



South Tees Hospitals  
NHS Foundation Trust



# South Tees Hospitals NHS Foundation Trust

Annual Report and Accounts 2025/26



Caring  
Better  
Together



South Tees Hospitals NHS Foundation Trust  
**Annual Report and Accounts 2025/26**

**Presented to Parliament pursuant to  
Schedule 7, Paragraph 25 (4)(a) of the  
National Health Service Act 2006**



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Annual accounts for the period 1 April 2025 to 31 March 2026

# Annual Report, 2025/26

## 1. Performance report

The purpose of the performance report is to provide an overview of South Tees Hospitals NHS Foundation Trust (the trust), its purpose and history. The Chief Executive and Chair's perspective is included together with the key issues and associated risks to the delivery of our objectives.

### Welcome to South Tees Hospitals NHS Foundation Trust's Annual Report and Accounts 2025/26.

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The 2025–26 financial year has been a period of meaningful consolidation, innovation and patient-focused progress for University Hospitals Tees (UHT).

Building on the foundations laid by North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust, this year has seen our hospital group increase efforts to deliver consistently high quality care, champion integrated clinical services, support our workforce and strengthen our partnership with the communities we serve.

Our strategic direction, articulated in our Caring Better Together 2025–2030 strategy, reflects a commitment to collaborative leadership, clinical excellence, digital transformation and improving patient experience across Teesside, North Yorkshire, County Durham and beyond.

This year marks our second full cycle since the formal creation of University Hospitals Tees as a hospital group—uniting the strengths of our two trusts to harness shared opportunities, enhance operational resilience and improve population health outcomes.

Our work has continued to reflect the voices of staff, patients and local partners, drawing on community feedback to inform both service improvement and future direction. Collaboration has been central to every success, from major capital developments to workforce events that celebrate and strengthen the critical contributions of our clinicians, allied health professionals and non-clinical support staff.

In an environment shaped by evolving health needs, workforce pressures and national challenges across the NHS, University Hospitals Tees has remained steadfast in its commitment to providing safe, compassionate, effective care.

We have sustained momentum across multiple fronts—introducing new models of care, expanding diagnostics capacity, deepening community engagement, and nurturing an inclusive, learning culture for our workforce. The initiatives and achievements reported in this report reflect the exceptional dedication of our expert teams across all sites and services.

We are committed to the local delivery of the governments achieving the ‘three shifts’ outlined in the 10-year plan for the NHS:

- Hospital to Community
- Analogue to Digital
- Sickness to Prevention

Initiatives including our Hospital at Home which sees patients receive hospital-quality care in their own home, our development of an advanced group-wide electronic prescribing system and our active public health teams pre-date the 10-year plan's ambitions. As you will soon see, University Hospitals Tees is leading the way in delivering the three shifts across multiple improvement projects and new service delivery models.

Another development we are proud to be playing a leading role in is the Neighbourhood Health Centre.

Stockton-on-Tees was selected by the government as one of just 43 national neighbourhood health pilot sites. We quickly established an Integrated Neighbourhood Multidisciplinary Team to bring together the local authority, primary care, community, mental health, social care and voluntary sector partners to develop the centre which will focus on providing support people aged 50–64 with three or more long term conditions in the Stockton central and Portrack areas.

We will soon agree on plans to scale the approach across the Borough as Stockton has also been selected as a national incubator site for neighbourhood health digital tools. In parallel, work is commencing to develop a Neighbourhood Health Centre model and business case focused on Stockton Town Centre, aligned with the Pride in Place regeneration programme.

These initiatives, planned and delivered in close partnership with key stakeholders, will contribute towards tackling the historic levels of health inequality faced by the people of Stockton for too long. We are confident the learnings from the Neighbourhood Health will aid other NHS trusts and their local partners around the country to improve the health of their local communities – our expertise and local care delivery will have nationwide impact.

At the heart of our progress stands a shared vision: caring better together.

As this report outlines performance, developments, achievements and learning from the past year, it also sets the direction for our next phase of transformation. We remain committed to high quality clinical care, strengthened partnerships, world-class digital infrastructure, and operational excellence.

### **Our highlights include:**

- Launched our Caring Better Together strategic framework (2025–30) – defining the vision, values and strategic objectives for our next phase of service improvement, workforce development and partnership working
- The Care Co-ordination Centre (CCC) pilot saw more than 1,000 calls from ambulance and primary care providers relating to older people screened before admission, leading to more than 300 receiving care at home or in a community venue thus avoiding admission to acute site
- Launched our new group values of respect, support and collaborate
- Annual General Meeting with University Hospitals Tees partners and stakeholders. Our first combined AGM, held on the state-of-the-art Teesside University campus, saw staff, governors and members of the public engage with group leadership on performance, priorities and future plans.
- Opening of the Tees Valley Community Diagnostic Centre in Stockton town centre — a major service milestone providing CT, MRI, ultrasound, X-ray, cardiology and blood tests in one accessible facility, made possible by close partnership with the NENC ICB and Stockton-on-Tees Borough Council.
- Three hub sites opened at Redcar Community Hospital, the Friarage and the University Hospital of Hartlepool to support the Tees Valley Community Diagnostic Centre

- The introduction of a Community Thoracic Service and a Day-1 Discharge Programme (D1DP) enables patients to recover safely at home with timely specialist review, rather than remaining in an acute hospital setting unnecessarily
- Opened the £35.5m Friarage surgical hub which features six new operating theatres with 12 recovery bays, two minor operating theatres with four recovery bays, a regional block room and a dedicated admission and discharge area
- Invested in new Elekta linear accelerator machines to create clearer imaging and deliver more reliable radiotherapy treatment for patients with cancer
- Engagement programmes to shape organisational values — inviting staff to help define and embed core values underpinning how UHT delivers excellent care and support to patients and colleagues alike
- Allocated government funding for essential upgrades at University Hospital of Hartlepool including investment in heating systems, fire safety, energy-efficient infrastructure and improved operating theatre environments, directly benefiting patient safety and comfort
- The continued embedding of digital solutions as central to our service delivery, including the 'patient wellness questionnaire' which won the Digital Skills Development Network Automation and Efficiency Award
- Celebrated 50 years of our volunteer-led hospital and community radio station Radio Stitch

**This year we also saw the formation of our clinical service units (CSU).**

This forward-looking clinical management structure has seamlessly replaced the former North Tees and Hartlepool care groups and the South Tees collaboratives.

Adopting a leadership approach of director of clinical services, nursing services and operations underpinned by clinical and nursing leads for each specialty, each CSU has hit the ground running, and each can already point to significant successes, including:

**CSU 1: Family Services:**

announced the reintroduction of births at the Rowan Suite at the University Hospital of Hartlepool after low staff numbers led to a temporary suspension of deliveries

**CSU 2: Digestive Health Urology and General Surgical Services:**

created a cross-group complex polyp team of specialists including surgeons, nurses, radiologists and pathologists

**CSU 3: Trauma & Orthopaedics, Reconstructive & Plastic Surgery, ENT & OMFS, Dermatology & Ophthalmology Services:**

A patient's life was changed after receiving the first transcutaneous bone conduction implant at The James Cook University Hospital which allows her to hear

**CSU 4: Theatres, Anaesthetics & Critical Care Services:**

The Friarage Hospital opened its new £35.5million surgical centre

**CSU 5: Cardiovascular Services:**

The James Cook University Hospital selected as a minimal invasive cardiovascular centre

**CSU 6: Cancer Institute:**

Patients at The James Cook University Hospital are among the first to trial an experimental injection for advanced prostate cancer that no longer responds to hormone therapy

**CSU 7: Clinical Support Services:**

The opening of a new diagnostic facility at Redcar Primary Hospital offering patients rapid tests to aid faster diagnosis

**CSU 8: General & Emergency Medical Services:**

University Hospital of North named as a top performing hospital emergency unit

**CSU 9: Neuroscience Services:**

A world first as clinicians makes spinal cord stimulation history, delivering low levels of electricity directly into the spinal cord to disrupt pain signals before they reach the brain

**CSU 10: Community & Neighbourhood Health Services:**

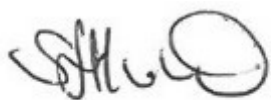
Celebrated 20 years of integrated occupational therapy services with local authority partners

The achievements of 2025–26 demonstrate what is possible when clinical expertise, strategic vision and community collaboration come together under one shared purpose.

This annual report is a testament to our vision and values in action.

We would like to take this opportunity to thank each one of our colleagues who have worked so hard to bring our ambitions to life. They are the lifeblood of our group, and their commitment and hard work continue to inspire us all..

Signed:



**Stacey Hunter**

Group Chief Executive and Accounting Officer

Signed:



**Professor Derek Bell OBE**

Group Chair

## Introduction to South Tees Hospitals

South Tees Hospitals NHS Foundation Trust delivers acute and community healthcare services across Middlesbrough, Redcar, East Cleveland, Hambleton and Richmondshire. The trust operates The James Cook University Hospital in Middlesbrough, Friarage Hospital in Northallerton and provides community wards at Redcar Primary Care Hospital, East Cleveland Primary Care Hospital and Friary Community Hospital.

We provide world class care to around 1.5 million patients across our region and beyond. We are proud to hold an overall 'Good' rating from the Care Quality Commission (CQC), reflecting the high standard of care we provide to our patients and service users.

Our dedicated teams have fostered a culture where safety, quality and continuous improvement are at the forefront. We are committed to innovation and excellence, supported by leading edge clinical research, education, training and development.

The James Cook University Hospital offers an extensive range of specialties on a single site and receives around half of all major trauma cases from across the North East and Cumbria.

Partnership work remains central to our activities. Be it working alongside patient groups, public health teams or providing training opportunities for the next generation of clinical and non-clinical colleagues, we are proud to be an active partner to deliver results for community and staff.

A productive working relationship with Middlesbrough Council has seen us ease pressure on the staff parking facilities at the James Cook University Hospital by creating a Park Active scheme which allowing colleagues to access reduced rate parking at the nearby Sport Village and enjoy the use of its fitness and leisure facilities.

Friarage Hospital is one of the region's fastest-growing healthcare sites, serving communities across the Dales, North Yorkshire and Teesside. This year saw the opening of our £35.5 million surgical centre, which will double the hospital's capacity for planned operations annually.

Together with our three primary care hospital wards and community NHS teams, we provide care closer to home for people from Hawes to East Cleveland. Our Hospital at Home programme is enabling more patients—particularly those who are frailer—to receive hospital level care in the comfort of their own homes.

Through our partnership with North Tees and Hartlepool NHS Foundation Trust, our hospital group - University Hospitals Tees - supports shared ambitions for our patients, service users and staff.

## Our Values

Our values are that we will respect, support and collaborate to provide the best patient care.

When we are working together, we need to be able to live our values, and so we have developed a 'values into action' framework. We will use this framework to better work with each other and for our patients.

We believe every interaction strengthens our culture.

### Respect:

We listen to others without judgement and treat others as they wish to be treated.

#### **Respect enables:**

- Promotion of equity, diversity and inclusion
- Compassionate, inclusive patient care
- Deliver the best possible care

#### **Respect in practice:**

- Treat others as we would wish to be treated
- Holding myself and others to account to demonstrate professionalism and integrity
- Listen and communicate to others
- Be open to feedback
- Be accountable for personal development and growth

### Support:

We always do the best for people by being kind and compassionate.

#### **Support enables:**

- Patient centred care
- Meeting individual needs with dignity and respect
- Ensuring all staff and patients feel included and connected

#### **Support in practice:**

- Work as a team
- Listen with compassion and empathy
- Speak and act with kindness
- Offer and ask for help
- Work through challenges together

## Collaborate:

We always provide the best patient care by working together as a team.

### **Collaboration enables:**

- Sharing knowledge and skills
- Clear and honest communications, appreciating all contributions
- Valuing each member of my team and my patients
- Work together towards shared goals, across services and organisations

### **Collaboration in practice:**

- Seek and respect other's views (even if we don't agree)
- Take ownership and do what we say we are going to do
- Show initiative and leadership
- Build trusting relationships

## Going concern

South Tees Hospitals NHS Foundation Trust entered into a Private Finance Initiative (PFI) scheme in 1999 to enable the re-location of its Middlesbrough services onto a single site - creating The James Cook University Hospital in its current location. The PFI was part of a first tranche of NHS schemes.

The revenue costs of the James Cook PFI were £55 million in 2025/26. In addition, 'life-cycle' costs (mandatory annual maintenance charges built into the PFI scheme) are required to be paid each year from the trust's capital budget.

The total annual payments (revenue and capital) by the trust for the James Cook PFI scheme are now £77 million per year. The PFI scheme is now adding approximately £25 million each year to the trust's expenditure compared to a hospital provided through public capital / borrowing. This additional cost is the largest single contributor to the trust's structural deficit.

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

## Performance analysis

### How the Trust measures performance

Performance against the A&E four-hour standard exceeded the agreed trajectory by 1.94% achieving 80.04% against the plan for March 2026 of 78.1%. The embedding of the co-located Urgent Treatment Centre has supported over 62,000 patients in an additional physical space to support pressures on the Type 1 Emergency Department at the James Cook site, expanding the footprint for Type 1 and Type 3 emergency capacity. During 2025/26 the Emergency Department waiting area was redesigned to accommodate a single front door and reception desk for ease of access for patients to improve their experience. The reception desk workforce includes a nurse practitioner who is able to stream patients to the most appropriate service for their presenting complaint ensuring that the Type 1 Emergency Department capacity is utilised for the most unwell patients. Collaborative work with partners has supported patient pathways in both mental health and care home patients to provide patients with care suited to their individual needs in the most appropriate environment. This included piloting a Care Co-ordination Centre for North and South Tees patients with senior physician input to support patients accessing the most suitable emergency pathway available to best suit their individual needs. Virtual Ward capacity has supported patients to be stepped down from inpatient admission to free up bed capacity and provide care for patients closer to home.

For elective care (referral to treatment standard), there has been continued focus on reducing the number of patients waiting over 65 and 52 weeks for treatment. Whilst the number of patients waiting more than 65 weeks fell short of the national ambition of zero, there were just 12 patients in this category by the end of March 2026. In relation to compliance with the 92% referral to treatment standard, the trust set an ambition to deliver a 5% improvement across the year. As at end March 2026, performance was 65.2% with improvements seen in Q4 supported by national sprint monies, enabling the delivery of additional funded activity. Patients over 52 weeks as at end March represented 1.2% of the overall waiting list, falling short of the national target of 1%. The plan for 2026/27 is to achieve 72% compliance for the referral to treatment standard, with a view to returning to 92% compliance by March 2029 in line with the government's national ambition.

In relation to the cancer standards, improvements have been seen in the proportion of patients that received a diagnosis or ruling out of cancer with 80.1% performance against a plan of 80% by end March 2026. For patients with a diagnosis of cancer the trust planned to deliver 7% improvement in performance in the number of patients being investigated and treated for cancer within the 62-day constitutional standard by March 2026. Significant work has been undertaken over the last year to achieve and exceed this ambition, with robust action plans developed by clinically-led task and finish groups. The 68.3% target was met ahead of plan in Q3 and in March 2026, the trust achieved 70.5% performance, 2% above the year end plan. Significant changes have been made in the prostate pathway to deliver this improvement and for patients requiring surgery to treat their cancer, improved access and treatment times have supported by the acquisition of a third Da Vinci Robot, supported in 2025/26 by funding from the Northern Cancer Alliance. Cancer performance is still being managed with external oversight via NHS England's Tier 2 regime and work is underway to deliver further improvements during the coming year.

## Performance Summary

| Single Oversight Framework Indicators                                                                                                                                                              | Standard / Agreed Trajectory | 2025-26 Performance | 2024-25 Performance | Achieved |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------------|---------------------|----------|
| A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (Mar 26)                                                                                                         | 78.1%                        | 80.0%               | 75.6%               | ✓        |
| Receipt of two week wait / screening referral to date patient is informed of a diagnosis (FDS) or ruling out cancer (Mar 26)                                                                       | 80.0%                        | 80.1%               | 72.5%               | ✓        |
| 31-day wait from decision to treat/earliest clinically appropriate date to treatment of cancer (Mar 26)                                                                                            | 93.1%                        | 81.6%               | 82.8%               | x        |
| 62-day wait from urgent GP referral for urgent suspected cancer or breast symptomatic referral or urgent screening referral or consultant upgrade to first definitive treatment of cancer (Mar 26) | 68.3%                        | 70.5%               | 62.3%               | ✓        |
| Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (Mar 26)                                                                                | 65.0%                        | 65.2%               | 60.3%               | ✓        |
| Referral to Treatment 52 Week Waits as a percentage of overall waiting list (Mar 26)                                                                                                               | 1.0%                         | 1.2%                | 2.7%                | x        |

The trust board receives an Integrated Performance Report, produced monthly, which provides headline metrics aligned to the NHS Oversight Framework, CQC domains and local operational plans with trends and commentary. It includes measures of patient safety, clinical effectiveness, performance and access across emergency care, cancer and planned care (including analysis to highlight potential inequalities), workforce key performance indicators and our financial position.

Underpinning the metrics summarised to the trust board is information made available to the relevant committees, groups and services. The trust suite of interactive online reports has grown again this year, becoming more sophisticated and real-time, further supporting organisational leaders to make informed decisions that support high quality patient care.

## Activity

The trust completes an annual planning cycle using analysis of demand and capacity to determine the expected activity and increasing case mix for each specialty, and to model any changes and developments. Activity and performance, workforce and financial position are triangulated to establish a forecast position.

Activity is monitored compared to plan, so that variances can be acted upon to best meet the needs of patients and service users. Activity plans in 2025/26 have focused on the continuation of NHS recovery by improving A&E waits and ambulance handover times, reducing waiting times in elective care and cancer services as well as increasing the volume of and improving access to diagnostic tests. Within our community services the focus has been to continue improving our virtual ward offer for both step up and step down from hospital, Urgent Community Response and innovative work with our partners to ensure patients only receive hospital care when appropriate. Innovative approaches across these pathways has highlighted the trust as an exemplar across the region and nationally.

The trust activity plans also reflect the need to make best use of available resources across emergency care, acute, community and social care services to provide the right care in the right place.

## Key issues and risks

To maintain a strong system of governance, the Board of Directors regularly review the key issues and risks that may undermine the achievement of the trust's strategic objectives. The matters outlined below are those that the Board of Directors considers to be of particular significance to the trust in relation to performance.

Risks arising from non-compliance with A&E standard: STHFT ended the year 25/26 compliant with the agreed plan for the A&E standard. However this remains open as a strategic risk given the challenge of further improvement next year and increasing demand. Investment in estates and ongoing development of pathways for clinically appropriate alternatives to A&E will mitigate the risk.

Risks arising from non-compliance with the referral to treatment standard: STHFT ended the year 25/26 compliant with the RTT standard (national recovery plan). This was facilitated by non-recurrent additional activity, as well as the opening of the Friarage surgical centre. However this remains open as a strategic risk given the challenge of a further 7% improvement expected next year on a background of increasing demand and financial constraints. Development of pathways for appropriate alternatives to outpatients, and a focus on productivity and efficiency will mitigate the risk in 26/27.

Risks arising from non-compliance with the diagnostic 6-week standard: STHFT ended the year 25/26 compliant with the agreed plan for the diagnostic standard. However this remains open as a strategic risk with a challenging improvement trajectory. Key risks remain around workforce availability in small, highly specialist diagnostic services. Development of succession plans, innovative workforce models, and capital investment to replace equipment at end of life will continue as core mitigations to support the delivery and recovery trajectories.

Risks arising from non-compliance with the cancer waiting time standards: STHFT ended the year 25/26 non-compliant with the 31-day standard but compliant with the 28-day and 62-day standards. This was facilitated by non-recurrent additional activity, as well as focused improvement work with specific care pathways. However this remains open as a strategic risk given the challenge of a further improvement working towards the national target of 80% compliance next year on a background of increasing demand. Changes to patient flows generating demand have been a particular issue for both trusts to manage in year. Planning for sustainable capacity to meet demand will mitigate the risk in 26/27.

## **Taskforce on Climate related Financial Disclosures (TCFD)**

### **Green Plan Summary**

In response to national NHS guidance, organisations were required to refresh their Green Plans in 2025. The Trust's Green Plan 2025–2028, approved in July 2025, outlines progress to date and sets out key priorities for the next three years. The plan is aligned with the Delivering a Net Zero NHS Strategy, alongside supporting national frameworks including the Estates Net Zero Delivery Plan, Net Zero Travel and Transport Strategy, and the Net Zero Supplier Roadmap, ensuring a coordinated approach to achieving net zero objectives.

### **Green Plan Governance**

Delivery of the Trust's Green Plan is supported through a clear governance and accountability structure, with executive leadership at Board level for net zero and sustainability to ensure strategic oversight and organisational commitment. Regular reporting is embedded within existing governance frameworks, with progress, risks and performance monitored through formal committee structures, including reporting to the Resources Committee, in line with corporate accountability arrangements.

Progress is further embedded within operational management through routine reporting into the Estates and Facilities Directorate Management Team, ensuring alignment with estates strategy and wider operational delivery. This structured approach reflects national guidance by ensuring clear lines of accountability, defined roles and responsibilities, and integration of sustainability into existing governance systems, supporting effective delivery of net zero objectives across the organisation.

## **Key areas of progress include:**

### **Workforce and Leadership**

Progress has been driven through strengthened collaboration with neighbouring NHS organisations and public sector partners, supporting delivery of the Trust's Green Plan and enabling the sharing of best practice. Sustainability is now embedded within Trust induction, ensuring all new starters understand key environmental priorities and their role in supporting them. In addition, the Trust now hosts an annual Sustainability Day, showcasing progress against Green Plan objectives and setting future priorities, with contributions from both internal teams and external guest speakers to support knowledge sharing and continuous improvement.

