds near Castle Road. Plans for this year include Phase 2 of the woodland scheme and the creation of a round house and wildflower meadow near Oncology for outdoor events.

WELLBEING SUITE

The Trust now has a purpose built staff wellbeing suite based at Castle Hill Hospital.

The facility has showers, lockers and two large rooms that allow for a variety of staff support activities to take place.

Current activity has focused on:

- Cycle to work events
- Walking groups
- Gardening club
- Psychological debriefing
- Weekly mindfulness sessions
- Coaching sessions
- Personal development sessions
- Sound baths
- Yoga

Our thanks go to the WISHH Charity, as without them this amazing facility would not be possible. There are plans to also have a wellbeing suite at the Hull Royal site to ensure that staff across the Trust can access a safe, relaxing space when needed.


NHS
Hull University
Teaching Hospitals
NHS Trust
ANNUAL
ACCOUNTS
ANNUAL REPORT
2021/22

Hull University Teaching Hospitals NHS Trust

Annual accounts for the year ended 31 March 2022

Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	2	710,081	640,267
Other Operating income	3	98,369	86,541
Operating expenses	5, 7	(793,781)	(725,505)
Operating surplus/(deficit) from continuing operations		**14,669**	**1,303**
Finance income	10	41	8
Finance expenses	11	(5,922)	(6,245)
PDC dividends payable		(7,677)	(6,049)
Net finance costs		**(13,558)**	**(12,286)**
Other gains / (losses)	12	(180)	10
Gains / (losses) arising from transfers by absorption	37	(1,066)	-
Surplus / (deficit) for the year from continuing operations		**(135)**	**(10,973)**
Surplus / (deficit) for the year		**(135)**	**(10,973)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(1,448)	(11,519)
Revaluations	16	6,429	1,979
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on financial assets mandated at fair value through OCI	18	144	392
Total comprehensive income / (expense) for the period		**4,990**	**(20,121)**

The adjusted financial performance for 2021/22 is a surplus of £330k (2020/21 £246k) and is disclosed in Note 43. The adjusted financial performance for System Achievement is £212k surplus, after adjusting for gains on disposal of assets of £118k.

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	13	8,790	5,980
Property, plant and equipment	14	385,243	334,338
Investment property	17	100	100
Other investments / financial assets	18	536	392
Receivables	21	3,291	3,722
Total non-current assets		**397,960**	**344,532**
Current assets			
Inventories	20	15,867	14,982
Receivables	21	32,959	19,169
Cash and cash equivalents	23	79,428	58,927
Total current assets		**128,254**	**93,078**
Current liabilities			
Trade and other payables	24	(141,211)	(96,895)
Borrowings	26	(2,989)	(2,917)
Provisions	28	(3,997)	(202)
Other liabilities	25	(3,277)	(730)
Total current liabilities		**(151,474)**	**(100,744)**
Total assets less current liabilities		**374,740**	**336,866**
Non-current liabilities			
Borrowings	26	(51,377)	(54,350)
Provisions	28	(2,924)	(5,683)
Total non-current liabilities		**(54,301)**	**(60,033)**
Total assets employed		**320,439**	**276,833**
Financed by			
Public dividend capital		330,863	292,247
Revaluation reserve		26,537	21,556
Financial assets reserve		536	392
Income and expenditure reserve		(37,497)	(37,362)
Total taxpayers' equity		**320,439**	**276,833**

The notes on pages 7 to 57 form part of these accounts

Christopher Long
Chief Executive

Date 21/06/2022

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Financial assets reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**292,247**	**21,556**	**392**	**(37,362)**	**276,833**
Surplus/(deficit) for the year	-	-	-	(135)	**(135)**
Impairments	-	(1,448)	-	-	**(1,448)**
Revaluations	-	6,429	-	-	**6,429**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	144	-	**144**
Public dividend capital received	38,616	-	-	-	**38,616**
Taxpayers' and others' equity at 31 March 2022	**330,863**	**26,537**	**536**	**(37,497)**	**320,439**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Financial assets reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' 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**
Fair value gains/(losses) on financial assets mandated at fair value through OCI		-	392	-	**392**
Public dividend capital received	65,464	-	-	-	**65,464**
Taxpayers' and others' equity at 31 March 2021	**292,247**	**21,556**	**392**	**(37,362)**	**276,833**

Information on reserves

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

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

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		14,669	1,303
Non-cash income and expense:			
Depreciation and amortisation	5.1	18,210	16,506
Net impairments	6	15,919	15,258
Income recognised in respect of capital donations	3	(17,454)	(2,608)
(Increase) / decrease in receivables and other assets		(11,730)	20,206
(Increase) / decrease in inventories	19	(885)	(382)
Increase / (decrease) in payables and other liabilities		40,939	12,047
Increase / (decrease) in provisions	28.1	1,031	3,442
Other movements in operating cash flows		(1)	-
Net cash flows from / (used in) operating activities		**60,698**	**65,773**
Cash flows from investing activities			
Interest received	10	41	8
Purchase of intangible assets	13.1	(3,062)	(1,569)
Purchase of PPE and investment property		(71,910)	(42,225)
Sales of PPE and investment property		136	3,069
Receipt of cash donations to purchase assets		12,249	807
Net cash flows from / (used in) investing activities		**(62,546)**	**(39,910)**
Cash flows from financing activities			
Public dividend capital received		38,616	65,464
Movement on loans from DHSC	26.2	(1,260)	(36,555)
Capital element of finance lease rental payments	26.2	(56)	(56)
Capital element of PFI, LIFT and other service concession payments	26.2	(1,583)	(1,929)
Interest on loans	26.2	(395)	(512)
Interest paid on finance lease liabilities	26.2	(4)	(4)
Interest paid on PFI, LIFT and other service concession obligations		(5,520)	(5,783)
PDC dividend (paid) / refunded		(7,450)	(6,994)
Net cash flows from / (used in) financing activities		**22,348**	**13,631**
		20,500	**39,494**
Cash and cash equivalents at 1 April - brought forward		**58,927**	**19,434**
Cash and cash equivalents at 31 March	23.1	**79,428**	**58,927**

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 2021/22 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 2021/22, 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 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 1.4 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 contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

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.

NHS injury cost 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, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of 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 grants 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.

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.

Note 1.6 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

NHS Pension Scheme 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. NHSEI have provided a calculation of the required provision.These figures use the latest available information on actual uptake of the scheme. They are derived from combining information on applications to join the 2019/20 scheme under the policy, together with information in the scheme pays election form where present, and with averages assumed where these forms are absent or clearly an estimate (values less than £100). Future liabilities based on individual member data and scheme rules are then discounted to give totals for each Trust.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.
Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

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

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.
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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

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

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

This includes assets donated to the trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

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.

Useful lives of property, plant and equipment

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

	Min life Years	**Max life Years**
Buildings, excluding dwellings	8	74
Plant & machinery	1	25
Transport equipment	5	12
Information technology	1	12

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

Note 1.10 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	**Max life Years**
Development expenditure	1	12
Software licences	1	7

Note 1.11 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 2021/22, 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 1.12 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 1.13 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. Cash, bank and overdraft balances are recorded at current values.

Note 1.14 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial 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, i.e., 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 profit and loss. Fair value is taken as the transaction price, 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.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On de-recognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income:

Financial assets and financial liabilities at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

The Trust has irrevocably elected to measure the following financial assets / financial liabilities at fair value through profit and loss:

Impairment of financial assets

For all financial assets measured at amortised 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 receivables, 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 departments, their executive agencies, the Bank of England, Exchequer 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 these 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.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

Note 1.15 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 a lessee

Finance leases

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

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

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

The trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

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 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

HM Treasury provides discount rates for post-employment benefits as follows:

	Rate	Prior year rate
Real Rate	Minus 1.3%	Minus 0.95%
Nominal Rate	1.55%	1.25%

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 28, but is not recognised in the Trust's accounts.

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 when the liability arises.

Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.18 Public dividend capital

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

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 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 1.20 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 23.2 to the accounts. The Trust benefits from Charitable donations that are held separately to the Trust's own finances.

Note 1.21 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.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.22 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 1.23 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 1.24 Transfers of functions to /from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

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

For functions that the trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net [loss / gain] corresponding to the net [assets/ liabilities] transferred is recognised within [expenses / income], but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 37 includes the details of the transfer by absorption of the Pathology service to York and Scarborough Teaching Hospitals NHS FT from 1.11.21.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.26 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 re-measurement 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 without restatement and 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. For 2022, this rate is 0.95%. 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 trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	7,659
Net impact on net assets on 1 April 2022	**7,659**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(1,961)
Additional finance costs on lease liabilities	(61)
Lease rentals no longer charged to operating expenditure	2,024
Estimated impact on surplus / deficit in 2022/23	**2**
Estimated increase in capital additions for new leases commencing in 2022/23	**898**

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. The PFI liability will be re-measured when a change in the index causes a change in future repayments 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 1.27 Critical judgements in applying accounting policies and sources of estimation uncertainty

The following are the judgements and sources of estimation uncertainty that management has made and considered in the process of applying the trust accounting policies and have the most significant effect on the amounts recognised in the financial statements:

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 1.9, 1.10 ,13, 14, 15 and 16)
- the current value of future costs under PFI and other finance lease contracts (note 32)
- 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

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 2022 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 2 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 2.1 Income from patient care activities (by nature)

	2021/22	2020/21
	£000	£000
Acute services		
Block contract / system envelope income	615,658	540,318
High cost drugs income from commissioners (excluding pass-through costs) ****	61,664	68,475
Other NHS clinical income**	1,261	12,482
Community services		
Income from other sources (e.g. local authorities)	340	370
All services		
Private patient income	471	303
Elective recovery fund***	11,331	-
Additional pension contribution central funding*	16,554	15,796
Other clinical income	2,802	2,523
Total income from activities	**710,081**	**640,267**

*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.

** The figure for 2020/21 was much higher than 21/22 as in 20/21 this included 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 2021/22 value is mainly in relation to provider to provider arrangements with other NHS Providers.

******* The elective recovery fund was new in 2021/22 and relates to incentive payments for delivering more elective activity and reducing waiting lists.

**** The high cost drugs income figure for 2021/22 relates only to that where NHSE is the commissioner as this is pass-through and considered separately to the block payments.

Note 2.2 Income from patient care activities (by source)

	2021/22	2020/21
Income from patient care activities received from:	**£000**	**£000**
NHS England	239,552	228,745
Clinical commissioning groups	465,655	406,718
Department of Health and Social Care	13	79
Other NHS providers	919	1,606
NHS other	329	1
Local authorities	340	370
Non-NHS: private patients	471	303
Non-NHS: overseas patients (chargeable to patient)	182	128
Injury cost recovery scheme	1,948	2,081
Non NHS: other	672	236
	710,081	**640,267**
Of which:		
Related to continuing operations	710,081	640,267

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

	2021/22	2020/21
	£000	£000
Income recognised this year	182	128
Cash payments received in-year	138	72
Amounts added to provision for impairment of receivables	175	615
Amounts written off in-year	-	16

Note 3 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	5,977	-	**5,977**	6,139	-	**6,139**
Education and training	34,551	1,138	**35,689**	31,210	1,022	**32,232**
Non-patient care services to other bodies	11,611		**11,611**	7,766		**7,766**
Reimbursement and top up funding	16,286		**16,286**	24,705		**24,705**
Income in respect of employee benefits accounted on a gross basis	4,831		**4,831**	2,182		**2,182**
Receipt of capital grants and donations		17,454	**17,454**		2,608	**2,608**
Charitable and other contributions to expenditure		2,279	**2,279**		7,870	**7,870**
Rental revenue from operating leases		39	**39**		39	**39**
Other income	4,203	-	**4,203**	3,000	-	**3,000**
Total other operating income	**77,459**	**20,910**	**98,369**	**75,002**	**11,539**	**86,541**
Of which:						
Related to continuing operations			98,369			86,541
Related to discontinued operations			-			-

Note 4 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.

	2021/22	2020/21
	£000	£000
Income	2,305	1,498
Full cost	(2,640)	(2,746)
Surplus / (deficit)	**(335)**	**(1,248)**
Staff & Visitor catering		
Income	1,572	1,163
Full cost	(1,923)	(2,120)
Surplus / (defict)	**(351)**	(957)
Car parking		
Income	733	335
Full cost	(717)	(626)
Surplus / (defict)	**16**	(291)

Note 5.1 Operating expenses

	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,515	-
Purchase of healthcare from non-NHS and non-DHSC bodies	24,878	15,124
Staff and executive directors costs	430,068	415,986
Remuneration of non-executive directors	164	225
Supplies and services - clinical (excluding drugs costs)	85,239	73,059
Supplies and services - general	19,255	16,366
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	100,448	89,024
Inventories written down	-	193
Consultancy costs	73	-
Establishment	7,586	6,482
Premises	34,331	27,449
Transport (including patient travel)	2,519	2,563
Depreciation on property, plant and equipment	16,314	14,730
Amortisation on intangible assets	1,896	1,776
Net impairments	15,919	15,258
Movement in credit loss allowance: contract receivables / contract assets	732	1,230
Increase/(decrease) in other provisions	-	971
Fees payable to the external auditor		
audit services- statutory audit*	102	102
other auditor remuneration (external auditor only)	4	6
Internal audit costs	116	114
Clinical negligence	20,196	18,589
Legal fees	296	337
Insurance	584	408
Research and development	6,043	6,008
Education and training	14,992	11,673
Rentals under operating leases	1,669	1,765
Redundancy	-	345
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	2,336	2,255
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	81	81
Car parking & security	1,466	1,475
Hospitality	21	83
Losses, ex gratia & special payments	10	179
Other services, e.g. external payroll	-	430
Other	1,929	1,220
Total	**793,781**	**725,505**
Of which:		
Related to continuing operations	793,781	725,505
Related to discontinued operations	-	-

* Includes VAT

All expenditure includes VAT where not recoverable.

Note 5.2 Other auditor remuneration

	2021/22 £000	2020/21 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	4	6
Total	**4**	**6**

Note 5.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2021/22 or 2020/21.

Note 6 Impairment of assets

	2021/22 £000	2020/21 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	232	1,243
Changes in market price	15,687	14,015
Total net impairments charged to operating surplus / deficit	**15,919**	**15,258**
Impairments charged to the revaluation reserve	1,448	11,519
Total net impairments	**17,367**	**26,777**

The £232k relating to the loss from normal operations is due to the demolition of assets required as part of the Capital developments. The remaining £15,687k charge to operating surplus/deficit is the impact of the valuation which also includes the impact of valuing new capital additions during 2021/22 at lower than their cost to build as they would not have a revaluation reserve. The impairments relate in full to buildings, there are no impairments for land.

Note 7 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	346,365	336,817
Social security costs	33,265	30,877
Apprenticeship levy	1,664	1,575
Employer's contributions to NHS pensions *	54,153	51,941
Pension cost - other	170	143
Temporary staff (including agency)	10,595	8,575
Total gross staff costs	**446,211**	**429,928**
Recoveries in respect of seconded staff	-	-
Total staff costs**	**446,211**	**429,928**
Of which		
Costs capitalised as part of assets	1,389	1,304

* The employer's contribution to NHS pensions figure includes the additional 6.3% (£16.554m) for which there is a corresponding entry on income.

** total staff costs figure is £16.1m greater than 'staff and executive director costs' recorded in note 5.1 due to the inclusion of pay costs that are associated with research and development, education and training and those that are capitalised as part of assets in note 5.1.

Note 7.1 Retirements due to ill-health

During 2021/22 there were 5 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £518k (£47k in 2020/21).

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

Note 8 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

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 9 Operating leases

Note 9.1 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.

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	39	39
Total	**39**	**39**

	31 March 2022 £000	31 March 2021 £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.	2,652	2,691
Total	**2,847**	**2,886**

Note 9.2 Hull University Teaching Hospitals NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Hull University Teaching Hospitals NHS Trust is the 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.

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	1,669	1,765
Total	**1,669**	**1,765**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	1,566	1,365
- later than one year and not later than five years;	3,505	2,905
- later than five years.	565	464
Total	**5,636**	**4,734**

Note 10 Finance income

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	41	8
Total finance income	**41**	**8**

Note 11 Finance expenditure

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

	2021/22	2020/21
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	393	439
Finance leases	4	4
Main finance costs on PFI and LIFT schemes obligations	3,255	3,374
Contingent finance costs on PFI and LIFT scheme obligations	2,265	2,409
Total interest expense	**5,917**	**6,226**
Unwinding of discount on provisions	5	19
Total finance costs	**5,922**	**6,245**

Note 12 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	118	99
Losses on disposal of assets	(298)	(89)
Total gains / (losses) on disposal of assets	**(180)**	**10**

Note 13.1 Intangible assets - 2021/22

	Software licences	Development expenditure	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**978**	**11,322**	**12,300**
Transfers by absorption	-	(108)	**(108)**
Additions	-	3,062	**3,062**
Reclassifications	-	1,690	**1,690**
Valuation / gross cost at 31 March 2022	**978**	**15,966**	**16,944**
Amortisation at 1 April 2021 - brought forward	**620**	**5,700**	**6,320**
Transfers by absorption	-	(62)	**(62)**
Provided during the year	142	1,754	**1,896**
Amortisation at 31 March 2022	**762**	**7,392**	**8,154**
Net book value at 31 March 2022	**216**	**8,574**	**8,790**
Net book value at 1 April 2021	**358**	**5,622**	**5,980**

Note 13.2 Intangible assets - 2020/21

	Software licences	Development expenditure	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**447**	**10,704**	**11,151**
Additions	-	1,569	**1,569**
Reclassifications	531	647	**1,178**
Disposals / de-recognition	-	(1,598)	**(1,598)**
Valuation / gross cost at 31 March 2021	**978**	**11,322**	**12,300**
Amortisation at 1 April 2020 - as previously stated	**288**	**5,825**	**6,113**
Provided during the year	282	1,494	**1,776**
Reclassifications	50	(21)	**29**
Disposals / de-recognition	-	(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**

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.

Note 14.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**9,641**	**242,916**	**25,001**	**81,700**	**310**	**25,204**	**384,772**
Transfers by absorption	-	-	-	(1,994)	-	(258)	**(2,252)**
Additions	-	16,682	36,404	22,597	-	5,500	**81,183**
Impairments	-	(23,078)	-	-	-	-	**(23,078)**
Reversals of impairments	-	1,942	-	-	-	-	**1,942**
Revaluations	1,121	2,441	-	-	-	-	**3,562**
Reclassifications	-	26,679	(27,403)	1,128	-	(2,094)	**(1,690)**
Disposals / de-recognition	-	-	-	(7,320)	(6)	(83)	**(7,409)**
Valuation/gross cost at 31 March 2022	**10,762**	**267,582**	**34,002**	**96,111**	**304**	**28,269**	**437,030**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**841**	**-**	**37,452**	**257**	**11,884**	**50,434**
Transfers by absorption	-	-	-	(1,041)	-	(191)	**(1,232)**
Provided during the year	-	7,215	-	6,784	13	2,302	**16,314**
Impairments	-	(2,434)	-	-	-	-	**(2,434)**
Reversals of impairments	-	(1,335)	-	-	-	-	**(1,335)**
Revaluations	-	(2,867)	-	-	-	-	**(2,867)**
Reclassifications	-	(49)	-	49	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	**-**
Disposals / de-recognition	-	-	-	(7,004)	(6)	(83)	**(7,093)**
Accumulated depreciation at 31 March 2022	**-**	**1,371**	**-**	**36,240**	**264**	**13,912**	**51,787**
Net book value at 31 March 2022	**10,762**	**266,211**	**34,002**	**59,871**	**40**	**14,357**	**385,243**
Net book value at 1 April 2021	**9,641**	**242,075**	**25,001**	**44,248**	**53**	**13,320**	**334,338**

Note 14.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**9,641**	**250,387**	**9,927**	**69,561**	**342**	**21,183**	**361,041**
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 / de-recognition	-	-	-	(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 - as previously stated	**-**	**169**	**-**	**37,057**	**271**	**11,874**	**49,371**
Accumulated depreciation at 1 April 2020 - restated	**-**	**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**
Reclassifications	-	-	-	(21)	-	241	**220**
Disposals / de-recognition	-	-	-	(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 14.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022							
Owned - purchased	10,762	188,193	34,002	50,587	40	12,975	**296,559**
Finance leased	-	1,813	-	-	-	-	**1,813**
On-SoFP PFI contracts and other service concession arrangements	-	63,165	-	-	-	-	**63,165**
Owned - donated/granted	-	13,040	-	9,284	-	1,382	**23,706**
NBV total at 31 March 2022	**10,762**	**266,211**	**34,002**	**59,871**	**40**	**14,357**	**385,243**

Note 14.4 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£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 15 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 £485k (2020/21 - £395k). 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 £3.3m (2020/21 - £1.8m)

Note 16 Revaluations of property, plant and equipment

Land and buildings were valued as at 31 March 2022 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 in 2021/22 as there was a full valuation in 2019/20. 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 for specialised assets (hospital) and reflects the current service potential of the assets to the Trust. The Trust has a couple of non-specialised buildings which are valued based on market value in existing use.

There was an overall net increase in property, plant and equipment of £50.9m which was after a £17.3m impairment of assets of which £1.4m is charged to the revaluation reserve and £15.9m is charged to the SOCI.

Overall PPE revaluation gains for the year amounted to £6.429m

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 land and buildings from opening 1st April 2021 to closing March 2022 was an increase of £26m.

Note 17.1 Investment Property

	2021/22	2020/21
	£000	£000
Carrying value at 1 April - brought forward	**100**	**3,100**
Disposals	-	(3,000)
Carrying value at 31 March	**100**	**100**

Investment assets comprise the remaining land adjacent to the Castle Hill Hospital site. The first part of the land was sold in 2018/19, with further sales in 2019/20 and 2020/21 for £2.95m and £2.94m respectively.

Note 18 Other investments / financial assets (non-current)

	2021/22	2020/21
	£000	£000
Carrying value at 1 April - brought forward	**392**	**-**
Movement in fair value through OCI	144	392
Carrying value at 31 March	**536**	**392**

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 £536,469 (2020/21 - £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 - Project Director sits on the board on behalf of the Trust.

Note 19 Disclosure of interests in other entities

The Trust also has an interest 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 20 Inventories

	31 March 2022 £000	31 March 2021 £000
Drugs	5,689	5,159
Consumables	10,178	9,823
Total inventories	**15,867**	**14,982**

Inventories recognised in expenses for the year were £185,859k (2020/21: £160,555k). Write-down of inventories recognised as expenses for the year were £0k (2020/21: £193k).

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 ongoing Covid19 pressures, the majority of Trust stocktakes were completed as expected. Where stock counts were not possible, estimates were made, calculated as 75% of the average value of the last 3 years stock counts. The estimated stock value came to £189k (2020/21 - £321k). 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 2021/22 the Trust received £2,244k of items purchased by DHSC (2020/21: £7,859k).