## Net Zero Clinical Transformation

- The Trust is progressing net zero clinical transformation through the development of Hospital at Home and wider out-of-hospital care models, enabling clinically appropriate patients to receive care in their own homes. This approach supports admission avoidance, earlier discharge and improved patient experience, while reducing reliance on the acute estate and associated carbon emissions.
- At James Cook, the Hospital at Home service forms part of a broader system-wide approach across South Tees, with similar models delivered through virtual wards and community-based services, supporting pathway redesign across acute and community care. These initiatives align with national priorities to deliver digitally enabled, preventative and lower-carbon care, embedding sustainability considerations into clinical transformation and service development.

## Digital transformation

- The University Hospitals Tees Digital Programme Team was recognised nationally, winning 'Digital Transformation Organisation of the Year' at the Health Service Journal (HSJ) Digital Awards. This award acknowledges a clinically led transformation from paper-based records to a fully electronic system, delivering significant benefits including enhanced patient safety, improved clinical decision-making, increased time for direct patient care, and notable efficiency and cost improvements

## Medicines

- The Pharmacy team has delivered key sustainability progress, including the full removal of nitrous oxide, with the manifold and terminal outlets decommissioned at James Cook University Hospital in May 2026, achieving a major Green Plan target; work is now required to progress this at the Friarage site. There has also been significant advancement in IV-to-oral medication switching, reducing both carbon impact and resource use. Work to optimise respiratory care and inhaler use remains at an early stage, with further review and reporting required to strengthen this priority area. Efforts to reduce waste continue, with Trust-wide campaigns on medication waste planned for October 2026, alongside initial steps to cut single-use plastics, including the transition to paper pharmacy bags and exploration of wider procurement opportunities. Internally, the department is strengthening sustainability through improved staff awareness and promotion of active travel, supported by a staff survey and initiatives such as the Cycle to work scheme.

## Travel and Transport

- The Trust's successful inclusion in the Modeshift STARS Healthcare programme will support a more structured and evidence-based approach to improving travel and transport. Through access to the STARS platform, training, and accreditation framework, the Trust will be able to better understand staff and patient travel behaviours, identify opportunities to reduce single-occupancy car use, and implement targeted initiatives that promote active travel, public transport, and sustainable commuting. This will help reduce congestion, lower carbon emissions, and improve access to sites, while also supporting staff wellbeing and contributing to wider Green Plan objectives.

- The Park Active scheme, introduced last year, continues to deliver strong benefits for sustainable travel, with 70 staff enrolled in the combined gym membership and parking offer at the sports village, alongside utilisation of 30 residential parking spaces. The scheme has gained national recognition, with the British Parking Association highlighting it as the first model of its kind adopted by an NHS Trust. The Trust's leadership in this area was further demonstrated through an invitation to present at the National Modeshift STARS Summit in London, showcasing progress in sustainable travel, staff engagement, and greener estates. This recognition reflects the Trust's growing reputation for innovation and alignment with national best practice in sustainability.
- Work is ongoing to expand sustainable travel options across the Trust, including exploring funding opportunities to develop active walking routes at James Cook University Hospital in line with the Active Hospitals programme. Collaboration with Northern Rail continues to be positive, with 16 staff participating in a trial scheme, receiving one month of free rail travel in exchange for feedback on their commuting experience. This insight will help shape how rail services can better support staff, patients and visitors, encouraging a shift towards lower-carbon travel and improving site accessibility.
- A staff travel survey is planned for 2026, which will inform the development of a Trust-wide travel strategy, to be delivered by December 2026.

## **Estates and Facilities**

- Salix-funded decarbonisation schemes are being delivered across both the Friarage Hospital and James Cook University Hospital, supporting the Trust's transition to low-carbon energy infrastructure. The programme includes the installation of air and water source heat pumps, conversion to low-temperature heating systems, and wider system optimisation, with additional measures at the Friarage such as solar photovoltaic panels, upgraded air handling systems and enhanced controls.
- These schemes are expected to deliver significant carbon reductions, with an estimated 20% (c.2,269 tonnes CO<sub>2</sub> per annum) at James Cook and 41% at the Friarage, alongside long-term energy efficiency improvements. Works have been carefully managed within live hospital environments, with ongoing monitoring and maintenance arrangements in place to ensure sustained performance.
- This investment represents a major step forward in reducing emissions from the Trust estate while maintaining resilient and effective heating systems to support patient care.
- We are reviewing existing EV charging infrastructure to support the transition to a low-emission fleet and position the Trust to take advantage of future funding opportunities, enabling further progress against Travel and Transport objectives and supporting staff access to greener travel options.
- Biodiversity progress has been advanced through a range of practical initiatives to enhance outdoor spaces and increase their use for wellbeing and recovery. This includes improving access to courtyard areas, introducing seating, planting and low-maintenance green infrastructure such as planters and potential living features, and supporting wildlife through initiatives like bird and bat boxes and NHS Forest tree planting. The Trust has also participated in No Mow May, supporting natural habitats and pollinators, and is working in

partnership with Natural England and Teesside University to explore opportunities for green therapy placements.

- Partnerships with community organisations and social prescribing teams are helping to connect patients and staff with nature-based activities, while proposals such as walking routes and “walking waiting rooms” aim to further embed green space use into care and wellbeing. Ongoing work is also addressing safety, accessibility and infrastructure improvements to maximise the benefit of these environments across Trust sites.
- Significant progress has been made in improving community waste management across South Tees. All community sites now have dry mixed recycling in place, exceeding the original target and supporting improved segregation of waste streams. Clinical waste performance has been maintained in line with national standards, with further opportunities identified to increase recycling rates beyond the current 26%.
- The Trust’s estates management strategy focuses on supporting safe and effective service delivery, improving utilisation of space, addressing backlog maintenance, and ensuring the estate remains financially and operationally sustainable. The Trust does not currently receives indicative alternative use values from its valuer.

In addition, food waste collection has been established at larger community sites, with plans in place to expand this provision more widely. These initiatives demonstrate continued progress in reducing waste, increasing recycling, and supporting the Trust’s wider sustainability objectives.

## **Supply chain and procurement**

- The Trust continues to strengthen circular economy and waste reduction activity through the ongoing Ambu disposable endoscope recycling pilot within ENT Outpatients and the Emergency Department at The James Cook University Hospital. Since the pilot commenced in August 2025, two van collections have taken place, resulting in the recovery of 16 bins containing 407 single use endoscopes. This equates to 67 kg of materials diverted from hazardous waste, including 63 kg of recyclable plastics and 2 kg of recoverable metals, achieving an overall recycling rate of 97%. To date, the pilot has delivered an estimated carbon saving of 209 kg CO<sub>2</sub>e when compared with high temperature incineration. Early engagement from clinical teams has been highly positive, although further collections are required to understand the long-term impact. With the initial six-month pilot concluding at the end of April, an extension to June 2026 has been proposed to allow additional data collection, increase device capture, and strengthen the evaluation of environmental benefits. This work has involved collaboration across key stakeholders reflecting a strong cross departmental commitment to sustainable clinical practice.

## **Food and nutrition**

- Food waste reduction has been a key focus for the Trust following analysis in 2025 which identified significant waste across acute sites, with 68 tonnes recorded at James Cook University Hospital and 29 tonnes at the Friarage, highlighting clear operational, financial and environmental impacts. In response, a comprehensive menu optimisation and waste reduction programme was implemented across James Cook and Redcar Primary Care Hospital, supported by collaboration between catering, dietetics, Speech and Language

Therapy, ward teams, PLACE representatives and Serco. Menu items with low patient uptake were removed, stock management improved and more appropriate choices introduced, balancing reduced waste with maintaining nutritional intake for recovery.

- Early outcomes are highly positive, with trolley waste reduced by 914 kg and plate waste by 1,587 kg in the first two months following implementation, equating to a combined reduction of 2,501 kg of food waste and approximately 1.2 tonnes CO<sub>2</sub>e avoided. Carbon considerations have also been embedded into menu planning, supporting wider sustainability goals without increasing costs. This work has improved both resource efficiency and patient experience, and has been recognised regionally, with the ICB adopting the initiative as a sustainability case study to inform wider system learning. The Trust also presented this collaborative approach at a regional event in 2026, receiving positive feedback and generating further opportunities for cross-system working.
- In parallel, an early-stage project focusing on nutritional supplement and enteral feed bottles is exploring opportunities for reuse, recycling and waste reduction, alongside potential cost savings. Initial engagement with regional partners has informed feasibility discussions, with further stakeholder involvement planned.

## **Adaptation**

- The Trust continues to strengthen its approach to climate adaptation and resilience, in line with national reporting requirements through the Estates Return Information Collection (ERIC). Key measures include monitoring and assessment of environmental risks across the estate, including:
- Overheating incidents triggering formal risk assessments in line with the Trust's Heatwave Plan, ensuring patient and staff safety during extreme temperatures
- Flood incidents requiring risk assessment and response measures, supporting ongoing estate resilience planning
- These metrics support a proactive approach to managing climate-related risks, ensuring that the Trust's estate remains safe, resilient and capable of delivering high-quality care under changing environmental conditions.

## **Energy and Carbon Performance**

The Trust has made strong progress in reducing energy consumption and carbon emissions, supported by targeted investment in estate infrastructure, including the energy centre optimisation works at James Cook University Hospital (JCUH). Since completion in July, JCUH has recorded a 2% reduction in electricity consumption and a 5% reduction in gas usage, delivering significant financial savings of approximately £581k and £276k respectively. These improvements place the Trust on track to achieve its lowest annual electricity consumption since 2020/21, with an estimated £120k saving against forecasted costs year-to-date and over £500k savings compared to the previous year.

At the Friarage Hospital, energy consumption has increased in-year; however, this has not resulted in a significant cost increase, reflecting reduced unit energy prices.

Overall, the Trust has achieved a 3% reduction in total carbon emissions, decreasing from 21,162 tCO<sub>2</sub>e to 20,473 tCO<sub>2</sub>e. This has been primarily driven by an 11% reduction in electricity emissions, reflecting both reduced consumption at JCUH and a lower national carbon factor, alongside a 2% reduction in gas emissions.

## Carbon data for the past 2 years

| Emission Source | Emissions<br>24/25 | Emissions<br>25/26 | %<br>Change | Comments                                                                   |
|-----------------|--------------------|--------------------|-------------|----------------------------------------------------------------------------|
| Gas             | 12,360             | 12,149             | -2%         |                                                                            |
| Electricity     | 8,299              | 7,348              | -11%        | Reduction in consumption at JCUH and lower carbon factor                   |
| Waste           | 310                | 552                | 78%         | Increase in waste sent for incineration due to segregation non-compliances |
| Oil             | 109                | 332                | 205%        | Increase in oil usage during Energy Centre works                           |
| Water           | 84                 | 93                 | 10%         | Increase in carbon factor                                                  |
| Overall         | 21,162             | 20,473             | -3%         |                                                                            |

## Energy and Gas Consumption

| Energy             | Consumption<br>24/25 | Consumption<br>25/26 | %<br>Change | Comments                                                   |
|--------------------|----------------------|----------------------|-------------|------------------------------------------------------------|
| Electricity - JCUH | 25,546,943           | 24,955,126           | -2%         | £581k reduction in costs                                   |
| Gas -JCUH          | 47,783,977           | 45,490,536           | -5%         | £276k reduction in costs                                   |
| Electricity - FHN  | 4,605,359            | 4,986,305            | 8%          | No major change in costs due to reduction in cost per unit |
| Gas -FHN           | 10,465,963           | 11,548,534           | 10%         | No major change in costs due to reduction in cost per unit |

## Taskforce on Climate-related Financial Disclosures (TCFD)

NHS England continues to implement a phased approach to TCFD-aligned reporting, with full coverage across the four pillars Governance, Strategy, Risk Management, and Metrics and Targets required by 2025/26. South Tees Hospitals NHS Foundation Trust has developed its approach in line with this guidance, with disclosures set out below.

### Governance

Oversight of climate-related matters is provided by a Board-level Net Zero Lead, with progress reported through the Resource Committee. Operational delivery is coordinated through the Waste and Sustainability Manager, supported by sub-groups aligned to Green Plan priorities, with assurance provided via the quarterly Sustainability Group and Estates and Facilities governance structures.

A Severe Weather Framework is in place, including a centralised adverse weather distribution group to ensure escalation of climate-related risks. Senior-led adverse weather group meetings are convened on a precautionary basis, informed by Met Office and UKHSA alerts (e.g. heat health alerts), to review response arrangements, assess forecast impacts and provide assurance that appropriate contingency measures are in place.

### Strategy

The Trust's Green Plan 2025–2028, approved in July 2025, sets out a structured programme of work aligned to the Delivering a Net Zero NHS Strategy, Estates Net Zero Delivery Plan, Travel and Transport Strategy and Net Zero Supplier Roadmap.

The Trust is developing its approach to climate adaptation, with work underway to assess risks and resilience across the estate and services, informed by national frameworks. This will support the development of a formal Climate Adaptation Plan in line with NHS guidance.

## **Risk Management**

Climate-related risks are identified, assessed and managed through established Trust risk management processes, including the Board Assurance Framework (BAF) and Emergency Preparedness, Resilience and Response (EPRR) arrangements.

Adverse weather is recognised as a key climate-related risk, defined as any meteorological event with the potential to cause disruption, infrastructure damage, or increased risks to health. To strengthen risk management, the Trust is implementing a coordinated approach through a Severe Weather Framework, supported by a centralised alert system.

All services are able to receive real-time weather and health alerts, including:

- National Severe Weather Warnings, providing risk-based forecasts of events such as heavy rain, snow, wind, fog and ice
- Weather Health Alerts, issued on behalf of the UK Health Security Agency, highlighting risks associated with prolonged temperature extremes
- Met Office Civil Contingencies updates, offering localised intelligence and forward planning insights

The timely receipt of these alerts provides improved situational awareness and supports early, risk-based decision-making across the organisation. Responsibility for responding to alerts sits with individual teams, ensuring that appropriate actions are taken, risks are mitigated, and concerns escalated where required.

This structured approach strengthens the Trust's ability to manage climate-related risks, particularly extreme weather events, and supports continuity of both corporate and clinical services.

## **Metrics and Targets**

The Trust measures progress against its sustainability objectives through a combination of Green Plan indicators and national reporting requirements, including the Estates Return Information Collection (ERIC).

### **Key adaptation metrics include:**

- Number of overheating incidents triggering risk assessments in line with the Trust's Heatwave Plan
- Number of flood incidents requiring formal risk assessment and response

# Acting together for population health equity

## Background

|                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <br>Legal requirements | <p>NHS trusts <u>must</u> publish an annual report reflecting the requirements of <a href="#">NHS England's Health Inequalities Statement</a>. This statement was updated in November 2025 with a suggested structure (see infographic below), Key Lines of Enquiry for trusts to consider and a Measurement Framework.</p>                                                                                                                                                                                                                                                                                          |
| <br>New Structure      | <p>This Health Inequalities report is structured to reflect the new statement, however, a significant proportion of work outlined occurred before release of the new statement. In the coming financial year, requirements of the new statement can be addressed prospectively. Key priorities for 2026/27 include a health inequalities board development session, implementation of our “Improving Population Health and Reducing Health Inequalities Strategy” and effective funding, implementation and evaluation of collaborative health inequalities action, building on our existing work and successes.</p> |

## New Health Inequalities Reporting Structure and summary of key findings

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Understanding health needs:</b>                               | <ul style="list-style-type: none"> <li>• Almost half of our population live in the 20% most deprived communities in England, this affects health through poorer access to housing/community/environment/food/education/work/services</li> <li>• Middlesbrough ranks 2<sup>nd</sup> most deprived local authority in England</li> <li>• In some areas people live around 10 years less than other areas</li> <li>• 1/5 private rented homes locally are “non-decent”</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Understanding healthcare access, experience and outcomes:</b> | <ul style="list-style-type: none"> <li>• Many people face a range of barriers to healthcare including transport/digital/communication</li> <li>• 40% of children live in poverty in Middlesbrough</li> <li>• Some areas of the trust catchment are the lowest 10% nationally for percentage of households with access to vehicles and would require travel to reach key trust sites</li> <li>• Some areas are in the highest 10% nationally where English is not the main language</li> </ul>                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Improving data quality, collection and analysis</b>           | <ul style="list-style-type: none"> <li>• We analyse our data by age, sex, ethnicity, and deprivation, and compare with other data to ensure everyone can access our services</li> <li>• We are acting to better record patient's ethnicity and disability/housing status to ensure there are good outcomes for all our population</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Using information on healthcare inequalities:</b>             | <ul style="list-style-type: none"> <li>• We have developed our “Improving population health and reducing healthcare inequalities strategy” and are collaborating via the Tees Valley Anchor Network, Health and Wellbeing Boards, Place and other partnerships to reduce inequalities</li> <li>• We are addressing DNAs, improving access to outpatient appointments, we are identifying and supporting patients to stop smoking, reduce alcohol intake and increase physical activity levels, addressing health literacy of patient information, supporting digitally excluded, addressing inequalities in frequent attenders to emergency department, personalised care, social prescribing, Making Every Contact Count, intervening early via screening, looking after the workforce, and addressing the needs of veteran and inclusion health work</li> </ul> |
| <b>Publishing information:</b>                                   | <ul style="list-style-type: none"> <li>• The Trust procedure biannual health inequalities implementation reports and population health and healthcare inequalities reports</li> <li>• The monthly board performance reports include inequity analysis, with action led by the multi agency Healthcare Inequalities Oversight Group, reports to the Quality Assurance Committee and update data via our Health Inequalities dashboard.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                  |

# 1. Understanding healthcare needs of our population

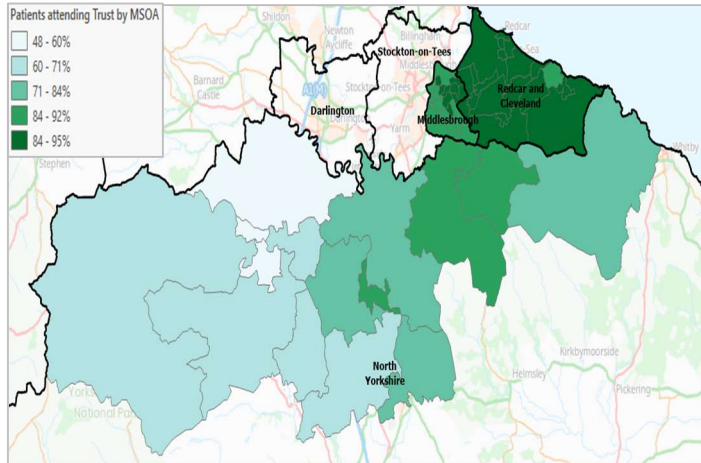
## Key line of enquiry 1.1:

What steps have been taken to understand health needs and inequalities experienced by local 'Core20' and 'PLUS' population groups, for example, ethnic minority communities, people with a learning disability, autistic people, groups that share protected characteristics, inclusion health groups and coastal or rural communities, across a range of clinical domains?

South Tees Hospitals NHS Foundation Trust mainly serves the whole of Middlesbrough and Redcar & Cleveland councils' populations, and parts of North Yorkshire (Hambleton, Richmondshire and Scarborough). The total population of the trust is approximately 420,000. Middlesbrough has been identified as the most deprived local authority nationally and Redcar and Cleveland is seeing increasing rates of deprivation.

The trust's catchment population, based on all admissions, is the fourth most deprived in the North East and North Cumbria (NENC) Integrated Care Board (ICB) region. Our Trust is the 22nd most deprived Acute Trust in England (source: OHID, NHS Acute Trust's catchment populations 2022). 96.2% of our catchment population are from a white ethnicity and 36.3% live in 20% most deprived communities.

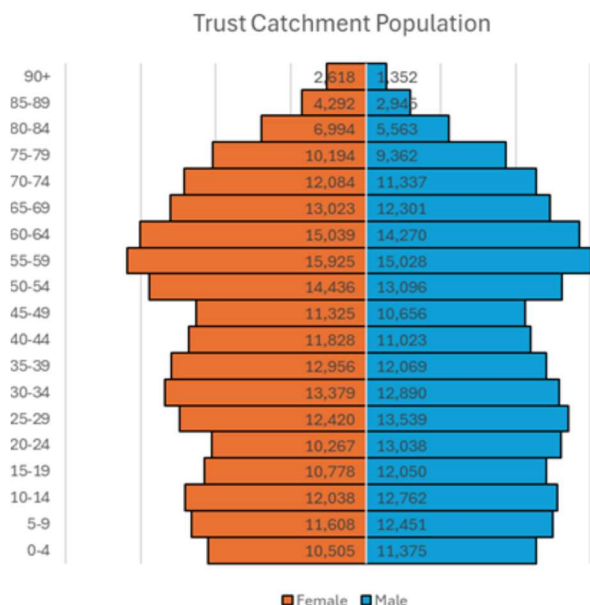
The map below from the [NHS trust catchment populations tool](#) shows, for each area, the proportion of patients admitted to any hospital in 2020, who were admitted to South Tees Foundation Trust.