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 21.1 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	25,867	14,361
Capital receivables	1,856	-
Allowance for impaired contract receivables / assets	(2,530)	(2,104)
Prepayments (non-PFI)	3,115	3,798
PDC dividend receivable	303	530
VAT receivable	2,385	1,295
Other receivables	1,963	1,289
Total current receivables	**32,959**	**19,169**
Non-current		
Contract receivables	2,769	3,075
Allowance for impaired contract receivables / assets	(876)	(822)
Other receivables	1,398	1,469
Total non-current receivables	**3,291**	**3,722**
Of which receivable from NHS and DHSC group bodies:		
Current	17,732	8,871
Non-current	1,338	1,469

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 21.2 Allowances for credit losses

	2021/22		2020/21	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**2,926**	**-**	**2,339**	**-**
New allowances arising	480	-	713	-
Changes in existing allowances	252	-	517	-
Utilisation of allowances (write offs)	(252)	-	(643)	-
Allowances as at 31 Mar 2022	**3,406**	**-**	**2,926**	**-**

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 22 Non-current assets held for sale and assets in disposal groups

At the Statement of Financial Position date, the Trust did not have any assets held for sale.

Note 23.1 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.

	2021/22	2020/21
	£000	£000
At 1 April	**58,927**	**19,434**
Net change in year	20,501	39,493
At 31 March	**79,428**	**58,927**
Broken down into:		
Cash at commercial banks and in hand	13	12
Cash with the Government Banking Service	79,415	58,915
Total cash and cash equivalents as in SoFP	**79,428**	**58,927**
Total cash and cash equivalents as in SoCF	**79,428**	**58,927**

Note 23.2 Third party assets held by the trust

Hull University Teaching Hospitals NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients (£2k) or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

The Trust operates a staff lottery, the cash balance owed to which is £83,660 (2020/21 - £98,586). This is included in the Trust's financial statements.

	2021/22	2020/21
	£000	£000
Bank balances	86	99
Monies on deposit	0	0
Total third party assets	86	99

Note 24.1 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	5,831	3,120
Capital payables	32,732	26,808
Accruals	95,439	61,785
Social security costs	17	7
Other taxes payable	-	17
Other payables	7,192	5,158
Total current trade and other payables	**141,211**	**96,895**
Of which payables from NHS and DHSC group bodies:		
Current	7,981	2,550
Non-current	-	-

All payables are due within one year.

Note 24.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2022 £000	31 March 2022 Number	31 March 2021 £000	31 March 2021 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 25 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	3,277	730
Total other current liabilities	**3,277**	**730**

Note 26.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Loans from DHSC	1,276	1,278
Obligations under finance leases	56	56
Obligations under PFI, LIFT or other service concession contracts	1,657	1,583
Total current borrowings	**2,989**	**2,917**
Non-current		
Loans from DHSC	8,167	9,427
Obligations under finance leases	1,799	1,855
Obligations under PFI, LIFT or other service concession contracts	41,411	43,068
Total non-current borrowings	**51,377**	**54,350**

Note 26.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2021	**10,705**	**1,911**	**44,651**	**57,267**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,260)	(56)	(1,583)	**(2,899)**
Financing cash flows - payments of interest	(395)	(4)	(3,255)	**(3,654)**
Non-cash movements:				
Application of effective interest rate	393	4	3,255	**3,652**
Carrying value at 31 March 2022	**9,443**	**1,855**	**43,068**	**54,366**

Note 26.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£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 27 Finance leases

Note 27.1 Hull University Teaching Hospitals NHS Trust as a lessee

Future lease receipts due under finance lease agreements where the trust is the lessee:
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 32 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 below.

	31 March 2022 £000	31 March 2021 £000
Gross lease liabilities	**1,919**	**1,979**
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.	1,619	1,679
Finance charges allocated to future periods	(64)	(68)
Net lease liabilities	**1,855**	**1,911**
of which payable:		
- not later than one year;	56	56
- later than one year and not later than five years;	225	225
- later than five years.	1,574	1,630

There was no contingent rent recognised as an expense during the year (2020/21 £nil)

Note 28.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2021	**540**	**1,244**	**216**	**3,885**	**5,885**
Arising during the year	17	(17)	69	1,262	**1,331**
Utilised during the year	(65)	(61)	(19)	-	**(145)**
Reversed unused	-	(74)	(81)	-	**(155)**
Unwinding of discount	(6)	10	1	-	**5**
At 31 March 2022	**486**	**1,102**	**186**	**5,147**	**6,921**
Expected timing of cash flows:					
- not later than one year;	65	61	62	3,809	**3,997**
- later than one year and not later than five years;	257	246	124	-	**627**
- later than five years.	164	795	-	1,338	**2,297**
Total	**486**	**1,102**	**186**	**5,147**	**6,921**

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 2022 the NHS Resolution held provisions in respect of the Trust's clinical negligence claims of £426m (2020/21 - £264m).

Within the 'Other' category, we have included a provision for; the Flowers legal case of £3,435k, Doctors nodal points of £384k and Clinicians Pension Provision of £1,338k.

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. NHS England provided a statement of provision liabilities arising from the 2019/20 clinicians' pensions compensation scheme based on the latest available information on actual uptake of the scheme. They are derived from combining information on applications to join the 2019/20 scheme under the policy, together with information in the scheme pays election form where present, and with averages assumed where these forms are absent or clearly an estimate (values less than £100).

The Clinician pension tax provision is £1,338k (2020/21 - £1,469k).

Note 28.2 Clinical negligence liabilities

At 31 March 2022, £425,528k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Hull University Teaching Hospitals NHS Trust (31 March 2021: £264,381k).

Note 29 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	(27)	(2)
Employment tribunal and other employee related litigation	(30)	(90)
Gross value of contingent liabilities	**(57)**	**(92)**
Net value of contingent liabilities	**(57)**	**(92)**

All contingent liabilities relate to legal claims made against the Trust (Employer and Public liability claims) and 1 employment tribunal. They are accounted for as contingent liabilities to the extent that they are not included in any formal provision.

There are no contingent assets

Note 30 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	2,800	6,316
Total	**2,800**	**6,316**

Note 31 Defined benefit pension schemes

The Trust has no defined benefit pension schemes.

Note 32.1 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. 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 32.2 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2022	31 March 2021
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**67,792**	**72,630**
Of which liabilities are due		
- not later than one year;	4,818	4,838
- later than one year and not later than five years;	20,604	20,136
- later than five years.	42,370	47,656
Finance charges allocated to future periods	(24,724)	(27,979)
Net PFI, LIFT or other service concession arrangement obligation	**43,068**	**44,651**
- not later than one year;	1,657	1,583
- later than one year and not later than five years;	9,378	8,285
- later than five years.	32,033	34,783

Note 32.3 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2022 £000	31 March 2021 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**183,054**	**196,904**
Of which payments are due:		
- not later than one year;	12,389	12,179
- later than one year and not later than five years;	52,900	51,995
- later than five years.	117,765	132,730

Note 32.4 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2021/22 £000	2020/21 £000
Unitary payment payable to service concession operator	**11,884**	**11,686**
Consisting of:		
- Interest charge	3,255	3,374
- Repayment of balance sheet obligation	1,583	1,929
- Service element and other charges to operating expenditure	2,336	2,255
- Capital lifecycle maintenance	2,445	1,719
	2,265	2,409
Total amount paid to service concession operator	**11,884**	**11,686**

Note 33 Off-SoFP PFI, LIFT and other service concession arrangements

Hull University Teaching Hospitals NHS Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT arrangements:

	31 March 2022 £000	31 March 2021 £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.	324	405
Total	**729**	**810**

Note 34 Financial instruments

Note 34.1 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 commissioners (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 2021/22. These arrangements have provided greater certainty and promoted System collaboration at no 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.

Foreign 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.