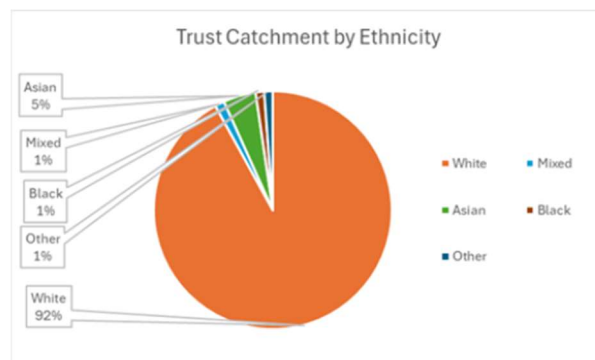
Almost 40% of our population live in the 20% most deprived communities nationally (the Core 20 of the core20plus5 and darkest section of the bar below)



## Our population by age, sex and ethnicity

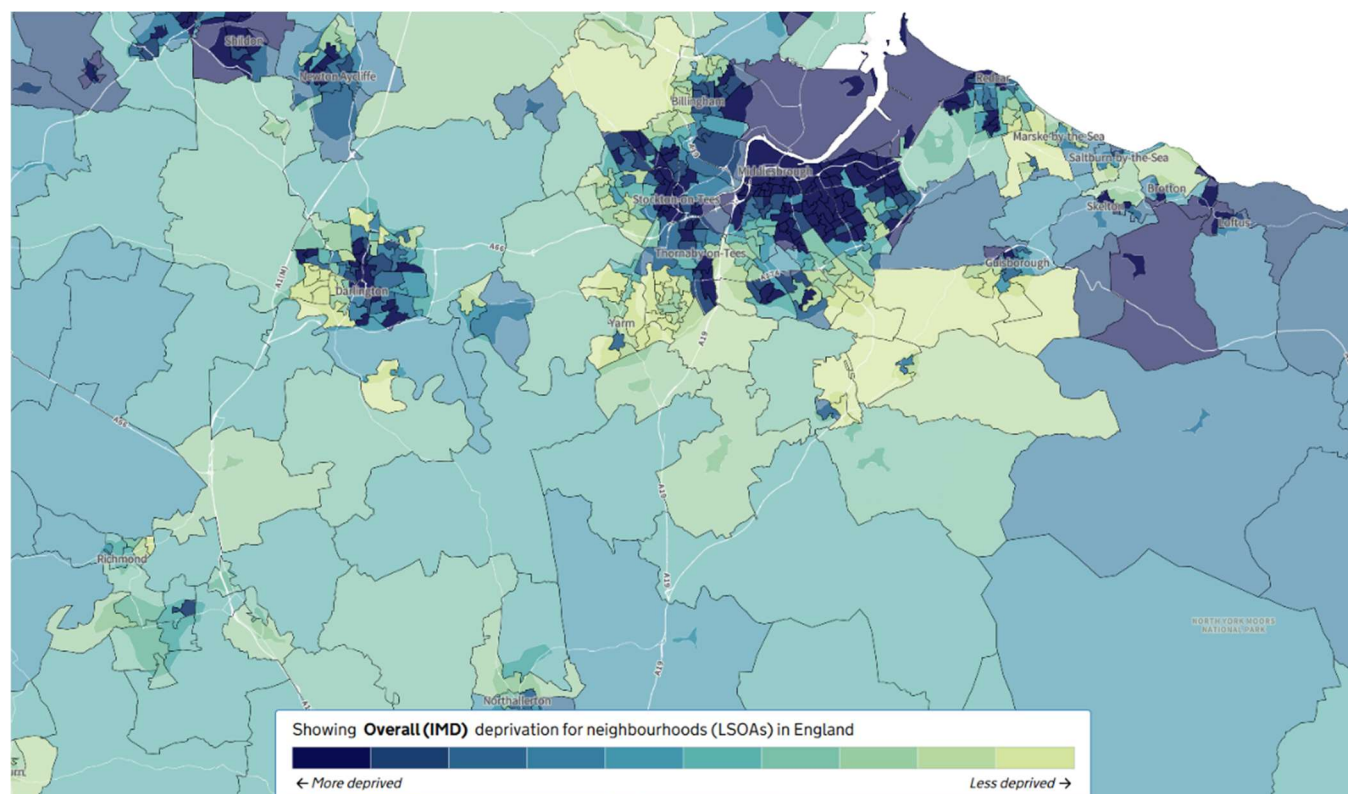


The graph shows the age, sex and ethnicity of people within the trust catchment. The trust's catchment by ethnicity includes white (92%, Asian (5%), Mixed (1%), Black (1%) and other (1%). Middlesbrough is the most ethnically diverse local authority in the Tees Valley



## Our Core20 Population (20% most deprived communities nationally)

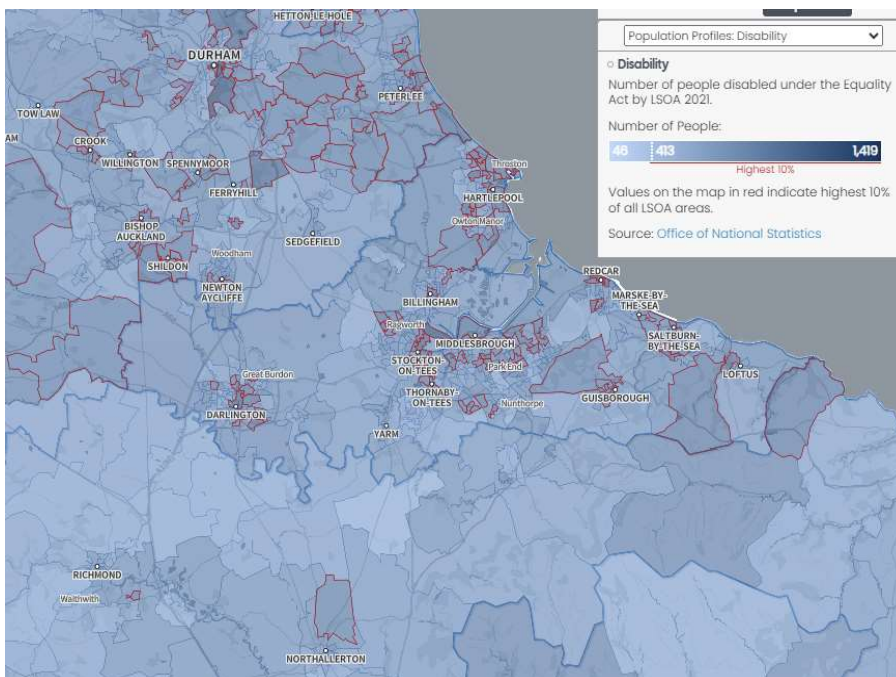
The [Local Deprivation Explorer](#) 2025 shows the level of deprivation at local areas. The map shows that the trust catchment has large areas of deprivation in both densely populated and rural areas.



## PLUS groups

NHS England notes that locally determined PLUS groups, may include but not limited to: ethnic minorities, inclusion health groups, people experiencing digital exclusion, rural and coastal communities, LGBTQ+ communities, people with multiple long-term health conditions, disabled people and other groups that share protected characteristics as defined by the Equality Act 2010. Many PLUS groups are discussed throughout this report. This section focusses on other PLUS groups where some public data is available, or information from interventions within the trust.

Publicly available local-level data is limited on many inclusion health groups. However, there is some data regarding [homelessness](#). The number of households owed a duty under the Homelessness Reduction Act varies across the trust catchment from 26.2 per 1,000 in Middlesbrough to 8.7 per 1,000 in Redcar & Cleveland [NHS England's national framework for NHS action on inclusion health](#) can be used to plan, develop and improve health services to meet the needs of people in inclusion health groups.

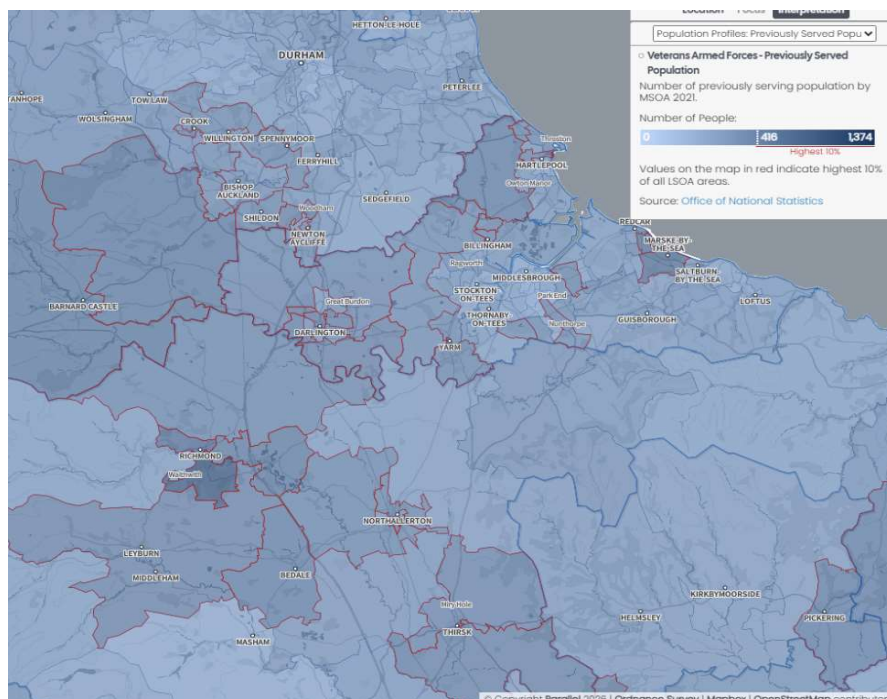


The map shows areas with greater numbers of disabled people (darker blue). Several areas in the trust catchment are in the highest 10% nationally for people recorded as disabled in the 2021 census (areas with a red outline).

Regarding learning disability, across the trust catchment, 0.5-0.9% of people are recorded on GP practice register as having a learning disability. This is compared to 0.6% in England.

Veterans (people who have served in the Armed Forces) often face health inequalities and can be given priority for care in some circumstances. The second map shows areas where greater numbers of people have previously served in the armed forces (darker blue). Several areas in the trust catchment are in the highest 10% nationally for veterans in the 2021 census (areas with a red outline).

Information regarding PLUS or inclusion health groups can also come through trust interventions to reduce health inequalities. For example, the Indigo Team is a specialist midwifery team that work with pregnant women with multiple complex needs. From April 2025 to 13 March 2026, 285 women have been referred to the service for enhanced support. 81 have a specialist midwife for vulnerable women as their named midwife with 149 remaining in the care of their named midwife and have been allocated an Enhanced Maternity Support Worker (EMSW). The remaining referrals were either directed to refer to a more appropriate service or signposting to local support was provided. Most women referred to this service are living in the most deprived areas - 72% in IMD decile 1, 14% in IMD decile 2.



## Women we care for are affected by a range of complex social factors including

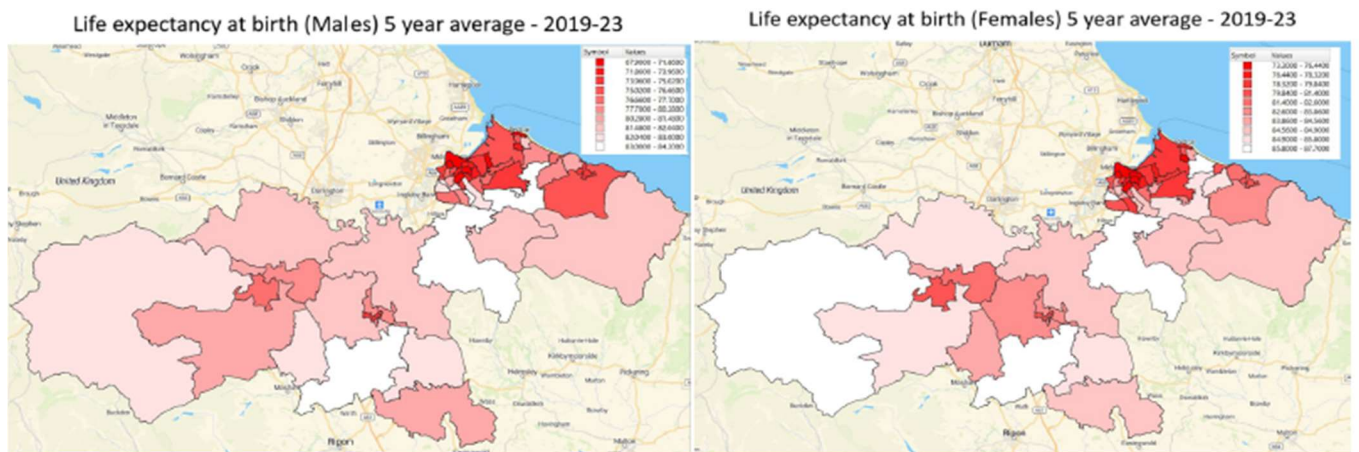
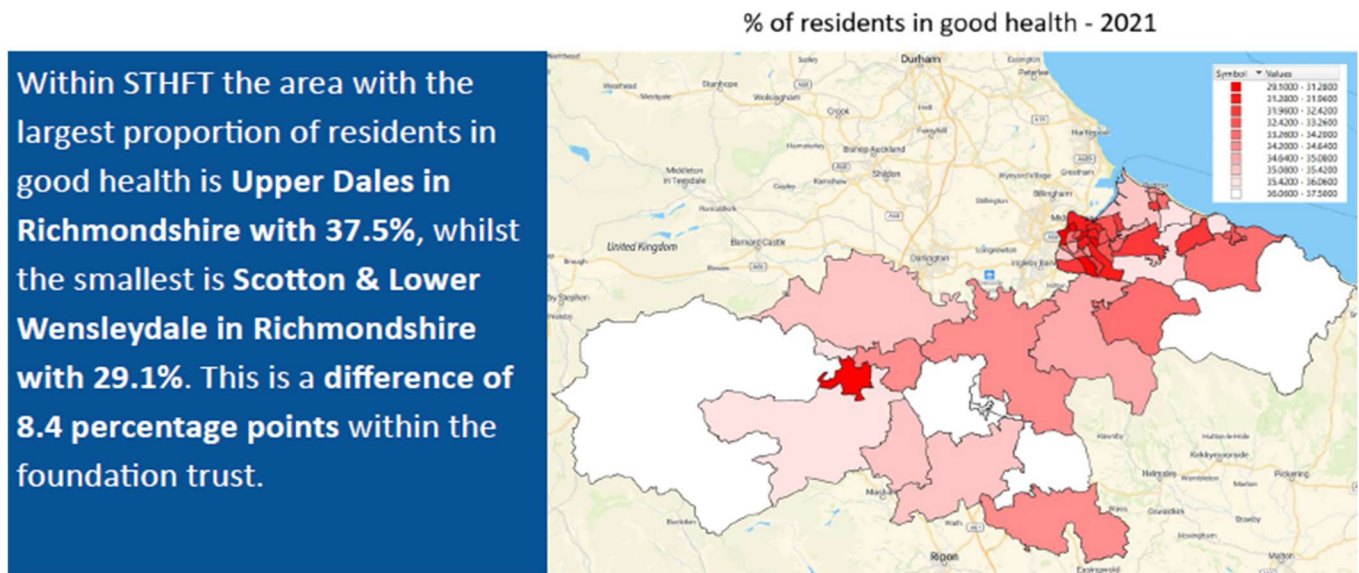
| Social factor                             | Percentage |
|-------------------------------------------|------------|
| Homelessness                              | 11%        |
| Drug and alcohol use                      | 22%        |
| Substitute prescribing                    | 3%         |
| Domestic abuse                            | 24%        |
| Recent arrival as a migrant               | 10%        |
| Asylum Seeker                             | 11%        |
| Difficulty speaking/understanding English | 17%        |
| Age under 20                              | 30%        |
| Mild moderate mental health               | 59%        |
| Significant mental health                 | 13%        |
| Learning disability                       | 6%         |
| ACES                                      | 55%        |
| Previous children removed from care       | 20%        |

## Health and life expectancy

Data analyst support has enabled mapping of self-reported health and inequalities in life expectancy across areas served by South Tees NHS Foundation Trust

There is more than 16 years difference in life expectancy across the trust catchment, with shorter lives and poorer health associated with more deprived areas.

In some more deprived areas of the trust catchment the average male can expect to live around 67.9 years old. This has implications for services aimed at older adults or with age specific criteria.

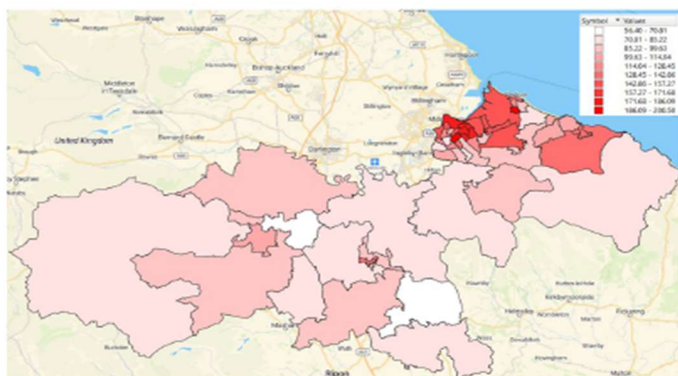


Male life expectancy at birth in STHFT ranges from **67.9 years in Central Middlesbrough**, to **84.2 years in Stokesley**. This is a difference of **16.3 years of life expectancy** within the foundation trust.

Female life expectancy at birth in STHFT ranges from **73.3 years in the Longlands & Beechwood area of Middlesbrough**, to **87.7 years in Aiskew & Leeming in Hambleton**. This is a difference of **14.4 years of life expectancy** within the foundation trust.

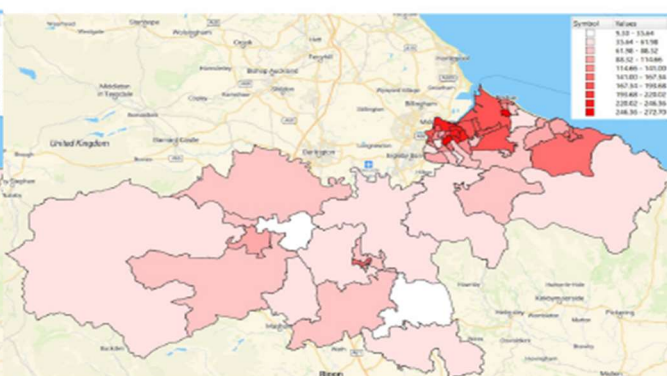
Some common causes of death are cancer, coronary heart disease (CHD), stroke, respiratory (lung) disease. The maps below show areas where deaths from these causes are more common than might be expected (darker red) given the age and sex of people living there. A Standard Mortality Ratio (SMR) above 100 means there are more deaths than would be expected. People in some deprived areas of the trust are significantly more likely to die from these causes.

Under 75 deaths by Cancer (SMR) - 2019-23

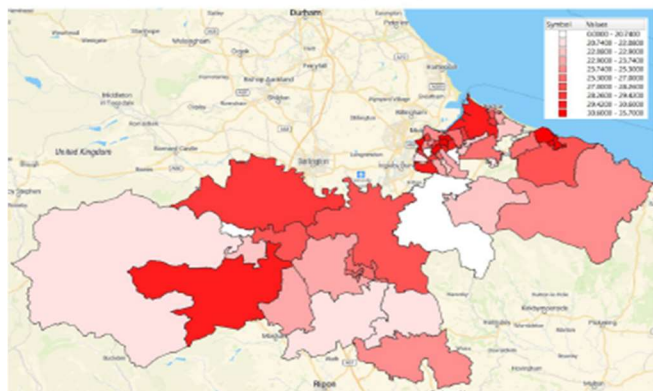


Within STHFT the area with the highest level of death from Cancer is **Longlands & Beechwood** in Middlesbrough, with an **SMR of 200.5**, whilst the smallest level is **Catterick Village & Brompton-on-Swale** in Richmondshire, with an **SMR of 56.4**. The **range of SMR in the trust is 144.1**.

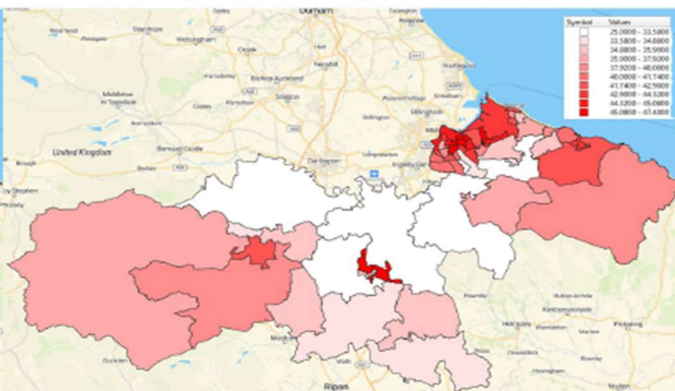
Deaths from CHD (SMR) - 2019-23



Reception prevalence overweight (%) - 2021/22-23/24



Year 6 prevalence overweight (%) - 2021/22-23/24



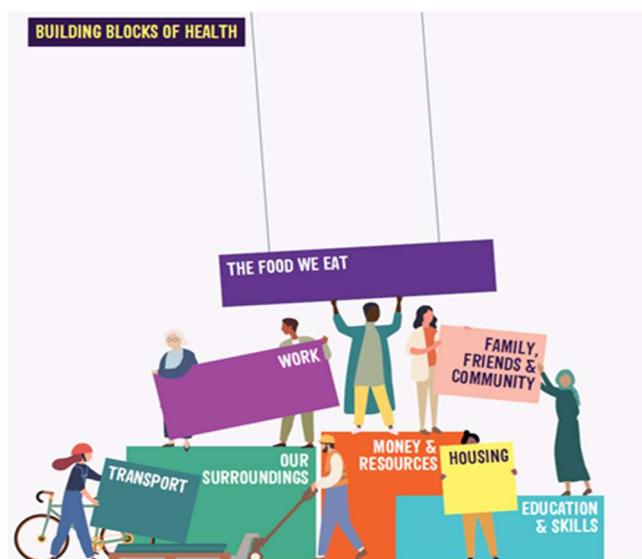
Within STHT the area with the largest prevalence of overweight children at Reception age is **North Ormesby in Middlesbrough**, whilst the smallest is **Richmond**. In North Ormesby **more than 1 in 3 children are overweight**, compared to approximately **1 in 6 in Richmond**.

Within STHT the area with the largest prevalence of overweight children at Year 6 is **Longlands & Beechwood in Middlesbrough**, whilst the smallest is **North Richmondshire**. In Longlands & Beechwood **almost half of the children are overweight**, compared to **1 in 4 in North Richmondshire**.

## Health Needs: Building blocks of good health

Good health depends on having access to a good home, food, transport, money and resources education, work, family and friends and our surroundings. There are significant disparities across the trust's catchment for many of these factors. This has implications for the holistic and personalised care support that will be required by our most disadvantaged patients to achieve equitable outcomes of care for our communities.

The NHS in its role as an anchor institution can influence the social determinants of health through employment, widening participation through apprenticeships, and work experience or buying local through procurement as well as having an impact on the environment through sustainability. These factors also provide important context for understanding healthcare needs and inequalities in access, experience and outcomes. Joint Strategic Needs Assessments (JSNAs) for Middlesbrough and Redcar & Cleveland provide more information on local health profiles in these areas.



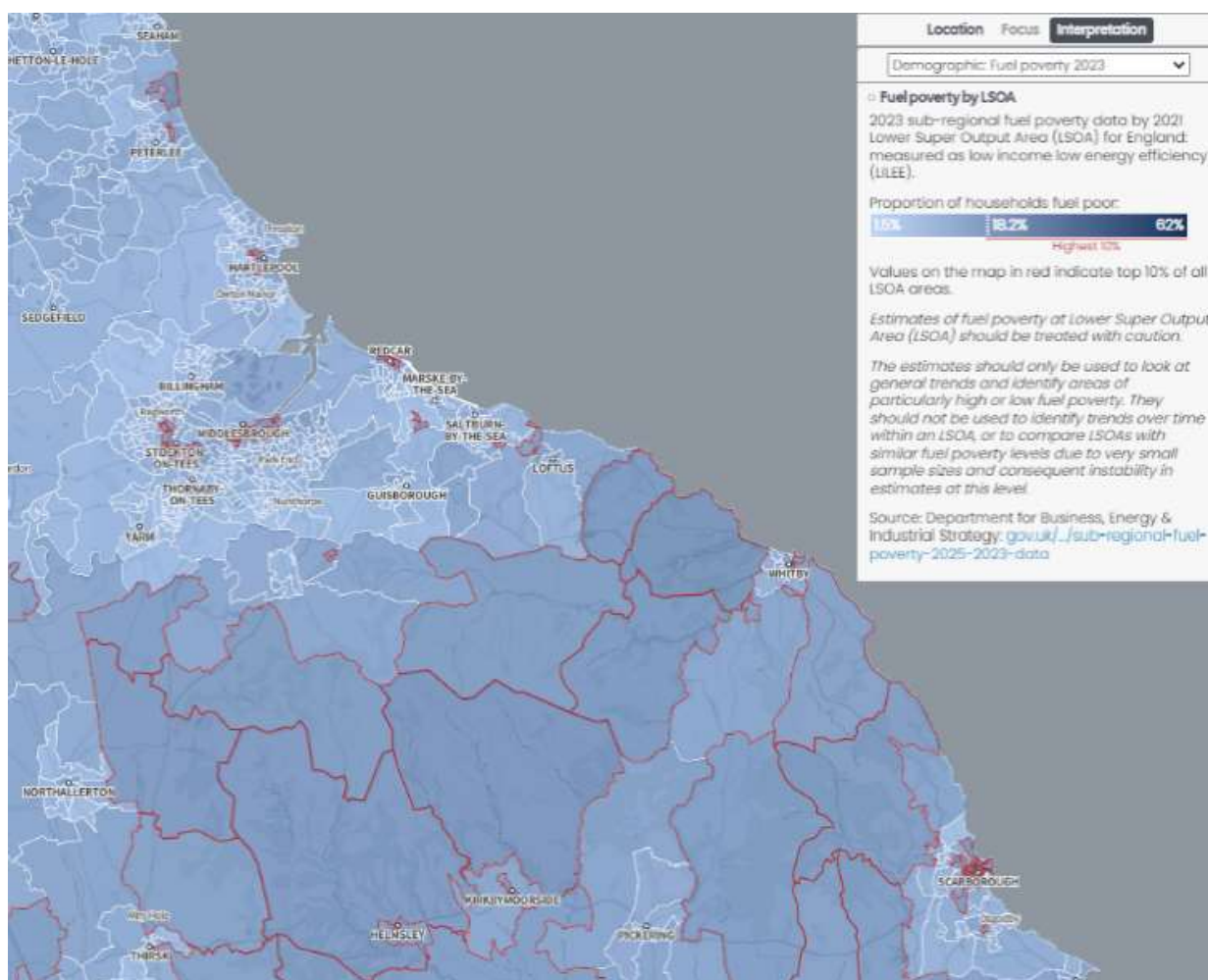
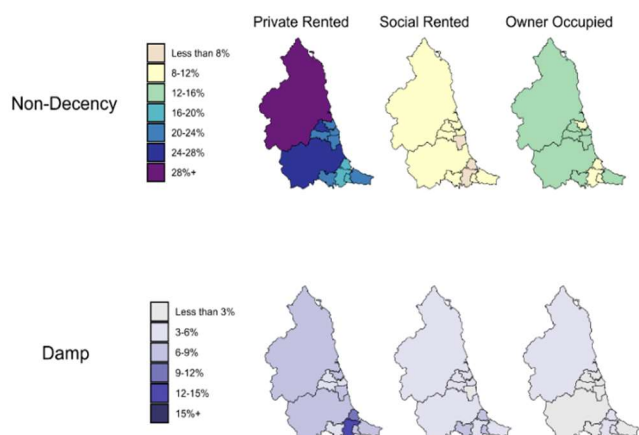
Trust initiatives such as The South Tees Prospect Programme is an example of an NHS organisation role as an anchor providing employment opportunities to local communities. The bespoke employability programme aims to support long term unemployed members of the public into work. The bespoke programme invites learners to work with the trust on a 12-week placement with active employability, development sessions and pastoral care.



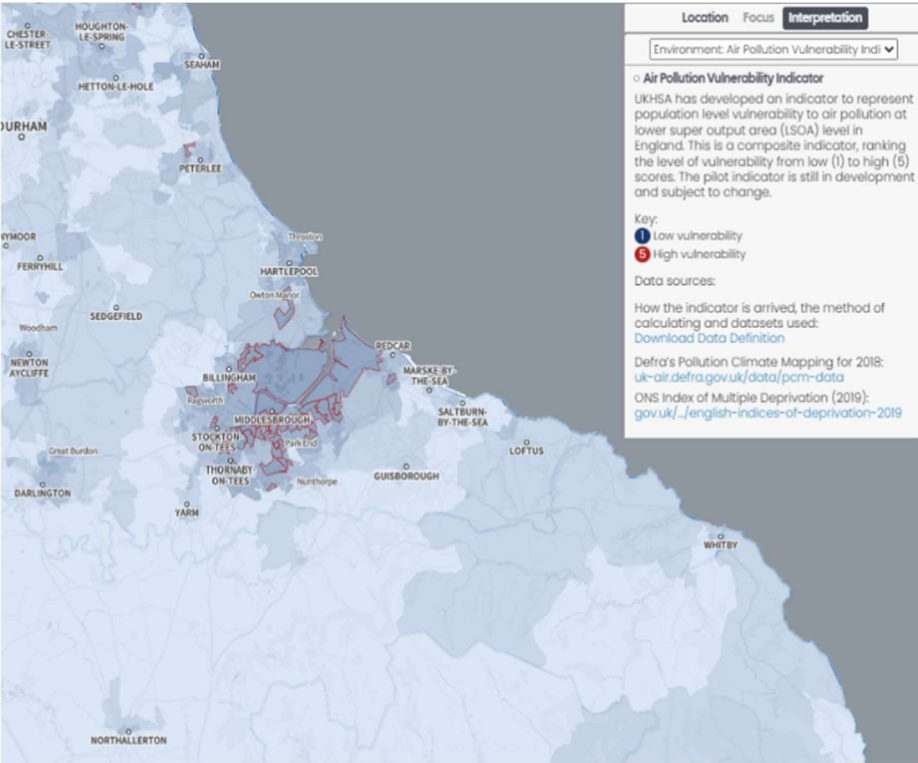
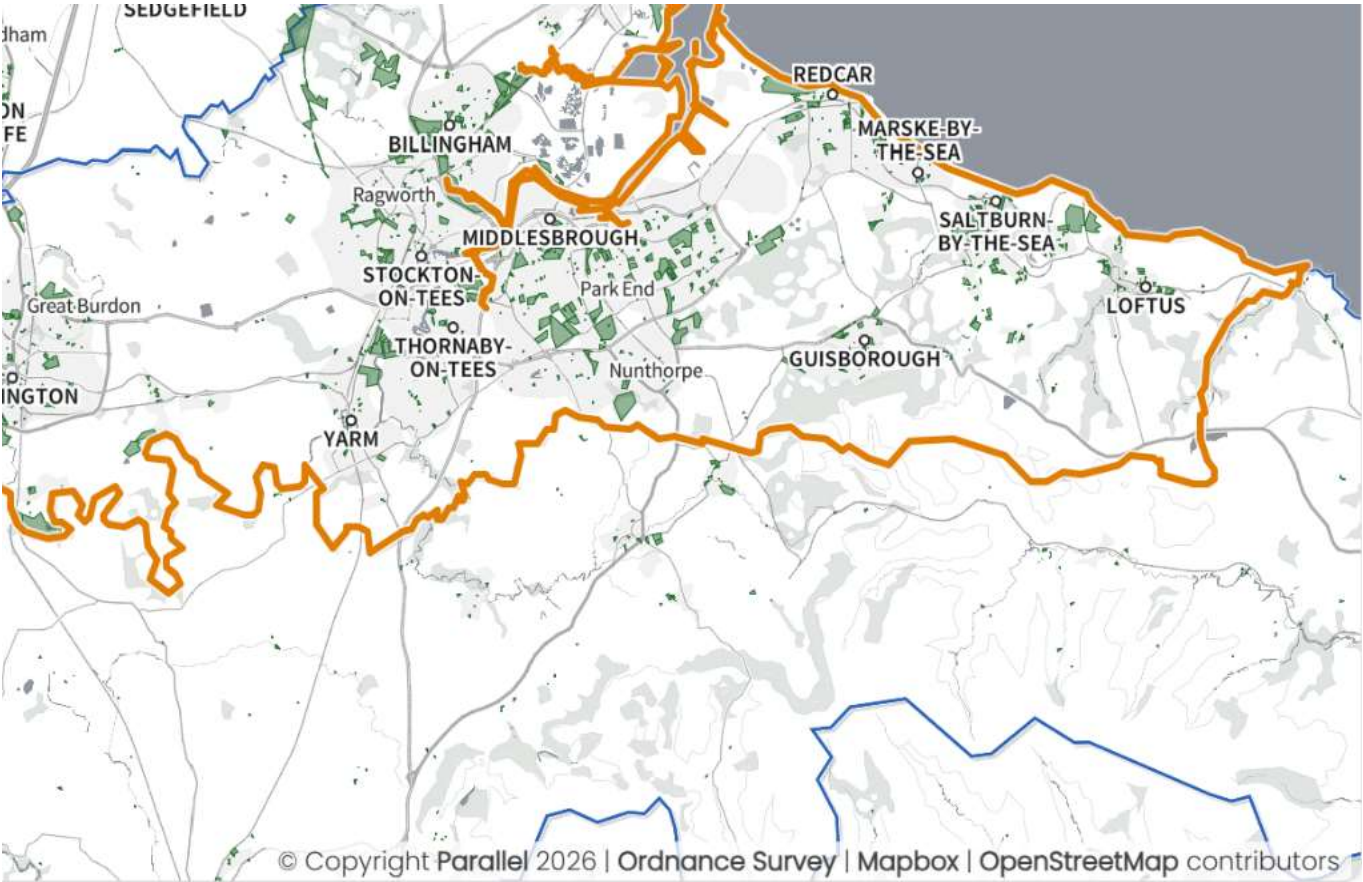
From April 2025 to March 2026, there were 64 people join the programme with 59 (92%) successfully completing the programme and of those 41 (67.8%) gained employment or moved onto further education.

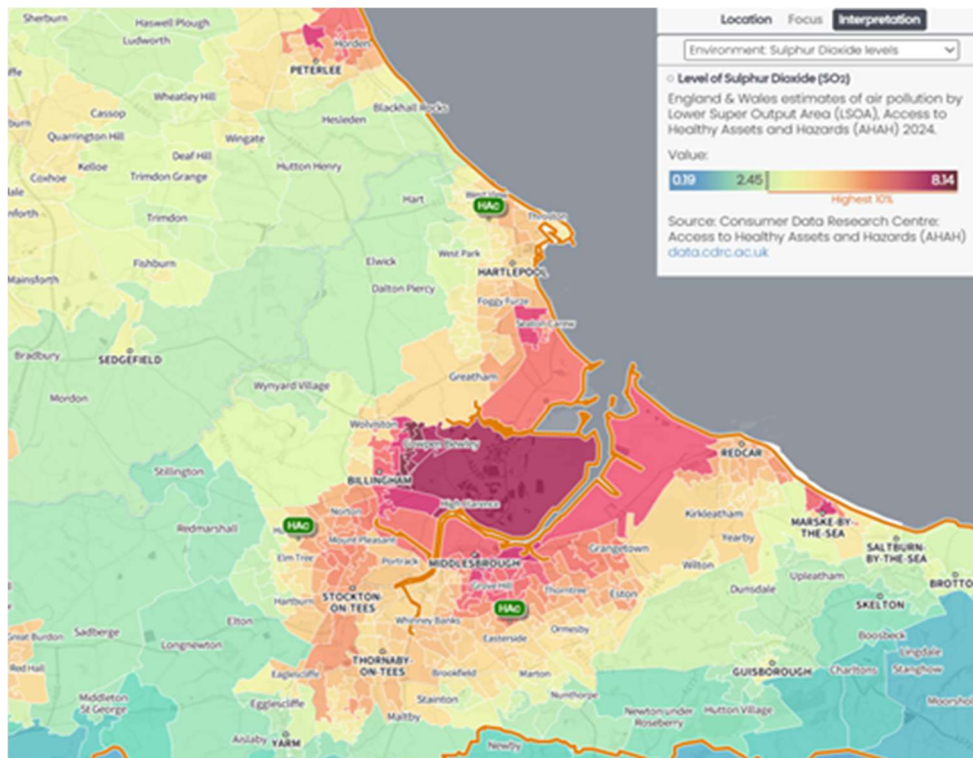
## Homes and living environment

In some areas of the trust catchment, more than 1 in 5 private rented homes are classed as non-decent and around 1 in 10 have damp. Owner occupier homes and social rented homes are slightly less likely to be identified as having these issues within our catchment. In the blue map, areas outlined in red indicate areas in the highest 10% nationally for fuel poverty.



Maps below show open green space and levels of different types of pollution experienced in different areas. several areas in the trust catchment are in the highest 10% nationally for the levels of sulphur dioxide.



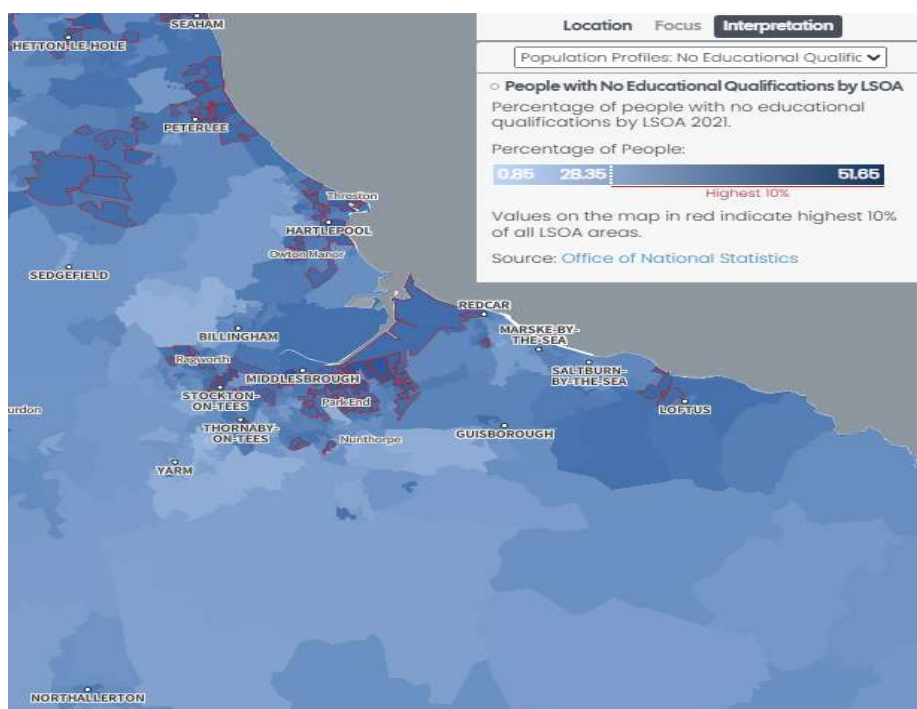


## Education

Education is key for future employment and health but several areas in the trust catchment are in the highest 10% nationally for the percentage of people with no qualifications (red outlined areas in the map).

### School Readiness statistics

suggest less than 6 in 10 of children in our trust catchment are achieving a good level or development at the end of reception, and for children eligible for free school meals this figure falls to around 5 in 10.



Pupil absence in our catchment is higher than national average and attainment in secondary school varies across our catchment. As with national figures attainment tends to be lower for children eligible for Free School Meals and children in care.

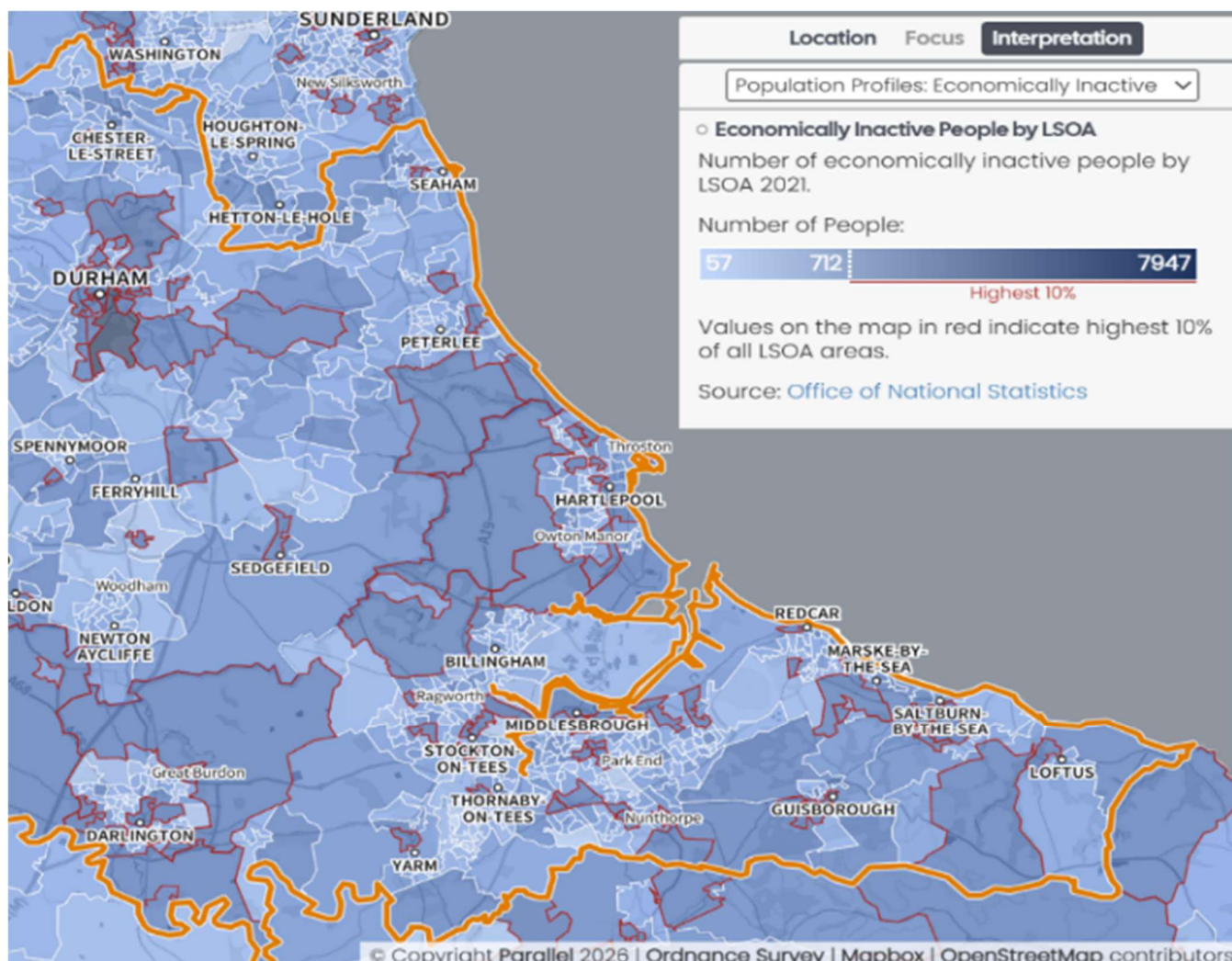
NHS trusts can support education through considering ways to reduce time absent from school to attend appointments, supporting children to avoid missing out on their free school meal and supporting aspirations and understanding of work opportunities in the NHS.

## Economic activity and occupation

Fingertips Data suggests, across the trust catchment, economic inactivity varies from 20% to 29% and the percentage of people in employment varies from 67% to 79%.

The map (right) shows areas of higher economic inactivity (darker blue), recorded in the 2021 Census.

Many areas in the trust are in the highest 10% nationally for economic inactivity (red outline).



## Intersectionality

### Key line of enquiry 1.2:

How is intersectionality between these groups explored, for example, inequalities that may exist for people with a learning disability from different ethnic backgrounds, or children and young people from deprived areas?

NHS England notes that disadvantage can be compounded when different factors, such as ethnicity and deprivation, intersect or occur together. It is important to understand such intersectionality to effectively reduce health inequalities. In South Tees we can explore intersectionality through our health inequalities dashboard which allows us to analyse data by ethnicity, age, learning disability, substance misuse etc.

### Ethnicity and deprivation

Due to small numbers, in depth bespoke ethnicity analysis of internal data is undertaken to ascertain any disparities that might need to be addressed. In Middlesbrough, the wards with the highest rate of ethnic minority population groups are Central with 55% and Newport with 40%, which are also some of the most deprived wards in England.