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 2022 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 34.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	29,109	-	**29,109**
Other investments / financial assets	-	536	**536**
Cash and cash equivalents	79,428	-	**79,428**
Total at 31 March 2022	**108,537**	**536**	**109,073**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	15,799	-	**15,799**
Other investments / financial assets	-	392	**392**
Cash and cash equivalents	58,927	-	**58,927**
Total at 31 March 2021	**74,726**	**392**	**75,118**

Note 34.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	9,443	**9,443**
Obligations under finance leases	1,855	**1,855**
Obligations under PFI, LIFT and other service concession contracts	43,068	**43,068**
Other borrowings	-	**-**
Trade and other payables excluding non financial liabilities	141,194	**141,194**
Other financial liabilities	-	**-**
Provisions under contract	-	**-**
Total at 31 March 2022	**195,560**	**195,560**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	10,705	**10,705**
Obligations under finance leases	1,911	**1,911**
Obligations under PFI, LIFT and other service concession contracts	44,651	**44,651**
Other borrowings	-	**-**
Trade and other payables excluding non financial liabilities	96,871	**96,871**
Other financial liabilities	-	**-**
Provisions under contract	-	**-**
Total at 31 March 2021	**154,138**	**154,138**

Note 34.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2022 £000	31 March 2021 £000
In one year or less	147,348	105,463
In more than one year but not more than five years	25,884	25,416
In more than five years	47,116	53,722
Total	**220,348**	**184,601**

Note 34.5 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 35 Losses and special payments

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases - Restated	Total value of cases - Restated
	Number	£000	Number	£000
Losses				
Cash losses	7	1	-	-
Bad debts and claims abandoned	-	-	4	17
Stores losses and damage to property	-	-	2	-
Total losses	**7**	**1**	**6**	**17**
Special payments				
Ex-gratia payments	18	9	16	2,207
Total special payments	**18**	**9**	**16**	**2,207**
Total losses and special payments	**25**	**10**	**22**	**2,224**
Compensation payments received		-		-

2020/21 figures have been restated to include overtime corrective payments of £2.2m that were made as special payments following the outcome of the 'Flowers' case.

Note 36 Related parties

Hull University Teaching Hospitals NHS Trust is a corporate body established by order of the Secretary of State for Health.

Details of related parties transactions must be disclosed in accordance with IAS 24; these are as follows:

	2021/22	2021/22	2021/22	2021/22		2020/21	2020/21	2020/21	2020/21
Organisation name / Trust Officer / Nature of Relationship	**Revenue from Related Party**	**Expend with Related Party**	**Amounts due from Related Party**	**Amounts owed to Related Party**		Revenue from Related Party	Expend with Related Party	Amounts due from Related Party	Amounts owed to Related Party
	£000s	**£000s**	**£000s**	**£000s**		£000s	£000s	£000s	£000s
Roche Pharmaceuticals - Clinical Director / Member of the Professional Advisory Board of Roche	65	5,120	35	6		117	3,202	1	4
Hull York Medical School - Non-Executive Director / Dean of Hull York Medical School	134	0	63	0		53	0	81	0
KPMG / Head of Procurement / Close relative is a KPMG partner	0	115	0	0		0	3	0	0
Taywel Engineering Limited / Director of Estates and Facilities / Director of Taywell Engineering Ltd	0	1	0	0		0	24	0	0

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 tabled below;

	2021/22	2021/22	2021/22	2021/22		2020/21	2020/21	2020/21	2020/21
Organisation name	**Revenue from Related Party**	**Expend with Related Party**	**Amounts due from Related Party**	**Amounts owed to Related Party**		Revenue from Related Party	Expend with Related Party	Amounts due from Related Party	Amounts owed to Related Party
	£000s	**£000s**	**£000s**	**£000s**		£000s	£000s	£000s	£000s
The University of Hull	235	3,043	523	0		249	3,600	174	5
Hull City Council	319	1,695	37	0		354	1,214	19	8
East Riding Council	299	946	123	0		235	1,520	83	0

Hull University Teaching Hospitals NHS Trust is supported by two charities, these are;

— Hull and East Yorkshire Hospitals NHS General Purposes Charity - registered charity number: 1052035

— The Hull and East Yorkshire Hospitals Health Charity (WISHH) - registered charity number: 1162414

Hull Royal Infirmary and Castle Hill Hospital benefit from the donations and fundraising endeavours of both charities, though primarily the Health Charity which is developing its role as the official charity of Hull University Teaching Hospitals NHS Trust. Equipment and miscellaneous items provided by the charities to the Trust during 2021/22 amounted to £543k. Hull University Teaching Hospitals NHS Trust provides adminstrative support to both charites under a service level agreement.

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 £536,469. 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 - Project Director, sits on the board on behalf of the Trust.

The Trust also has an interest 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:

UK Health Security Agency

Health Education England

NHS Improvement

Supply Chain Coordination Ltd

Department of Health and Social Care

NHS Resolution

NHS Blood And Transplant

Leeds Teaching Hospitals NHS Trust

Northumbria Healthcare NHS FT

North Lincolnshire And Goole NHS FT

York and Scarborough Teaching Hospitals NHS FT

Humber Teaching NHS Foundation Trust

Harrogate and District NHS FT

Calderdale And Huddersfield NHS FT

Northern Care Alliance NHS FT

North Tees And Hartlepool NHS FT

Sheffield Teaching Hospitals 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

Note 37 Transfers by absorption

On the 1st November 2021, the Trust transferred its Pathology Service to York and Scarborough Teaching Hospitals NHS Foundation Trust, as part of the establishment of a Pathology Collaborative. Under the basis of transfer by absorption, the Trust transferred some of its fixed assets to York (equipment and IT). This was an absorption loss of £1,066k and is reflected in the accounts.

Note 38 Better Payment Practice code

Non-NHS Payables	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Total non-NHS trade invoices paid in the year	100,314	334,874	96,855	277,917
Total non-NHS trade invoices paid within target	96,881	300,239	93,648	253,865
Percentage of non-NHS trade invoices paid within target	96.6%	89.7%	96.7%	91.3%
NHS Payables				
Total NHS trade invoices paid in the year	3,388	41,471	4,237	22,594
Total NHS trade invoices paid within target	2,761	37,237	3,685	19,367
Percentage of NHS trade invoices paid within target	81.5%	89.8%	87.0%	85.7%

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 39 External financing limit

The trust is given an external financing limit against which it is permitted to underspend

	2021/22 £000	2020/21 £000
Cash flow financing	15,217	(12,569)
Finance leases taken out in year		
Other capital receipts		
External financing requirement	**15,217**	**(12,569)**
External financing limit (EFL)	15,217	26,381
Under / (over) spend against EFL	**-**	**38,950**

Note 40 Capital Resource Limit

	2021/22 £000	2020/21 £000
Gross capital expenditure	84,245	64,973
Less: Disposals	(316)	(3,059)
Less: Donated and granted capital additions	(17,454)	(2,608)
Plus: Loss on disposal from capital grants in kind	155	-
Charge against Capital Resource Limit	**66,630**	**59,306**
Capital Resource Limit	67,123	59,354
Under / (over) spend against CRL	**493**	**48**

Note 41 Breakeven duty financial performance

	2021/22 £000
Adjusted financial performance surplus / (deficit) (control total basis)	330
Remove impairments scoring to Departmental Expenditure Limit	232
Add back non-cash element of On-SoFP pension scheme charges	-
	-
Breakeven duty financial performance surplus / (deficit)	**562**

Note 42 Breakeven duty rolling assessment

	1997/98 to 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	2021/22
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(8,051)	2,616	(7,134)	25,220	11,072	1,489	562
Breakeven duty cumulative position	26,598	29,214	22,080	47,300	58,372	59,860	60,423
Operating income	526,253	561,128	579,847	629,192	662,676	726,808	808,450
Cumulative breakeven position as a percentage of operating income	5.1%	5.2%	3.8%	7.5%	8.8%	8.2%	7.5%

Note 43 Adjusted Financial Performance (SoCI control total basis)

Adjusted financial performance (control total basis):	**2021/22**	**2020/21**
Surplus / (deficit) for the period	(135)	(10,973)
Remove net impairments not scoring to the Departmental expenditure limit	15,687	14,015
Remove (gains) / losses on transfers by absorption	1,066	-
Remove I&E impact of capital grants and donations (see below)	(16,734)	(2,162)
Prior period adjustments	-	-
Remove non-cash element of on-SoFP pension costs	-	-
Remove net impact of inventories received from DHSC group bodies for COVID response	291	(635)
Remove loss recognised on return of donated COVID assets to DHSC	155	
Adjusted financial performance surplus / (deficit)	**330**	**246**
Less gains on disposal of assets	(118)	
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**212**	**246**

The I&E impact of capital grants and donations is as follows:			
Income from capital grants and donations	(17,454)	(2,608)	(as per note 3)
Depreciation on grants and donations	720	446	
Net I&E impact	**(16,734)**	**(2,162)**	

Hull University Teaching Hospitals NHS Trust

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

21 June 2022

Dear Mark

Hull University Teaching Hospitals NHS Trust - audit for year ended 31 March 2022

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 2022 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 DHSC 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.

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 DHSC 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 DHSC 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.

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 2021/22 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:

- 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.
- Ukraine – we have assessed the potential impact of Russian Forces entering Ukraine on the Trust, including the impact of mitigation measures and uncertainties and are satisfied that the financial statements and supporting notes fairly reflect that assessment.
- 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.

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

Unadjusted misstatements

I confirm that the effects of any uncorrected misstatements are immaterial both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to this letter as an Appendix.

Yours sincerely,

Accountable Officer

APPENDIX

UUNADJUSTED MISSTATEMENTS

		SOCI		SOFP	
		Dr (£000)	Cr (£000)	Dr (£000)	Cr (£000)
1	Dr: Trade Payables			1,776	
	Cr: Property, Plant and Equipment				1,776
	This relates to the capitalisation of an asset in 2021/22 that does not relate to 2021/22 capital expenditure.				
2	Dr: Other Operating Income	646			
	Cr: Cash				646
	Income testing identified income of £17k included in 2021-22 that related to 2020-21. The income had not been accrued for in the 2020-21 financial year. The value of £646k reflects the value of the extrapolated error across the untested population.				
3	Dr: Stock			1,570	
	Cr: Operating Expenses		1,570		
	Inventory testing identified a difference in price of £4k in the sample population between the price used per the count dates to value inventory and the prices used per the review of year end price records. The value of £1,570k reflects the value of the extrapolated error across the sampled population.				

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

16/6/22 Date ..... Chief Executive

16/6/22 Date ..... Finance Director

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 16/6/22

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 2022, 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 2021/22 as contained in the Department of Health and Social Care Group Accounting Manual 2021/22, 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 2022 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 2021/22; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

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 of £14.982m because we were 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 2021 was necessary, or whether there was any consequential effect on operating expenses in relation to inventory expenditure for the year ended 31 March 2022.

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 2021/22 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 statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General 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 2022.

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 December 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2022.

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 of the Local Audit and Accountability Act 2014 (as amended) 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 December 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
Leeds
LS1 4AP

21 June 2022

Auditor's Annual Report

Hull University Teaching Hospitals NHS Trust – year ended 31 March 2022

September 2022

mazars

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 2022. 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 21 June 2022. Our opinion on the financial statements was modified. This was due to us not being able to obtain sufficient appropriate audit evidence regarding the inventory balance as at 31 March 2021 (as a result of not being able to attend and test year end stock takes due to Covid-19 restrictions at that time).

Wider reporting responsibilities

In line with group audit instructions issued by the NAO, on 21 June 2022 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 21 June 2022, 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. No significant weaknesses in arrangements were identified through our work.

Following the completion of our work we have issued our audit certificate which formally closes the audit for the 2021/22 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 2022 and of its financial performance for the year then ended. Our audit report was issued on 21 June 2022. Our opinion on the financial statements was modified. This was due to us not being able to obtain sufficient appropriate audit evidence regarding the inventory balance as at 31 March 2021 (as a result of not being able to attend and test year end stock takes due to Covid-19 restrictions at that time).

Qualitative aspects of the Trust's accounting practices

We reviewed the Trust's accounting policies and disclosures and concluded they comply with Department of Health and Social Care Group Accounting Manual 2021/22, appropriately tailored to the Trust's circumstances.

Draft accounts were received from the Trust on 26 April 2022 and were of a good quality.

Significant difficulties during the audit

During the audit we did not encounter any significant difficulties and we had the full co-operation of management.

We would like to thank the Finance Team for the quality of their supporting working papers and for being available throughout the audit to respond to 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 five internal control recommendations. Implementation of the recommendations made will improve internal controls over the year end stock takes and valuation of stock, the completeness of related party disclosures and the evidence and review of monthly payroll processes.

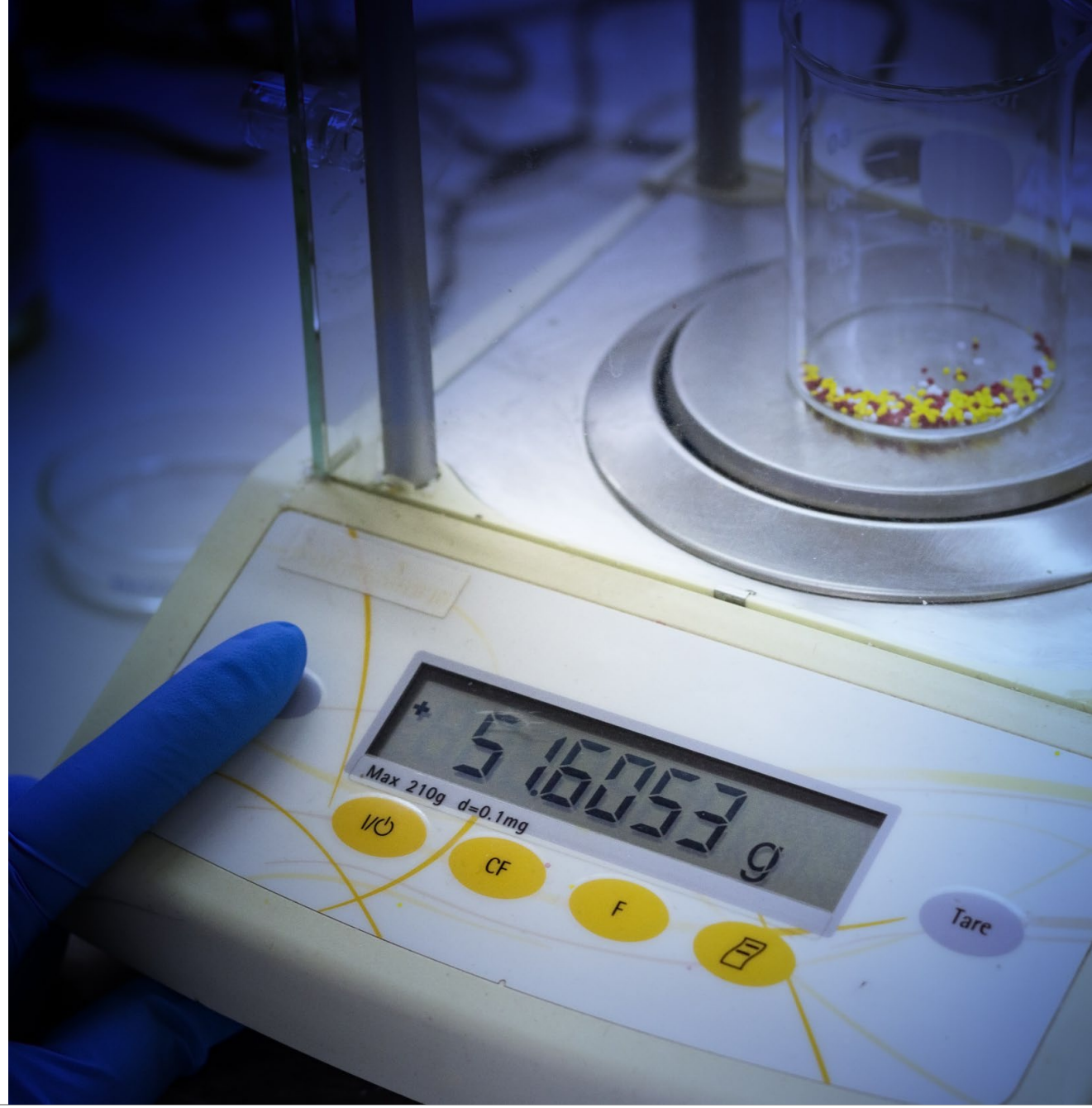
03

Section 03:

Our work on Value for Money arrangements

3. VFM arrangements

Overall Summary



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

Our work is carried out in three main phases.