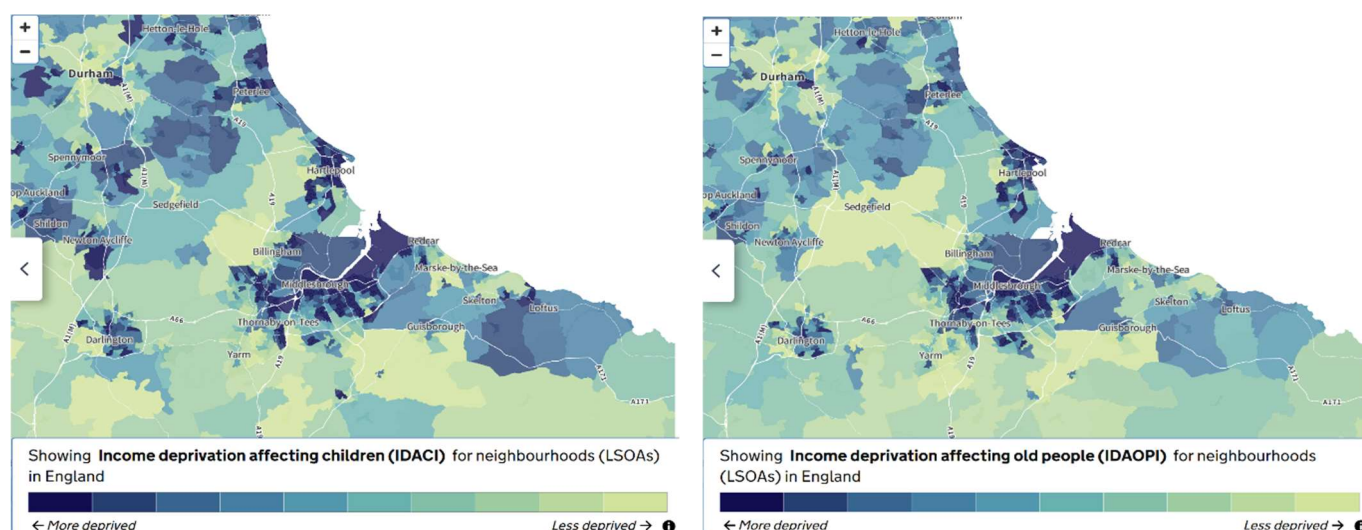
### Age and deprivation and geographical factors

A significant proportion of children in our catchment are from low-income families, and this can affect children's health and families' ability to attend hospital appointments. Analysis of our data highlighted that children from our most deprived backgrounds are twice as likely to not be brought to hospital appointments, this resulted in consultation with over 800 families living in decile 1 that had missed paediatric outpatient appointments in the previous three months to understand reasons for missed appointments and what improvements could be made to improve access for these families.

The table below shows the five reasons for missed appointments and the improvements that were put in place to support attendance.

| Reasons for missed appointments   | Suggested improvements from families                                                                                              |
|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| <b>Appointment timing</b>         | Appointments that fit around school times (after school, early evening or weekends)                                               |
| <b>Forgotten appointment</b>      | Biggest reason declared; patients wanted more reminders increasing in frequency closer to appointment                             |
| <b>Appointment administration</b> | Difficulty trying to rearrange, receiving appointment letter after appointment date                                               |
| <b>Health literacy</b>            | 1 in 5 found letter confusing, not clear what appointments was for, letter in English, 100% felt care navigator would have helped |
| <b>Cost of attendance</b>         | Barrier raised by a few parents. Patients were not aware they could claim back travel costs if eligible.                          |

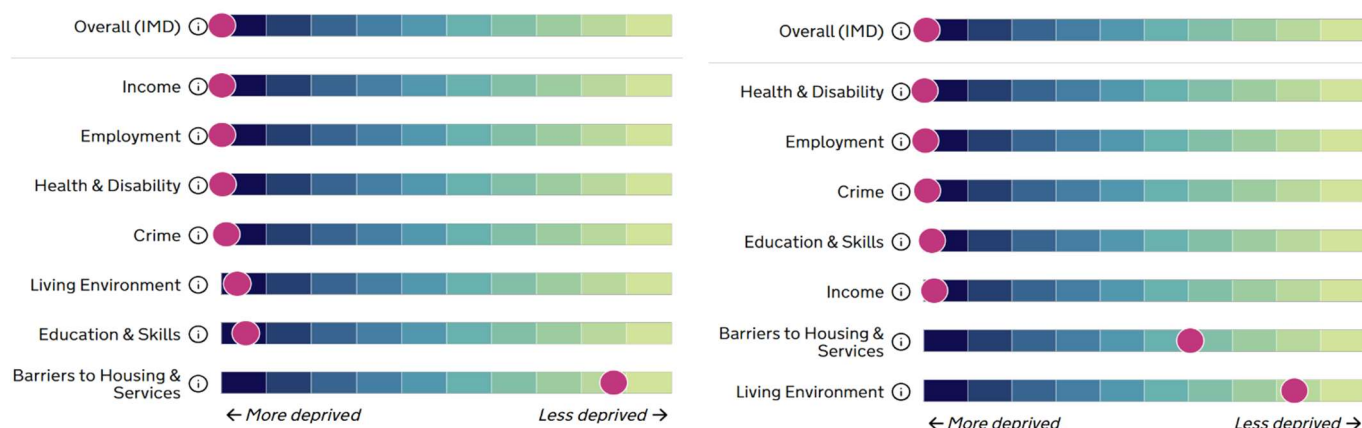
Deprivation can also impact on older people. The Local Deprivation Explorer 2025 maps show income deprivation affecting children, and income deprivation affecting older people, are generally concentrated in similar areas.



However, there are some differences on a very local scale. In some areas income deprivation affecting older people is around the average of all neighbourhoods in England but, for children, the same area is more deprived than 90% of neighbourhoods. In other areas, deprivation affecting older people is higher. Older people living in some areas may also face challenges accessing services due to geographical/other factors.

## Intersectionality of key health determinants

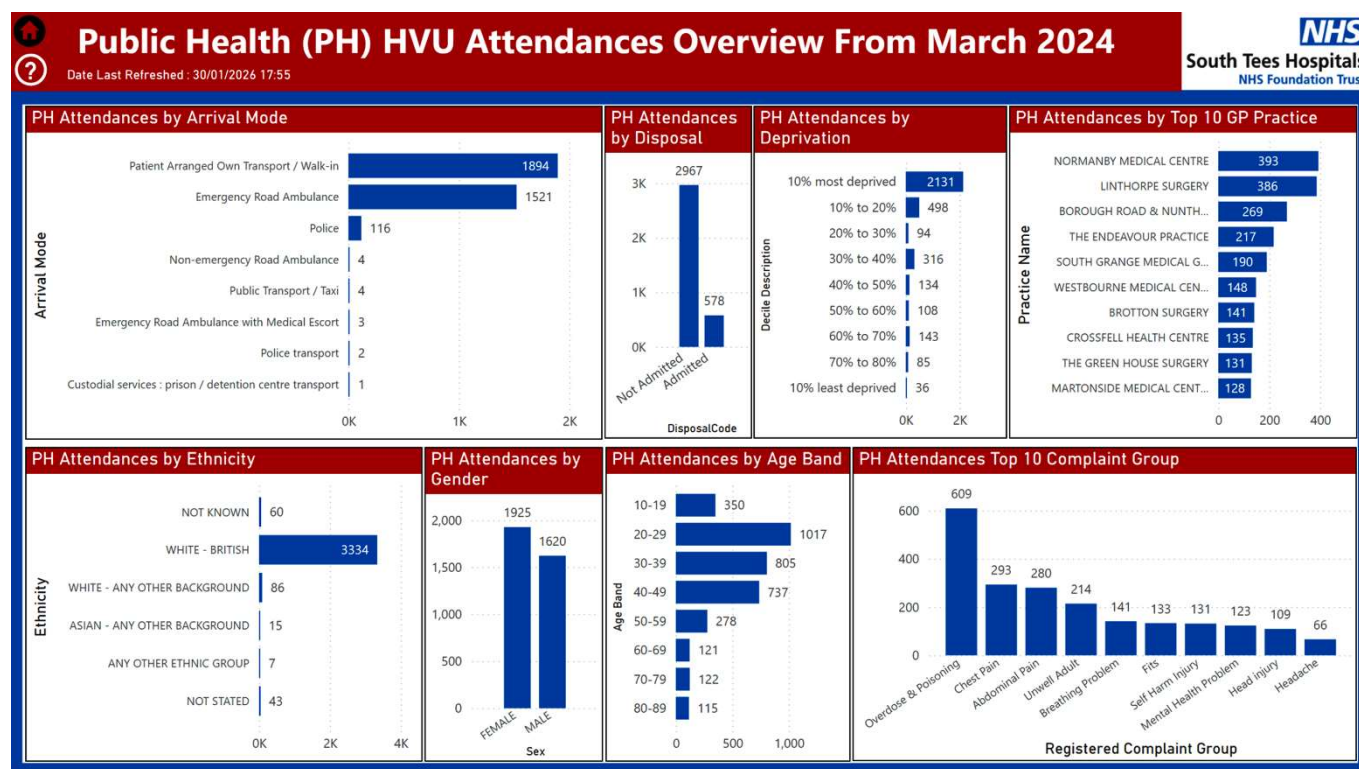
Some areas within the trust catchment are more deprived than 99% of all neighbourhoods in England. Many areas of high deprivation may also have reduced access to good health such as suitable housing, access to healthy food, good education/employment, green space, clean air and safe communities. However, as the example profiles below show, even the most deprived 1% of areas can have significant strengths. An asset-based approach, collaborating with communities and other statutory/voluntary organisations, can provide opportunities to benefit the population within the trust catchment area.



## Intersectionality observed within trust interventions

As well as dashboards and routine data, information regarding intersectionality can also come through trust interventions to reduce health inequalities. Figures from our Emergency Department High volume user's service highlights that most high-volume attendances are from those living in the 10% most deprived communities. Top

presenting complaint is overdose and poisoning. All these patients have complex social factors such as mental ill health, homelessness, drug/alcohol problems and experiencing domestic violence.



## Barriers to healthcare

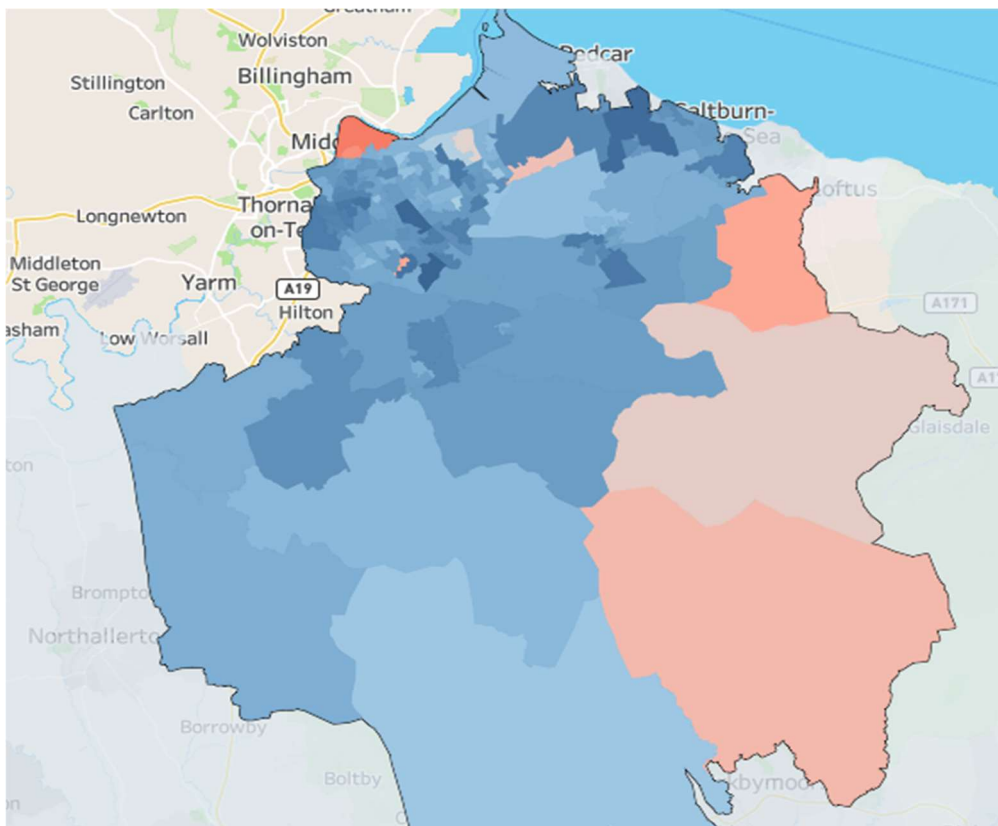
### Key line of enquiry 1.3:

What steps have been taken to understand the prevalence and distribution across your geography of risk factors for healthcare inequalities, for example, digital exclusion, geographical access barriers such as transport, health literacy, language barriers? How has this insight informed targeted planning, commissioning and delivery of services?

### Digital exclusion

Digital inclusion is increasingly important for healthcare and is a key part of the NHS 10-year Plan. The Digital Exclusion Risk Index (DERI) suggests that some of the trust catchments are at higher risk of digital exclusion (red in map below). These areas appear to include rural communities. The reasons for the higher risk reported by DERI in these areas seem to differ. The rural areas score worse in the broadband access component of the DERI and the urban areas score worse for deprivation and demographic (e.g. age or disability) components.

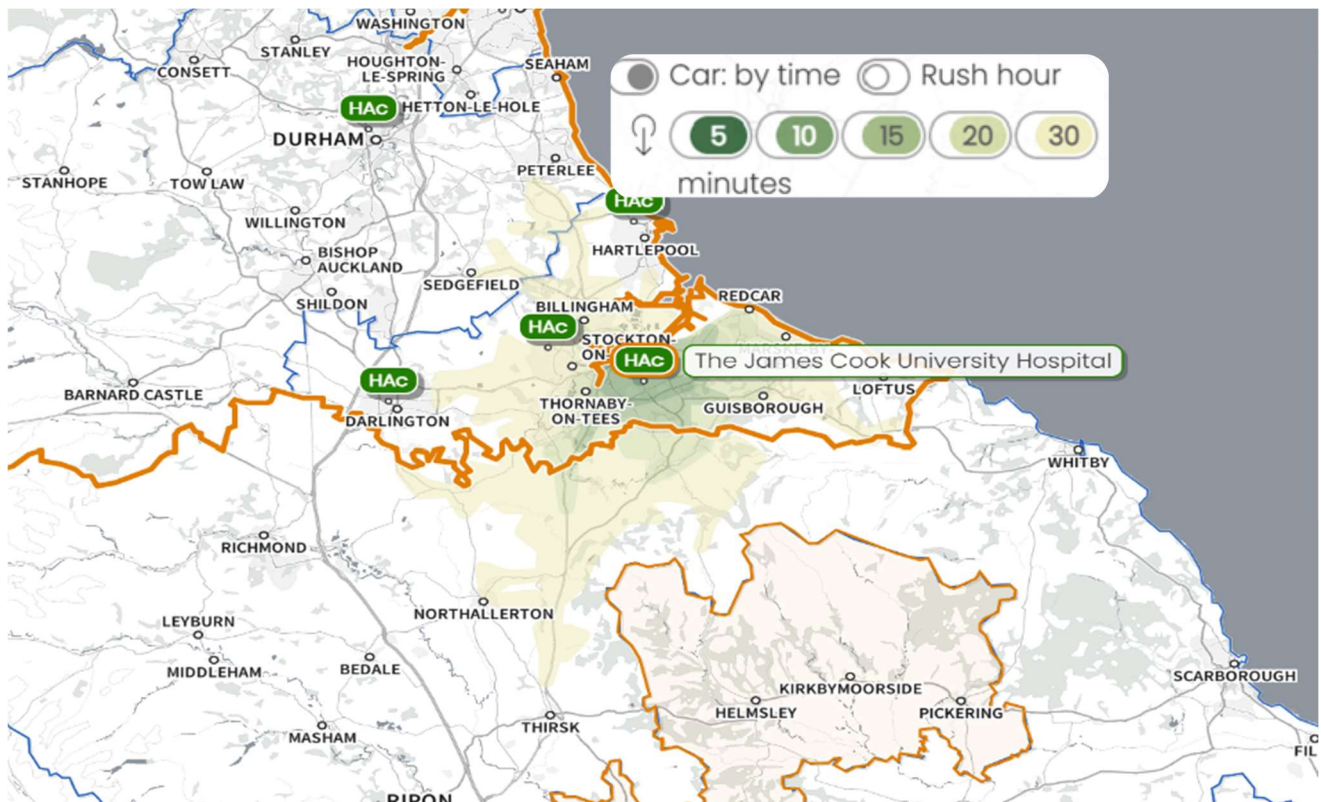
Although some areas of the catchment appear to be at lower risk for digital exclusion (blue in map on right), this may not reflect challenges faced by many people on low-income or from inclusion health groups in these areas. The trust's support in providing digital devices has been vital for many people unable to access such devices. Such initiatives can help reduce barriers to healthcare, and impact on health inequalities more generally.

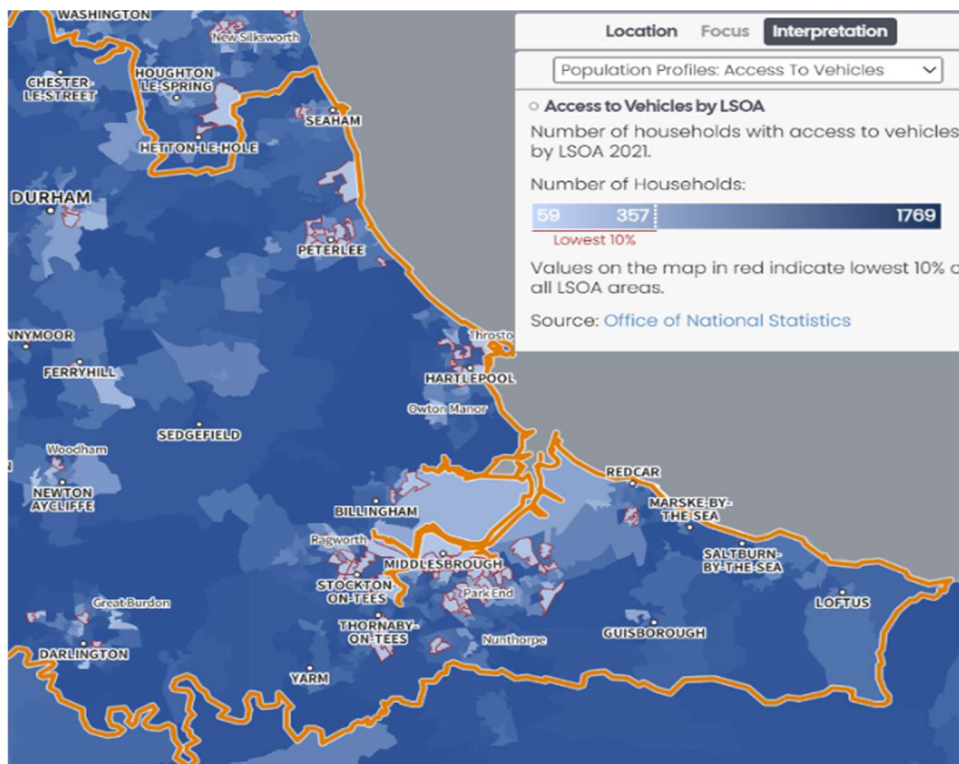
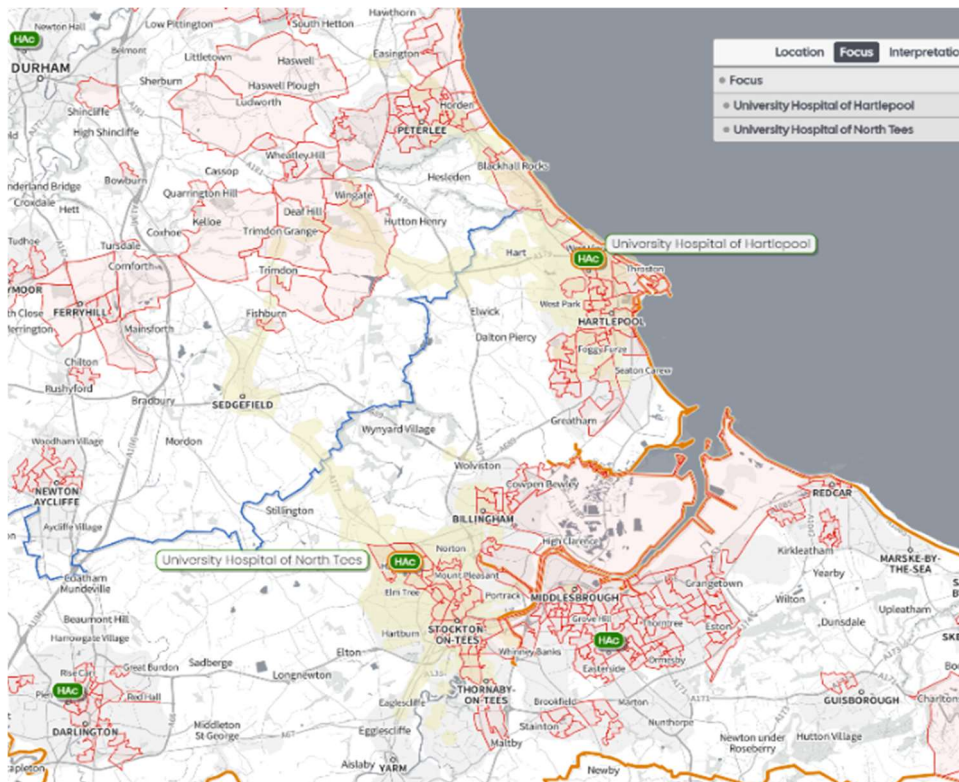


## Geographic or transport barriers to healthcare

[Strata](#) maps can also suggest areas of the trust catchment experiencing transport barriers to healthcare access. The trust operates through [several locations](#) but key sites include the South Tees Hospital Trust and the Friarage. The pale green areas on the map below are estimated to be within 30 minutes of James Cook University Hospital. This suggests a proportion of the trust's catchment (both rural and urban) would require more than 30 minutes to reach these sites using a car and longer with public transport.