Phase 1 - Planning and risk assessment

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.

We obtain our understanding or arrangements for each of the specified reporting criteria using a variety of information sources which may include:

- NAO guidance and supporting information
- Information from internal and external sources including regulators
- Knowledge from previous audits and other audit work undertaken in the year
- Interviews and discussions with staff and directors

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.

Phase 2 - Additional risk-based procedures and evaluation

Where we identify risks of significant weaknesses in arrangements, we design a programme of work to enable us to decide whether there are actual significant weaknesses in arrangements. We use our professional judgement and have regard to guidance issued by the NAO in determining the extent to which an identified weakness is significant.

We outline the risks that we have identified and the work we have done to address those risks on page 10.

Phase 3 - Reporting the outcomes of our work and our recommendations

We are required to provide a summary of the work we have undertaken and the judgments we have reached against each of the specified reporting criteria in this Auditor's Annual Report. We do this as part of our Commentary on VFM arrangements which we set out for each criteria later in this section.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust. We refer to two distinct types of recommendation through the remainder of this report:

- **Recommendations arising from significant weaknesses in arrangements**
  We make these recommendations for improvement where we have identified a significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Where such significant weaknesses in arrangements are identified, we report these (and our associated recommendations) at any point during the course of the audit.

- **Other recommendations**
  We make other recommendations when we identify areas for potential improvement or weaknesses in arrangements which we do not consider to be significant but which still require action to be taken

The table on the following page summarises the outcomes of our work against each reporting criteria, including whether we have identified any significant weaknesses in arrangements or made other recommendations.

3. VFM arrangements – Overall summary

Overall summary by reporting criteria

Reporting criteria	Commentary page reference	Identified risks of significant weakness?	Actual significant weaknesses identified?	Other recommendations made?
 **Financial sustainability**	**11**	No	No	Yes – see commentary on page 13
 **Governance**	**14**	No	No	No
 **Improving economy, efficiency and effectiveness**	**17**	No	No	No

3. VFM arrangements

Financial Sustainability

How the body plans and manages its resources to ensure it can continue to deliver its services

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 2021/22. 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 10 occasions during the year and was stood down in January and February 2022 due to the COVID-19 pandemic and operational pressures. The focus of each meeting is on the Trust's Performance Report, which includes reporting of the Trust's performance against national standards. Other key agenda items over the year include reporting of the Trust's financial position, with a particular focus on the monthly reported position, income and expenditure variances to plan, commentary on reasons for variances and the forecast outturn. Financial reporting also includes monitoring of capital expenditure against plan, as well as the Trusts liquidity position, outstanding debtors and stock levels. The Non-Executive Chair of the meeting provides a briefing to the Board of the areas discussed at the Performance and Finance Committee.

Our review of supporting papers confirmed the committee complied with its Terms of Reference effectively during 2021/22.

Background to the NHS financing regime in 2021/22

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 second half of the 2020/21 year (October 2020 to March 2021) there was a move to "system envelopes", with funding allocations covering most NHS activity made at the system level, including resources to meet the additional costs of the COVID-19 pandemic. The 2021/22 financial year was also split into two halves, with a different funding regime in each. However, the regimes were largely a continuation of those introduced in 2020/21 in response to COVID-19, where system envelopes and block payment arrangements remained in place.

The 2021/22 H1 (April 2021 to September 2021) envelopes comprised of adjusted Clinical Commissioning Group (CCG) allocations, system top-up and COVID-19 fixed allocations, based on the H2 2020/21 envelopes, adjusted for known pressures and policy priorities.

The 2021/22 H1 NHS guidance also confirmed that block payment arrangements would remain in place for relationships between NHS commissioners and NHS providers. The guidance for H2 (October 2021 to March 2022) confirmed that the arrangements would stay broadly consistent with a continuation of the H1 framework. The 2021/22 H2 "system envelopes" contained adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H1 2021/22 envelopes adjusted for additional known pressures, such as the impact of pay awards, and increased efficiency requirements.

Over the course of the year and into 2022/23, the focus of the funding regime has shifted from responding to the immediate challenges caused by COVID-19 to supporting recovery in the healthcare system.

This has facilitated the need for collaborative working between commissioners and providers, as local systems were expected to work together to deliver a balanced position in 2021/22, with additional funding available for those systems exceeding target activity levels through the Elective Recovery Fund. The planning guidance for 2022/23 supports the transition back to local agreement of contracts and requires systems to achieve a break even position each year. This will necessitate further collaboration through the planning process, as individual organisations work together to achieve system-level outcomes.

The Trust's arrangements and approach to 2021/22 and 2022/23 financial planning

Throughout the year the Trust reported its financial position to the Performance and Finance Committee. Reports 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 financial position is also reported to the Trust Board.

The Trust manages any identified funding gaps through its efficiency programme, which the Productivity and Efficiency Board has oversight of. A small efficiency programme was in place for 2021/22 and the Trust delivered non-recurrent savings of £8.3m through vacancies and other reduced non-pay activity.

The Trust's financial plans are under pinned 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.

3. VFM arrangements – Financial Sustainability

Overall commentary on the Financial Sustainability reporting criteria - continued

Following confirmation that the financial regime in place for the second half of 2020/21 would continue into quarter 1 of 2021/22, the Trust submitted a financial plan for the first six months of 2021/22 (H1) to deliver a £1.7m deficit, within an overall Humber Coast & Vale ICS target of break-even. The Trust delivered the £1.7m deficit for months 1 to 6 and as such met the H1 control total. The financial arrangements for H2 were based on block contracts for H1 with an inflationary uplift to cover the agreed 3% pay award and non-pay uplift. There was also an increased efficiency requirement of 1.1% minimum. The Trust submitted a H2 financial plan to deliver a £1.7m surplus, which enabled the Trust to achieve break even across the full financial year. The H2 plan also included a £5.8m efficiency target. The Trust reported a H2 closing position of £1.9m surplus, which was an improvement on plan and gave a total annual position of £0.2m surplus.

For 2022/23 the NHS will revert to contracting arrangements instead of the current block payments system introduced to simplify arrangements during the pandemic. NHSE/I has allocated revenue allocations to Integrated Care Boards (ICBs) based on the system funding envelopes calculated for H2 2021/22. This continued the basis of calculating funding at ICS level introduced at the start of the COVID-19 pandemic. Core ICB allocations have grown in 2022/23, against an adjusted 2021/22 baseline. This is intended to fund inflation and activity growth, however there is a 1.1% efficiency requirement. Specific allocations to meet COVID-19 costs have also reduced as NHSE/I expects savings to be made as the NHS recovers from COVID-19 and direct costs associated with the pandemic. Additional funding has been made available for elective recovery.

The financial plan submitted in April 2022 showed a £19.1m deficit. This was part of an overall Humber and North Yorkshire (HNY) Health and Care Partnership ICS position of £56.2m deficit. A large element of the Trust deficit (£14.2m) was linked to expected high levels of inflation for both utilities and general non-pay costs. NHSE/I required that all 2022/23 plans be resubmitted by 20 June 2022 and offered the ICSs additional funding to help broker breakeven positions in local plans. The Trust's resubmitted plan projects a breakeven position for 2022/23. The plan includes delivery of efficiencies of £29.7m. There is a Cash Releasing Efficiency Savings (CRES) plan in place for 2022/23 and this is monitored monthly at both the Health Group and Corporate Services level.