Communities where car ownership may be lower (e.g. deprived neighbourhoods or older people) may face particular barriers to attending hospital-based appointments. Strata mapping shows many of the 20% most deprived neighbourhoods lie outside of the estimated 30 min travel time by public transport (map below).





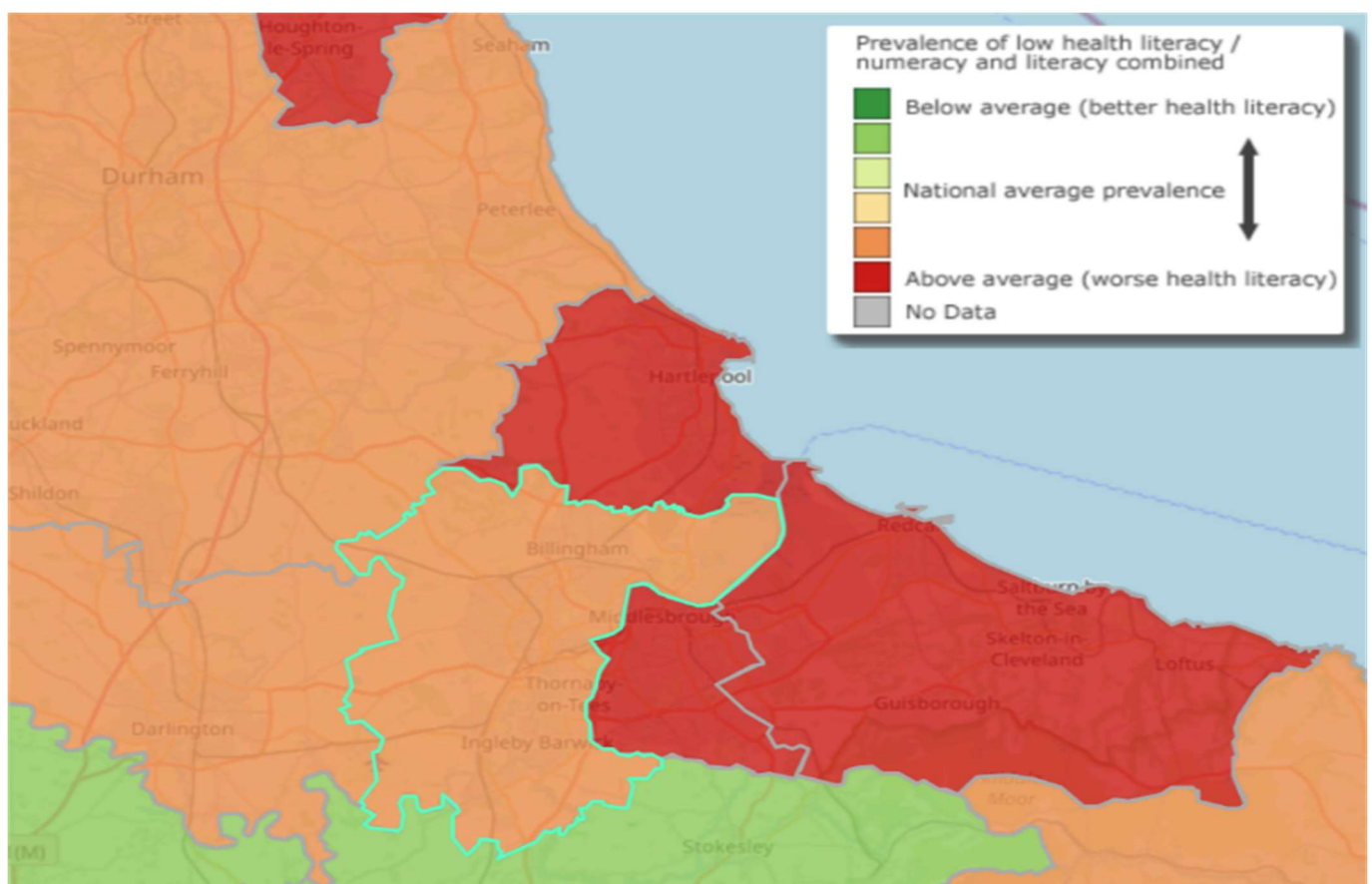
Some areas of the trust catchment are in the lowest 10% nationally for the percentage of households with access to vehicles. Ensuring our services are accessible to people without access to a vehicle and people from deprived communities is vital to reducing health inequalities. Planning services in line with the NHS 10 Year Plan's shift from hospital to community is an opportunity to develop greater equity of access and health.

## Health literacy

Health literacy is about someone being able to access, understand and use information to make choices about health. People with low health literacy are more likely to die younger, have long-term conditions, miss appointments more often, find it hard to take medication correctly, feel worried and angry or struggle to look after their own health effectively.

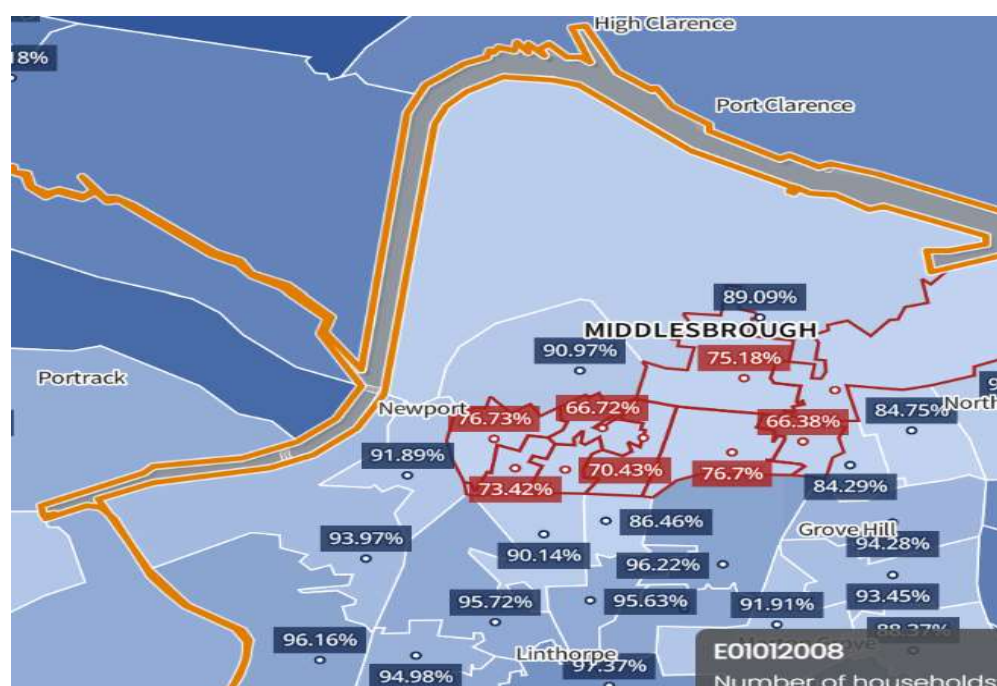
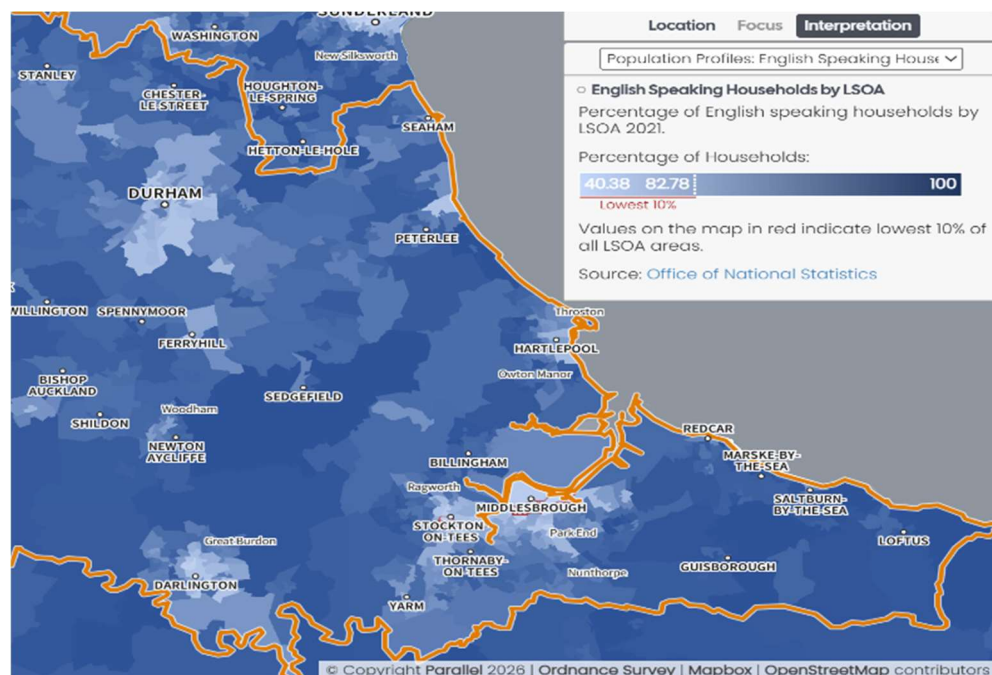
Nationally, around half of adults find it hard to understand health information and that the average reading age of adults is 9-11 years old. In the North East and North Cumbria, 62% of adults struggle to understand health information that contains words and numbers.

Middlesbrough is higher than the regional average at 68%. This is highlighted in the mapping of the trust's catchment population which has worse than average health literacy. It is, therefore, vital to ensure we make health information easy to understand. [Health literacy](#) training can help us all to speak and write in ways that are clear and help our patients make informed choices about their health.



## Language barriers

Across the trust catchment, there is some variation in the percentage of households recorded as having English as the main language in the 2021 Census (maps below). In some areas English was recorded as the main language in 100% of households (darkest blue) and some areas the percentage was 80% (lightest blue). These figures may change over time but the 2021 Census data is one of the most robust data sources available regarding main language. In the second map (below right) the areas in Middlesbrough outlined in red were in the lowest 10% nationally for the percentage of households with English as the main language. This suggests that one in four people in these areas may face some degree of language barrier in accessing trust services, and other services that support wellbeing.



## How understanding of risk factors for healthcare inequalities has informed service planning and delivery

Understanding risk factors for healthcare inequalities has informed service planning and delivery in many ways. For example, the health inequalities navigator service can support patients attending appointments with many of these barriers, such as reimbursement of travel expenses to support eligible patients on low incomes or qualifying benefits access hospital appointments

Bespoke resources have been developed and placed in reception areas to raise awareness of the travel scheme, including information added to patient engagement portal. Further work is underway with service improvement and finance to explore options such as prepaid travel passes and advance payments. The digital device access pathway for supplying digital device and sim/data to eligible patients is established and will be promoted with staff to improve distribution to patients. The staff campaign for device donation is soon to be launched.

To address health literacy related barriers, training is provided for all staff, and we have been reviewing outpatient letters, trust leaflets, hospital signage from a health literacy perspective to embed health literacy throughout the trust. Many of our patient pathways have also been reviewed, making health literacy better throughout a patient's journey. This might be from the point at which a patient is referred to a service through to when they are discharged. We start by mapping out the patient journey. This includes finding out where patients go to access a service, who they speak to, and what information they receive. Changes have been made to written information to make it understandable and at a reading age of 11 years or lower. Going forward a Tees Valley Health Literacy group has been established to address health literacy across the system with a strong focus on health care.



## 2. Understanding healthcare access, experience and outcomes

### Key line of enquiry 2.1:

To what extent have health inequalities across a range of population groups and clinical domains been identified as a driver of trends in performance, productivity and resource utilisation?

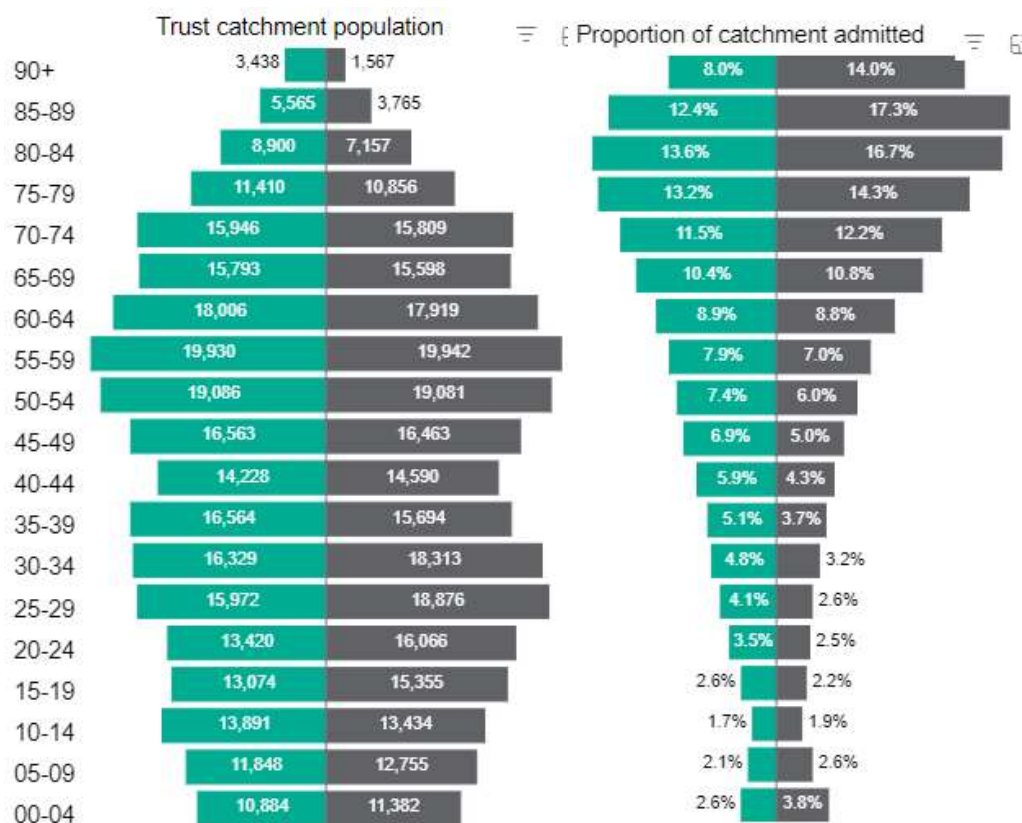
Health inequalities have been identified as a driver of trends in performance, productivity and resource utilisation across a range of population groups (Core 20, inclusion health, age/sex/ethnicity) and clinical domains (e.g. cancer and surgery).

For example, it was noted that people from our Core20 communities were more likely to die in the first five years following a cancer diagnosis. People from Core20 communities were also less likely to attend screening or outpatient appointments and more likely to have procedures cancelled. These issues led to projects to increase uptake of screening, increase clinic attendance and reduce cancellation of procedures (e.g. Waiting Well) for our Core20 population.

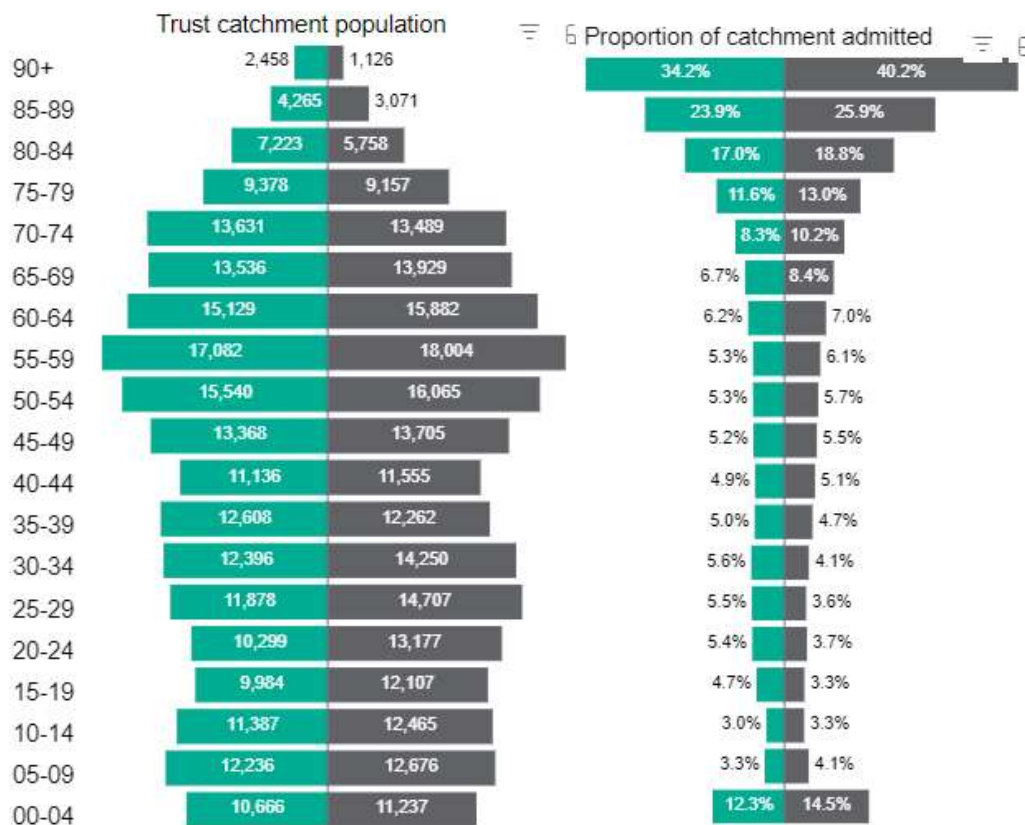
### Admissions by age, sex and ethnicity

Table below shows for elective admissions and emergency admissions for South Tees Hospitals NHS Foundation Trust the age and sex breakdowns of the catchment population and the proportion of catchment population admitted.

#### Elective Admissions



## Emergency Admissions



Source – NHS Acute (hospital) trust catchment populations, OHID

## Routine care data by deprivation, ethnicity, age and sex with triangulation

### Key line of enquiry 2.2:

How is routine performance data – including elective and urgent and emergency care data – analysed and broken down by deprivation, ethnicity, age and sex, to better understand areas of inequality, and how have other triangulated sources of insight supported an understanding of the drivers of these including barriers to access or inequalities in patient experience?

Through our trust Health Inequalities Dashboard that monitors health inequalities in outpatients across all specialities. The dashboard has been examined by indices of deprivation, ethnicity, and sex and plotted on a heatmap for geographical variation. Analysis shows significant differences in does not attend rates (DNA) by deprivation, ethnicity, age group, learning disability and history of substance use. The dashboard enables services to use the health inequality data to shape and design delivery of care, explore greater understanding of patient profiles across specialities analysing data to see who is not accessing services and why and improve pathways and services to increase equity of access for all groups.

This work involves deep dives into clinics including gaining intelligence from clinicians and service managers whilst ensuring equity in patient and public involvement, community engagement to allow understanding of all access issues.

### DNA/WNB rate and numbers



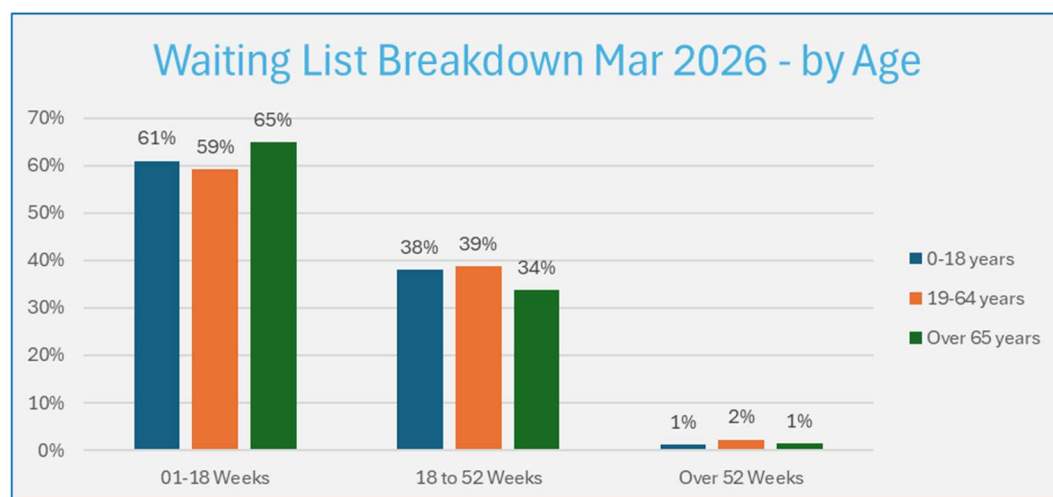
This information is being used by clinical service units and trust board to inform service improvement and reductions in healthcare inequalities, addressing inequalities in access, experience and outcomes.

Due to small numbers, in-depth bespoke analysis of our BAME population is undertaken to ascertain any disparities that might need to be addressed. We have also undertaken bespoke analysis to ascertain any disparities for our patients who are flagged as having a learning disability. We also ensure the views of patients, public and people with lived experience in understanding healthcare needs is included.

## Elective care waiting time

Analysis for potential inequalities in waiting time has been carried out by age, gender, ethnicity and deprivation.

The latest data from the Waiting List Minimum Dataset (March 2026), show 55,379 people are on the South Tees Hospitals NHS Foundation Trust waiting list for elective treatment. Of these 55,379 people on the South Tees Hospitals NHS Foundation Trust waiting list, 61% have been waiting less than 18 weeks for elective treatment. There is statistically significant variation by age and by sex, with a larger percentage of working age people recorded as waiting 18 weeks or more and a higher proportion of females. Of people aged 19-64 years, 59% had been waiting less than 18 weeks. This compares to 61% of people aged 0-18 years, and 65% of people aged over 65. Of the females 60% had been waiting less than 18 weeks compared to 63% for the males.