Review of the report to Trust Board accompanying the 2022/23 financial plan highlights that the assumptions within the plan may be challenging and will need further work during the year. The report also brings to the attention of the Board the risks associated with the plan, particularly the impact on elective recovery income if activity is below plan and the need to increase in-house productivity and to continue to identify efficiencies to deliver the breakeven position.

Review of the month 2 monitoring reported to the Performance and Finance Committee and Trust Board shows an overall deficit of £0.4m, which is £0.8m worse than the plan. It is however clear that the Trust is closely monitoring the progress against plan to date, is aware of where the risks and uncertainties lie and the financial pressures that exist.

Other recommendation

1	Achievement of the 2022/23 efficiency target - totaling £29.7m, 4.1% of operating expenditure - will be a significant challenge for the Trust.	The Trust should ensure it continues its arrangements to identify how it will deliver un-costed efficiency savings included in the financial plan. It should also ensure that its scrutiny arrangements, to monitor and deliver its efficiency savings plans are maintained throughout 2022/23.

The Trust have set a capital plan of £33.9m, this excludes the impact of changes to lease accounting (IFRS16) that will be implemented from 1 April 2022, for which the Trust is expecting Capital Department Expenditure Limit (CDEL) cover totalling £0.97m. The CDEL allocation for 2022/23 is £23.1m, with the remaining capital spend to be funded largely through grant funding.

Given the NHS's national response to the COVID-19 pandemic, and the ongoing changes to the financial regime to enable Trusts to focus on responding to COVID-19, the Trust have continued to adapt their arrangements during the year. We have not identified any significant weaknesses in relation to financial sustainability.

Conclusion

Given the above, we are satisfied there is not a significant weakness in the Trust's arrangements in relation to the financial sustainability reporting criteria.

3. VFM arrangements

Governance

How the body ensures that it makes informed decisions and properly manages its risks

3. VFM arrangements – Governance

Overall commentary on the Governance reporting criteria

We have reviewed the Trust's Board and committee reports during the year as well as key documents in relation to how the Trust ensures that it makes informed decisions and properly manages its risks. Through this review we note that the Trust's governance arrangements are consistent with prior years. As a result, our commentary on those arrangements is also consistent with our commentary as reported through our AAR for 2020/21.

The Trust's arrangements for budget setting and budgetary control

As noted above, the financial regime changes from 2020/21 continued into 2021/22, with block payment arrangements remaining. The Trust continued to monitor and report its financial position monthly which included reasons for any variances to the plan and mitigations that had been put in place.

The Trust has a well-established system of monthly reporting through its budgetary control system which reports upwards to the Chief Finance Officer, Executive Management Committee, Performance and Finance Committee and Trust Board. Review of budget monitoring reports at the Health Group level shows detailed analysis of year-to-date budget, actual spend and variances, along with explanations for areas of over or under spending. Where appropriate action required to address overspending is identified.

Monthly performance meetings are held by the Trusts executive management team with the Health Group leaders and key support staff to review financial and non-financial performance.

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 (DATIX) 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, including finance. Risks are identified from a variety of 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.

Board Assurance Reports including risks relevant to the committee's remit are taken to the Performance and Finance Committee and Quality Committee, with overall reporting to the Trust Board. Reports detail risks and associated risk ratings, as well as a risk appetite score. Reporting also provides details of actions taken in the current quarter and planned actions to mitigate risks going forwards, along with, were appropriate proposed changes to risk ratings. During 2021/22 assurance ratings have been added to Board Assurance Report to assess whether sufficient actions are being taken to achieve the target risk ratings. Formal escalation to the Board is made where it is considered target risk ratings will not be achieved along with the reasons for potential non achievement.

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.

Our review of the Trust's governance framework confirms appropriate arrangements are in place. The Trust has established committees with responsibility for specific areas, such as finance and performance, and the quality of care, including:

- Performance and Finance Committee
- Audit Committee
- Quality Committee
- Remuneration Committee
- Charitable Funds Committee

3. VFM arrangements – Governance

Overall commentary on the Governance reporting criteria - continued

Throughout 2021/22 the Trust continued to operate its Board meetings and sub committees as in prior years, however these were held remotely, where necessary. The Performance and Finance Committee was stood down in January and February 2022 to enable the Trust to respond to the ongoing COVID-19 pandemic. 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.

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.

We have reviewed the Internal Audit Plans for 2021/22 and 2022/23 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

How the body uses information
about its costs and performance to improve the way it manages and delivers its services

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), Scan for Safety data 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. 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. 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. Lessons learned are also communicated throughout the Trust via a monthly Lessons Shared newsletter. The newsletter's includes clear actions to be taken, points to remember and provide links to further support and guidance.

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. CQC is only able to update findings on well-led at the overall trust level or update the other trust-level ratings when they have inspected the well-led component, as such the overall Trust ratings where not updated from those obtained in the 2018 inspection. There have been no further CQC inspections of the Trust during 2021/22.

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 has continued to be a member of several groups across the Humber region including the HCV Partnership Board, HCV Provider Collaborative Board, Cancer Alliance Board and HCV Local Maternity System.

The revised finance regime means that financial performance is now measured at an ICS level and the organisations of the Humber and North Yorkshire (HNY) Health and Care Partnership have collective performance targets.

This shared responsibility is discharged through timely and transparent sharing of data and regular joint meetings to develop a consensus on approach and risk mitigation across the ICS. This is an example of how the Humber and North Yorkshire organisations are working together at an ICS level.

During 2021/22 the Trust has continued to jointly lead 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 aim of the collaboration is to establish new and sustainable arrangements within priority service areas across the Humber to ensure they can continue to operate safely, as well as addressing the significant challenges in terms of staffing and infrastructure across the two Trusts. During 2021/22 the Trust Board approved the transfer of neurology outpatient services to form a single Humber service that will operate out of the Humber hospitals under single leadership. This is the first service to be delivered in this way and became operational from Oct 2021. The intention being for haematology and oncology to be reviewed next with the aim to also move these to a single Humber service. At this stage it is too early to see the full impact of the neurology service changes, however identified benefits of the single service have been determined and ongoing monitoring is taking place to confirm achievement of these benefits and the reasons for non-achievement if applicable

From 1 November 2021 the Trust transferred the pathology service to a new network pathology service hosted by York and Scarborough Teaching Hospital Foundation Trust (YSTHFT). The new Scarborough, Hull, York Pathology Service (known as SHYPS), was set up to meet the growing demand, increased complexity of testing, increased cost of testing, as well as address inconsistencies in testing and ensure a sustainable service going forward. Again, the new service is still relatively new and therefore the full impact of the changes has not yet been realised, however the proposal set out clear programme benefits and mechanisms for measuring the success of the new service.

The Trust recognises the importance of partnership working to deliver its own and the wider ICS objectives and this is demonstrated through the long-term goals of the Trust which include partnership and integrated working. The Trust identifies the failure of partnerships and integrated services as a risk to the achievement of its strategic objectives and this is reported and monitored in accordance with the BAF process outlined above.

3. VFM arrangements – Improving Economy, Efficiency and Effectiveness

Overall commentary on the Improving Economy, Efficiency and Effectiveness reporting criteria - continued

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 of 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 provides 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; 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 have concluded and reported 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 February 2022. Having completed our work for the 2021/22 financial year, we can confirm that our fees are as follows:.

Area of work	2021/22 fees
Planned fee in respect of our work under the Code of Audit Practice	**£85,000 (plus VAT)**
Total fees	**£85,000 (plus VAT)**

Fees for other work

We have been engaged to carry out the independent examination of the Hull and East Yorkshire Hospitals NHS Trust General Purposes Charity. The fee for 2021/22 is £3,500 (plus VAT).

Mark Dalton, Director – Public Services

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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 2022

In our auditor's report dated 21 June 2022 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 21 June 2022 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 2022.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in December 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
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12 September 2022