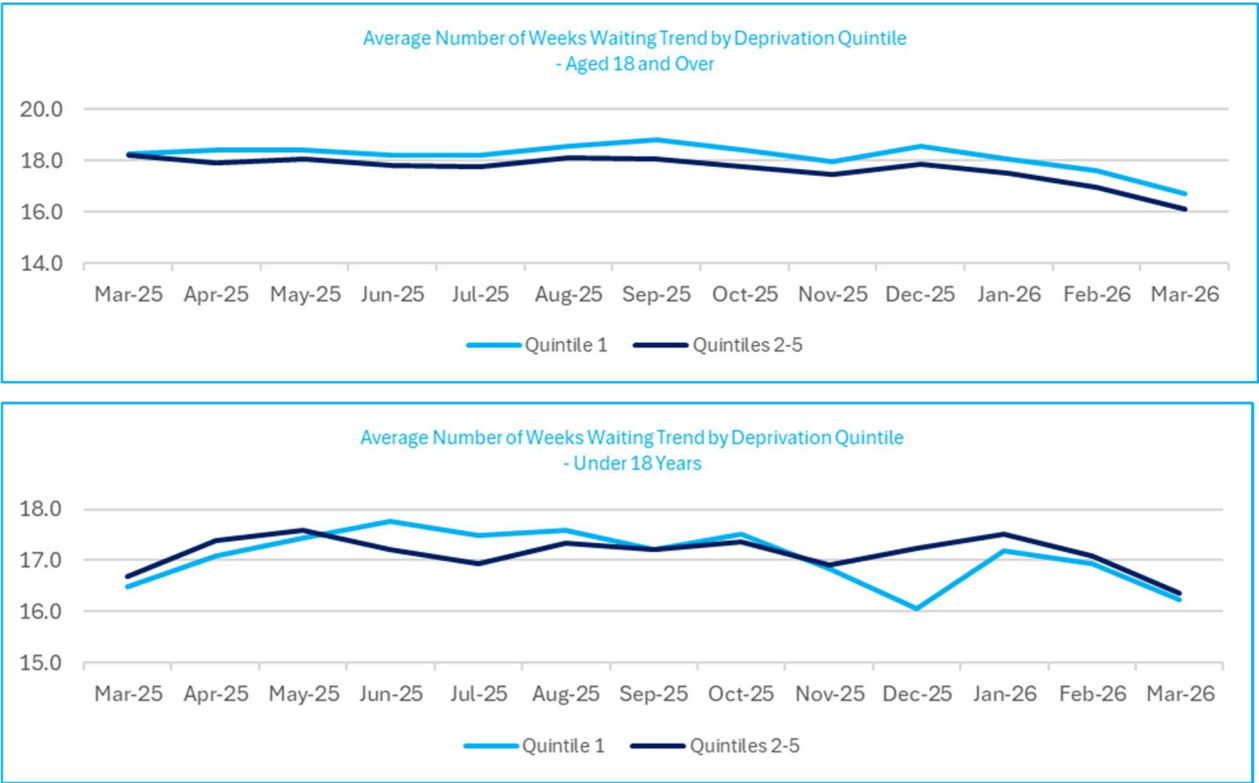


There is a statistically significant variation in the waiting experience by ethnicity, with 56% of people with a black ethnicity recorded less than 18 weeks and 59% of people with Other recorded as their ethnicity waiting less than 18 weeks compared to the overall average of 61%. The highest level recorded was in the unknown/not stated group with 63%, while people of Southern Asian heritage or of mixed race having 62% waiting less than then 18 weeks. People with white ethnicity were at the average of 61%.

There is also a significant difference in the waiting experience by deprivation quintile with people living in our most deprived areas (Core20 communities that sit within the most deprived 20% of the population of England) waiting longer. Only 60% of people from these Core20 areas have waited less than 18 weeks compared to 62% from other areas.

Just under 2% of patients had been waiting 52 weeks or more. There is no significant difference by deprivation or ethnicity but there is by sex and by age, with 2.1% of females waiting 52 weeks or more compared to 1.6% of males and 2.2% of people aged 19-64 compared to 1.1% of people aged 0-17 and 1.4% of people aged 65 or more.

Looking at how the average waiting time for patients on the waiting list has changed over recent months, shows that it has fallen from 18.1 weeks in March 2025 to 16.3 weeks now. The graphs below show that waiting times have fallen both for our Core20 communities and others. The fall has happened both in adults and in children, though the reduction has been much less pronounced in the latter group.

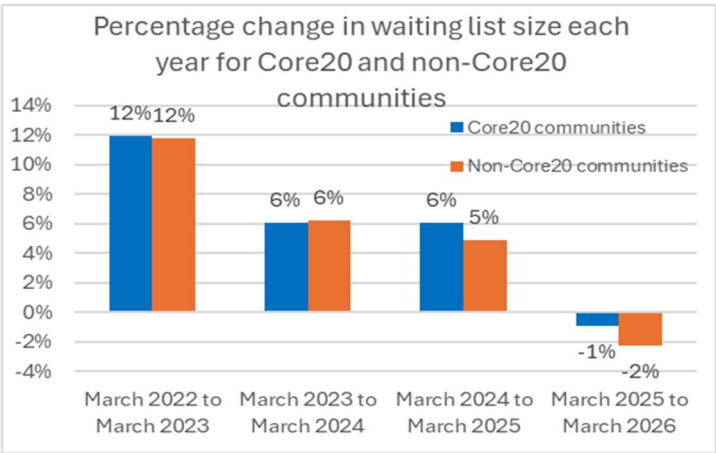


**Waiting list size (number of people waiting for elective care)**

The trust’s waiting list size has increased from 44,976 people waiting in March 2022 to 53,379 people in March 2026, with most of the increase between 2022 and 2024. Compared with last year, there was a 3% reduction in the number of people waiting.

**Waiting list size for Core20 communities.**

32% of people on the trust’s waiting list live in our Core20 communities. This broadly matches the proportion in our catchment population. Compared with March 2025, the waiting list size for our Core20 communities reduced by 1%, to 16,437 people in March 2026. The waiting list for non-Core20 communities reduced by 2%. The graph shows how the waiting list for both groups has changed each year.



## Waiting list size by ethnicity

The table below shows people on the waiting list by recorded ethnicity, in March 2025 and March 2026. The growth in numbers in the 'Other Ethnic Groups' and the 'Not Stated/Known' categories reflects a worsening in the quality of the data which makes interpretation difficult.

| Recorded Ethnicity     | Number of people on waiting list in March 2025 | Number of people on waiting list in March 2026 | Change in list size |            |
|------------------------|------------------------------------------------|------------------------------------------------|---------------------|------------|
| Asian or Asian British | 1,385                                          | 1,347                                          | -38                 | -3%        |
| Black or Black British | 396                                            | 318                                            | -78                 | -20%       |
| Mixed                  | 389                                            | 314                                            | -75                 | -19%       |
| White                  | 43,184                                         | 40,371                                         | -2,813              | -7%        |
| Other Ethnic Groups    | 6,368                                          | 7,118                                          | 750                 | 12%        |
| Not Stated / Known     | 5,396                                          | 5,911                                          | 515                 | 10%        |
| <b>Grand Total</b>     | <b>57,118</b>                                  | <b>55,379</b>                                  | <b>-1,739</b>       | <b>-3%</b> |

## Waiting list size by age

In March 2026, 57% of people on the waiting list were aged 18-64 years, 9% were under 18 years and 34% were over 65 years of age. The table below shows people on the waiting list by age, for 2024, 2025 and 2026. In 2026, the number of people waiting fell in all age groups with the largest fall being in the 0-17 age group.

| Age (years)        | Number of people on waiting list in March 2024 | Number of people on waiting list in March 2025 | Number of people on waiting list in March 2026 | Change in list size |            |
|--------------------|------------------------------------------------|------------------------------------------------|------------------------------------------------|---------------------|------------|
| Under 18           | 5,612                                          | 5,581                                          | 5,005                                          | -576                | -10%       |
| 18-64              | 30,032                                         | 31,719                                         | 31,331                                         | -389                | -1%        |
| 65 and over        | 18,672                                         | 19,818                                         | 19,043                                         | -774                | -4%        |
| <b>Grand Total</b> | <b>54,316</b>                                  | <b>57,118</b>                                  | <b>55,379</b>                                  | <b>-1,739</b>       | <b>-3%</b> |

## Waiting list size by gender

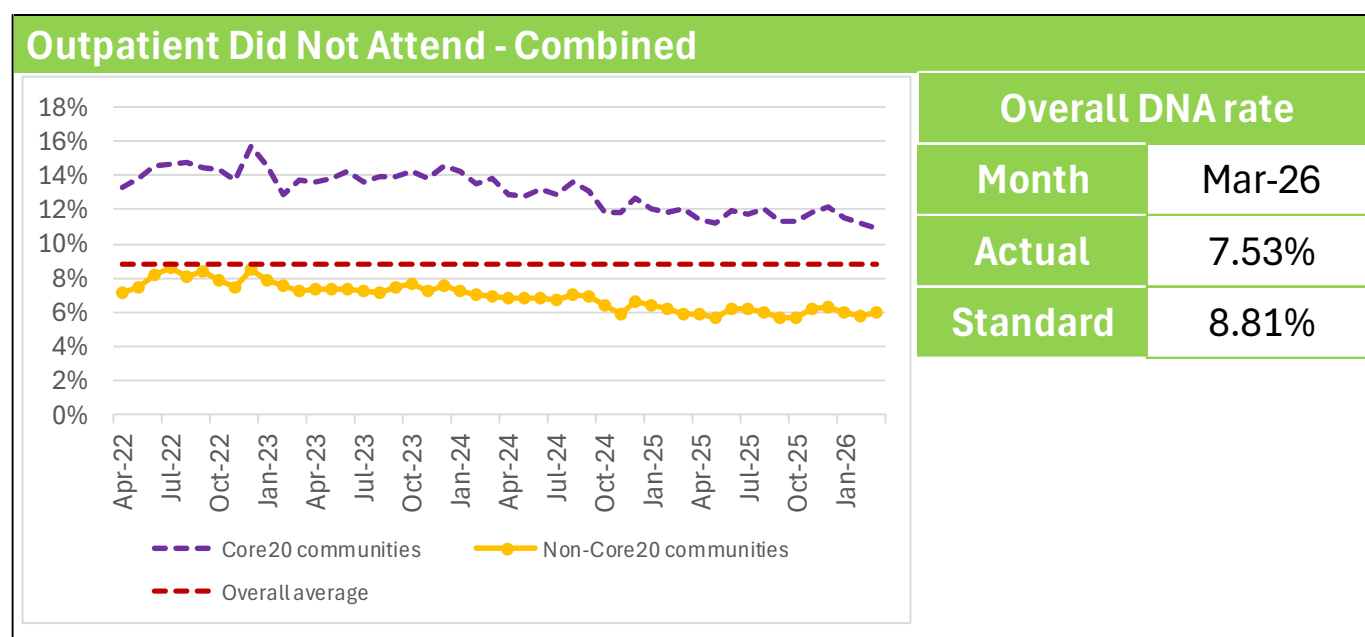
In March 2026, 45% of people on the waiting list were recorded as male and 55% recorded as female. From 2025 to 2026, the number of males waiting effectively stayed the same, while the number of females fell by 3%.

## Community Care

The average waiting time for community services was 20.7 days. On average males waited 19 days and females 22. The average wait for people recorded as being from a white ethnic group was 18.2 days, while people from other known ethnic groups waited 35.5 days. However, people from ethnic minorities made up only 3% of the total activity and these differences in waiting times may reflect these low numbers. People from our Core20 communities waited an average of 19.1 days. 68% of activity was for people aged 65 or more and they waited 11.9 days compared to 40.3 days for people aged 18-64 and 38.1 days for people aged 0-17. These differences reflect the very different services that people of different ages are accessing.

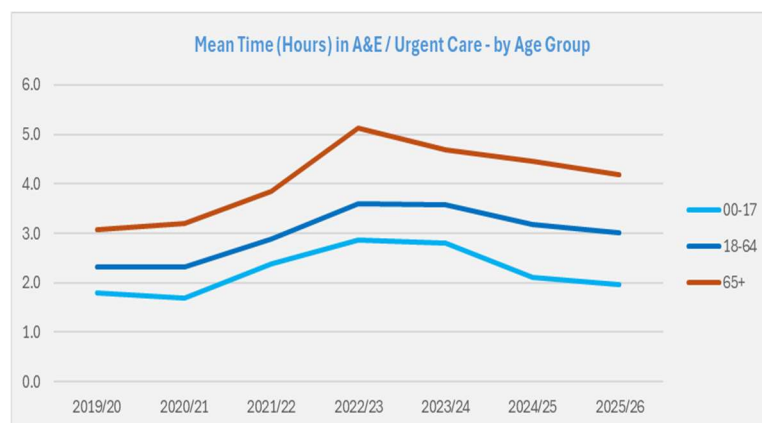
## Outpatient attendance

In 2025/26 the proportion of people who “Did Not attend” (DNA) or “Were Not Brought” (WNB) to their outpatient appointment at the trust was 7.7%, higher than the national median for all providers of 6.6%. The post-Covid downward trend in DNA/WNB rates continues but the rate for our Core20 communities continue to be much higher than for other communities as shown below.



## Urgent and Emergency care

In 2025/26, the average time patients spent in A&E or urgent care was 3.0 hours. As shown in the graph below, the time has been declining since the post-Covid peak of 2022/23 for all ages but people aged 65 and overspend considerably longer than younger people. People aged 65+ spent an average of 4.2 hours in A&E or urgent care in 2025/26, compared to 2.0 hours for people aged 0-17 years and 3.0 hours for people aged 18-64 years.

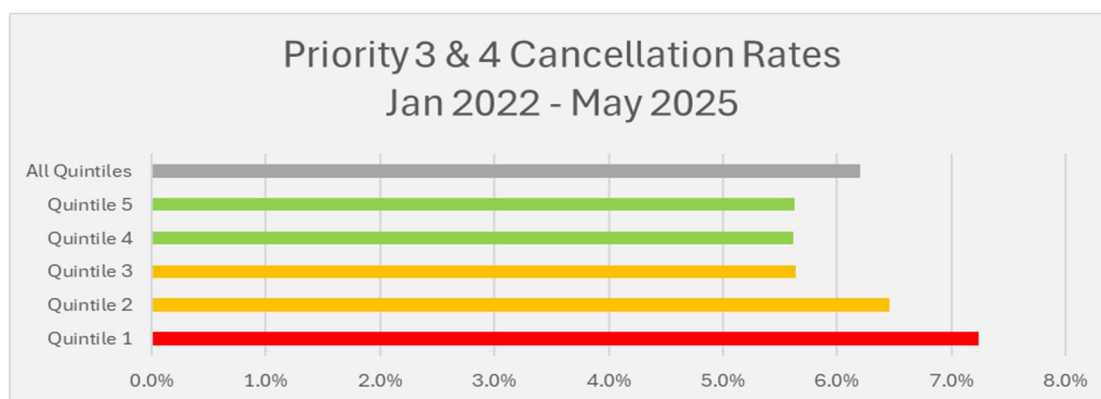


The average time in A&E for people from our Core20 communities was 3.3 hours (compared to 2.9 hours for people from our non-Core20 communities). The table below shows the average time by ethnic group.

| Financial Year | 1. Asian or Asian British | 2. Black or Black British | 3. Mixed | 4. White | 5. Other Ethnic Groups | 6. Not Stated / Known |
|----------------|---------------------------|---------------------------|----------|----------|------------------------|-----------------------|
| 2019/20        | 2.52                      | 2.39                      | 2.15     | 2.36     | 2.19                   | 2.19                  |
| 2020/21        | 2.48                      | 2.42                      | 2.23     | 2.42     | 2.28                   | 2.31                  |
| 2021/22        | 3.30                      | 2.98                      | 2.81     | 2.96     | 2.99                   | 3.01                  |
| 2022/23        | 3.87                      | 3.48                      | 3.40     | 3.72     | 3.50                   | 3.77                  |
| 2023/24        | 3.69                      | 3.51                      | 3.13     | 3.63     | 3.42                   | 3.70                  |
| 2024/25        | 3.02                      | 2.78                      | 2.55     | 3.26     | 2.86                   | 2.96                  |
| 2025/26        | 2.83                      | 2.61                      | 2.46     | 3.08     | 2.87                   | 2.81                  |

## Procedure cancellation rates in our Core20 population

Operations or procedures may be cancelled for many different reasons such as the patient being not well enough for the procedure, non-attendance or hospital-related issues. Patients in our Core20 population (most deprived 20% and quintile 1 in the graph) who are waiting for a priority 3 or 4 procedure are more likely to have the procedure cancelled than people from less deprived neighbourhoods. However, the trust Waiting Well programme offers support to these patients and noted a significant reduction in cancellation rates for people who participate.



## Timing of first antenatal appointment in pregnancy (“booking”)

NICE recommends that a first “booking” antenatal appointment occurs within the first 10 weeks of pregnancy. The percentage of pregnancies “booked” within 10 weeks of the pregnancy starting has increased from 60% in 2023/24 to 67% in 2025/26. In our Core20 communities 59% of pregnancies were booked within 10 weeks (compared to 73% of pregnancies in our non-Core20 communities).

At 58% mothers ages under 20 and at 62% mothers ages 35 and over were statistically less likely to book before 10 weeks compared to mothers ages 20-34 where the rate was 68%.

Though the table below shows the percentage of bookings by 10 weeks has increased over time for each ethnic group, people recorded as being from an ethnic minority group were still considerably less likely to book before 10 weeks.

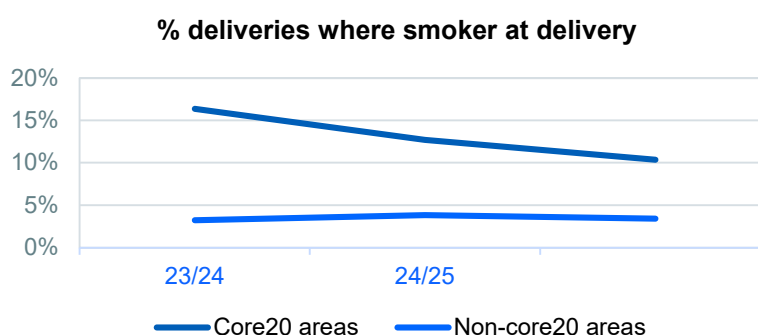
| Ethnic group | 2023-24    | 2024-25    | 2025-26    |
|--------------|------------|------------|------------|
| Asian        | 52%        | 58%        | 58%        |
| Black        | 33%        | 44%        | 45%        |
| Mixed        | 37%        | 42%        | 56%        |
| White        | 66%        | 71%        | 72%        |
| Other        | 39%        | 46%        | 50%        |
| Not known    | 51%        | 66%        | 58%        |
| <b>Total</b> | <b>60%</b> | <b>66%</b> | <b>67%</b> |

## Preterm birth and post-partum haemorrhage (PPH)

Overall, 8.1% of deliveries were pre-term (before 37 weeks of gestation). Women from our Core20 communities (9.0%) and women aged 35 and over (9.6%) were more likely to give birth early. 2.8% of women had an estimated post-partum haemorrhage of 1,500 ml or more. While in some years some groups had significantly higher rates of PPH there was no consistent pattern across the last three years.

## Smoking in pregnancy and at Time of Delivery (SATOD)

The proportion of women smoking at time of delivery has fallen from 8.9% in 2023/24 to 6.2% in 2025/26. The fall has been largest in our Core20 areas but women from there are still nearly three times as likely to smoke at delivery as women from other areas.



In terms of age the biggest reductions have been in women under 20 at delivery (10.1% to 7.2%) and women aged 20-34 (9.4% to 6.1%). In women aged 35 or more the rate has remained the same at 6.7%. Smoking was more common in the white ethnic group at 7.6% and was only 2.2% in women of other ethnicities.

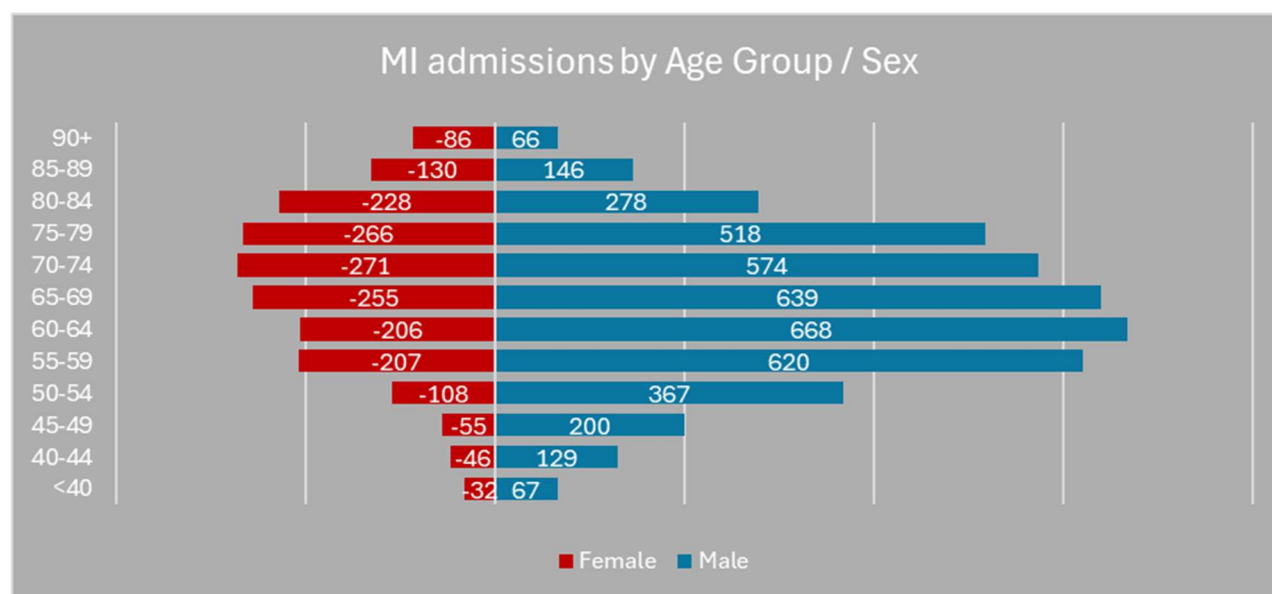
In 2025/26, of the women whose smoking status was known at the time of booking and at 36 weeks' gestation, 277 of them were smoking at booking. 52 of these (19%) were recorded as having stopped smoking at 36 weeks. This compared with 10% of the equivalent women in 2023/24 who stopped smoking. The proportion recorded as stopping smoking was lowest in our Core20 communities at 16.5% compared to 24% in our non-core20 communities but this was still more than double the 7.6% rate from in 2023/24.

## Cardiovascular disease

Myocardial infarction (MI) is known as a “heart attack” and involves damage to heart muscle, usually caused by a blockage in the arteries carrying oxygen to the heart. Stroke involves damage to sections of the brain due to blockage of arteries or bleeding in the brain. As well as providing DGH level treatment for its own catchment population South Tees Hospitals NHS FT also provides immediate treatment for specific myocardial infarction and stroke patients for the whole of the Tees Valley and surrounding area.

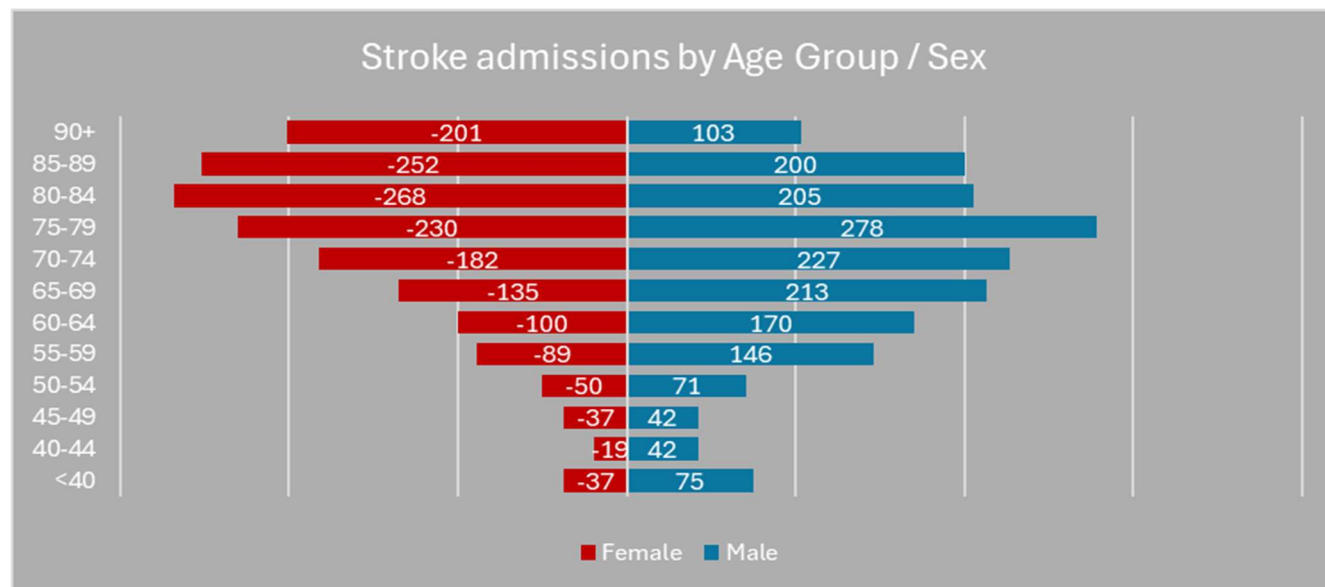
Between April 2022 and March 2025 there were 6,162 admissions for myocardial infarction. Of these, 69% involved male patients and 31% female patients.

The graph below shows the age and sex of people admitted with myocardial infarction. Myocardial infarction admissions for males peaked at 60-64 years and were higher than females for all age ranges except 90 years old and over. Female admissions peaked at 70-74 years old and are generally shifted towards the older ranges.



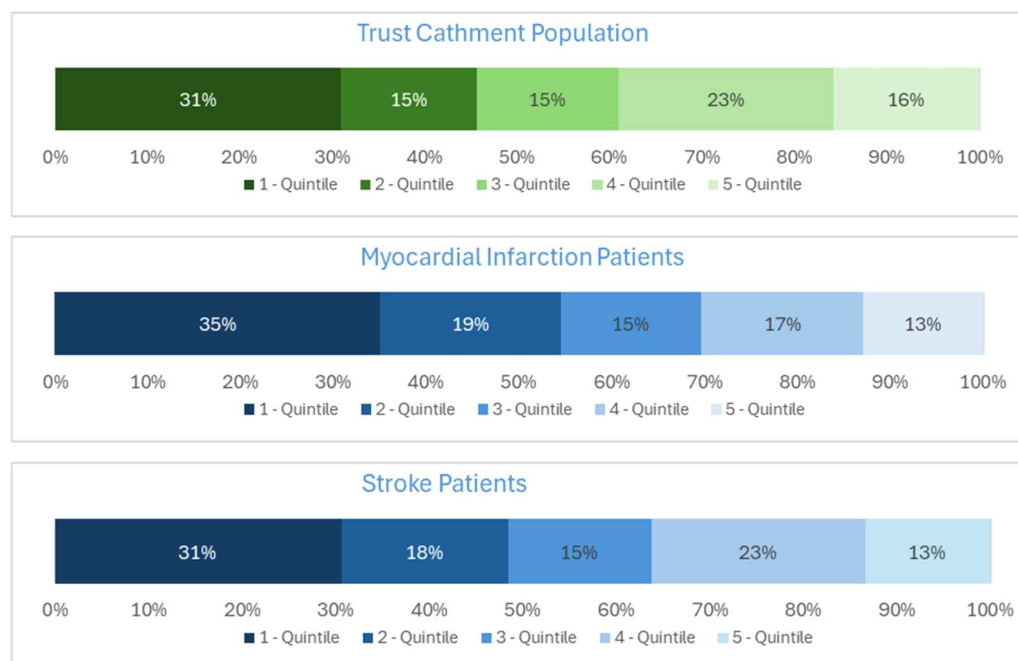
Myocardial infarction admissions in our Core20 population are shifted considerably towards younger ranges with peaks at 55-60 for both males and females. 11.8% of Myocardial infarction admissions in this population are under 50 compared to 8.6% overall.

For stroke, there were 3,372 admissions between April 2022 and March 2025 (53% male and 47% female). The peak age for admissions for stroke was 75-79 years for males and 80-84 years for females. Admissions in all age groups under 80 were higher for males. However, admissions involving people aged 80 or over were more likely to involve females. 7.5% of stroke admissions involved people aged under 50 years old.



For our Core20 communities the peaks were the same at 75-79 for males and 80-84 for females. However, 11.0% of admissions were under 50.

Approximately 31% of our catchment population are from our Core20 communities. At 35%, for myocardial infarction the proportion of admissions from these communities was higher than in the catchment. For stroke the ratios were very similar. For both conditions people from quintile 2 (the next most deprived) areas were over-represented.

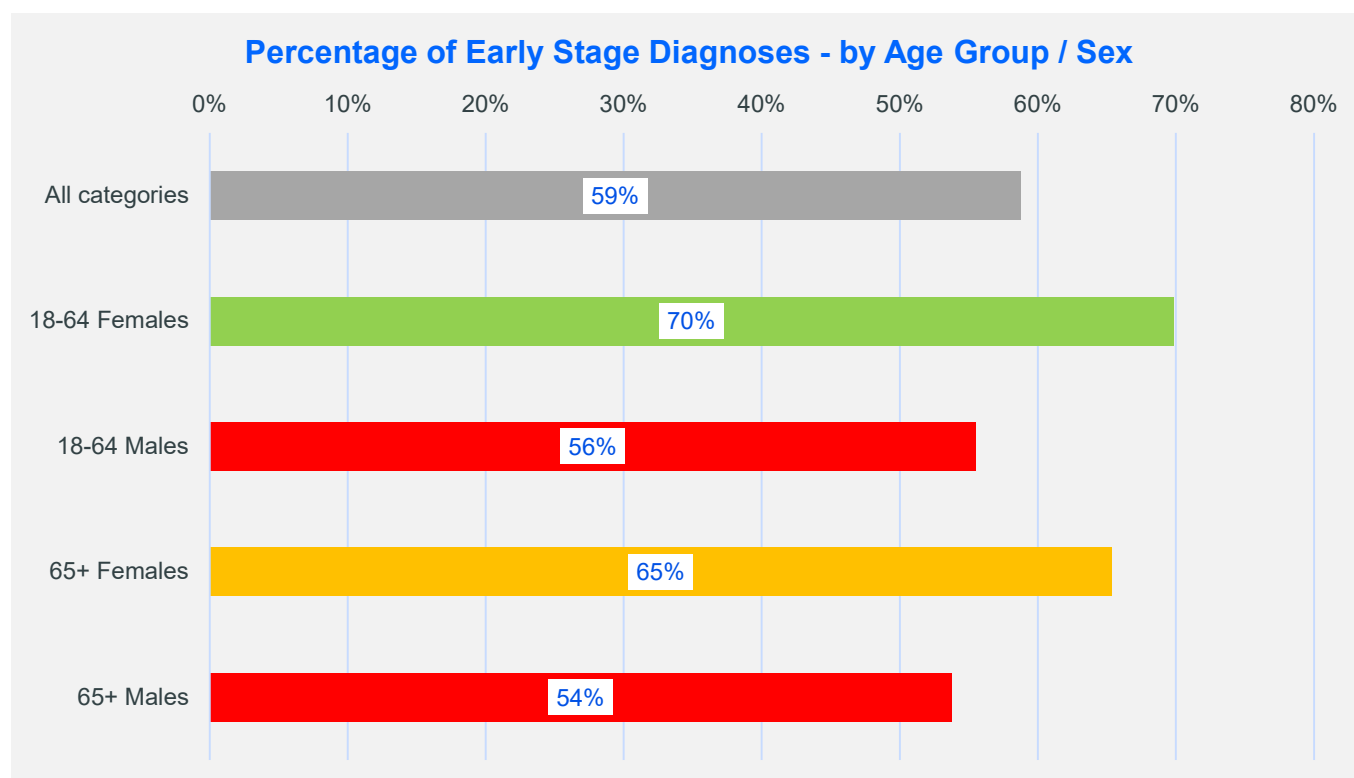


## Cancer stage at diagnosis and 5-year survival

If cancer is diagnosed at an earlier stage (pre-cancerous, stage I or II) this can improve survival. Determining the stage of cancer may require different investigations for different cancers and it may not be possible to accurately determine the stage for all patients and in some cancers, staging is not relevant.

Of people diagnosed with cancer within the trust, 28% are from our Core20 communities. Of cancers in our Core20 communities, 45% have a known stage (compared to 43% in our non-Core20 communities).

Of the patients who cancer was staged, females aged under 65 were most likely to be diagnosed at an earlier stage. The graph below shows that, where staging is known, 70% of females aged 18-64 years were diagnosed at an early stage compared with 54% of males aged 65+ years.

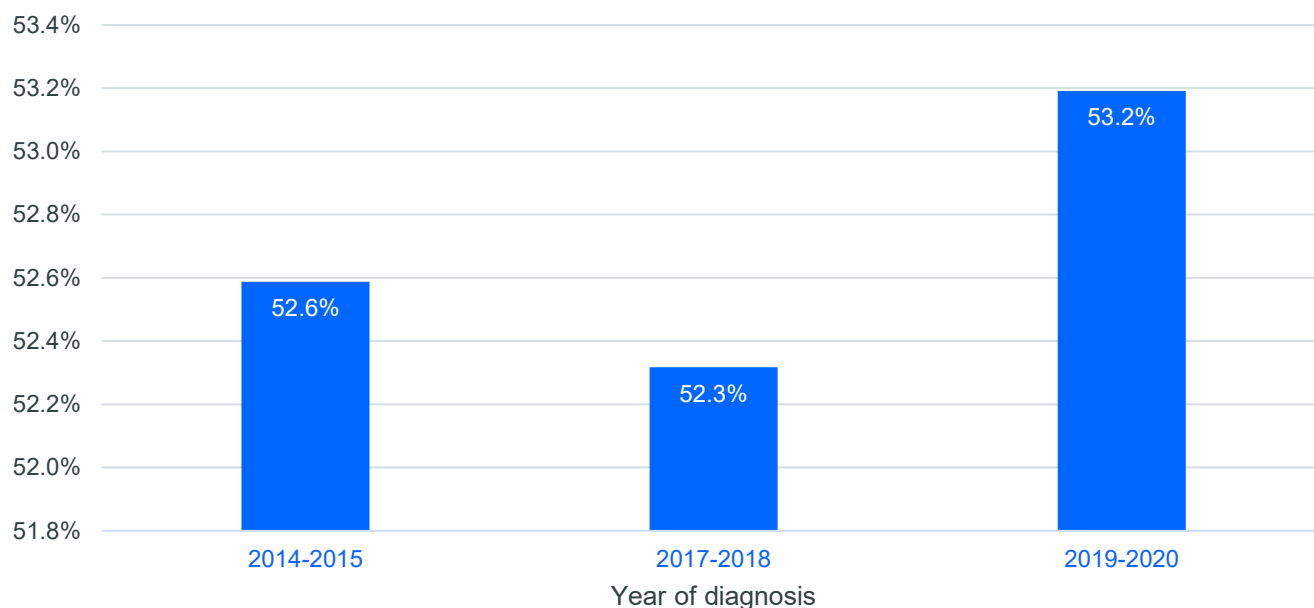


When adjusted for cancer type there was no statistically significant difference in the percentage of cancers diagnosed at an early stage by deprivation or ethnic group.

As well as stage of diagnosis, many factors can affect the chances of a patient surviving for 5 years or more after diagnosis (e.g. cancer type, patient age and general health and suitable effective treatment). As a tertiary centre for many cancers South Tees Hospitals NHS Foundation Trust treats many patients who are at advanced stages of disease. In addition, as a provider of radiotherapy treatment the trust also provides palliative treatment to patients whose disease has progressed beyond the curable stage.

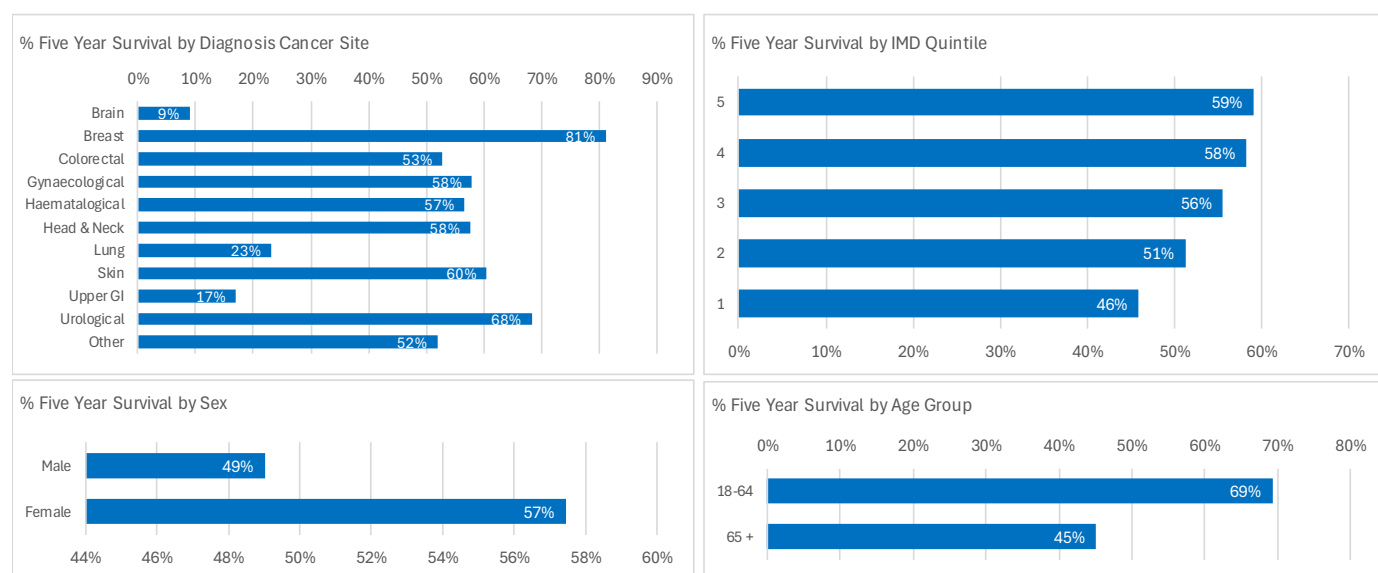
Raw 5-year survival rates show that they are slowly increasing as shown below

### Age adjusted 5 year cancer survival rate by year of diagnosis cohorts



These raw figures show lower survival rates for our Core20 communities, males and older patients. However, the graph by cancer type shows the high variation in survival rates between different cancer types and the known differences in how often these cancers occur in the different groups makes interpretation difficult. However, when cancer type is controlled for there appear to be significant differences in survival rates by deprivation and age, though not for sex or ethnicity.

### 5 Year Survival for STHFT Patients Diagnosed in 2019 & 2020



## Frequent A&E attendance

### Key line of enquiry 2.2:

How is routine performance data – including elective and urgent and emergency care data – analysed and broken down by deprivation, ethnicity, age and sex, to better understand areas of inequality, and how have other triangulated sources of insight supported an understanding of the drivers of these including barriers to access or inequalities in patient experience?

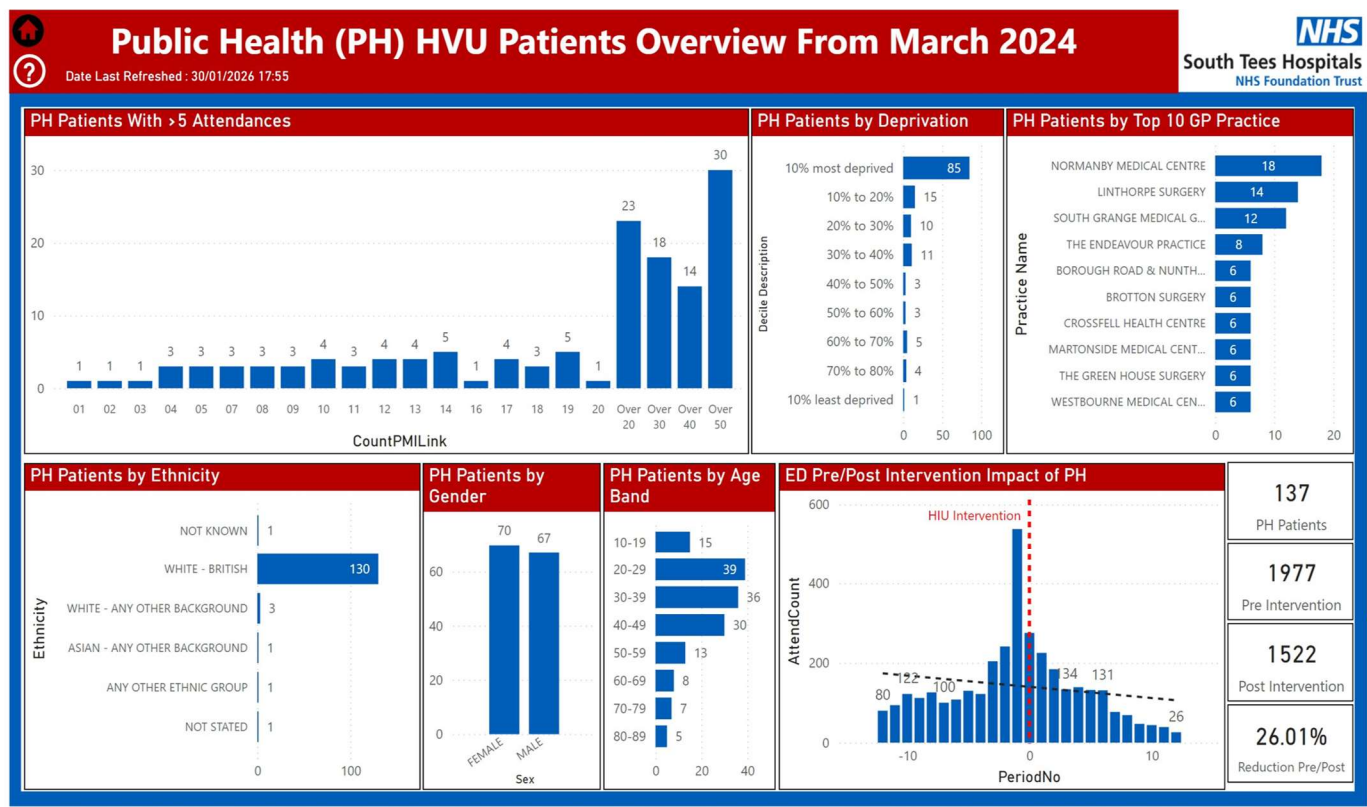
A programme of work has been underway for the last two years to identify those who frequently attend A&E and provide proactive targeted support.

High Intensity Users (HIUs) or frequent attenders are defined as patients who attend an emergency department five or more times in a 12-month period. There is a clear link between high intensity use of urgent and emergency services and health inequalities, and it is recognised that for some of these patients their needs can be better met elsewhere such as social care or community services.

Funded by the ICB, two enhanced case workers from the Changing Futures Team Public Health South Tees work with the most frequent attenders, using a non-medical approach focussing on social, practical, and emotional support. Enhanced case workers divert non clinical, non criminal vulnerability away from acute services by taking on individuals who frequently present in these settings. Instead of signposting, they actively arrange and support attendance at appointments, working alongside local specialist services to create and sustain positive change. Their focus is on helping people understand their needs, build strengths, and develop the skills to manage independently, ultimately reducing reliance on emergency or crisis pathways.

In the last 12 months case workers have offered direct interventions to 137 patients. The data below provides an overview of the demographics of those patients with 85 living in the 10% most deprived communities and 30 patients having 50 ED attendances in last 12 months.

The reduction in attendances pre/post intervention are currently showing a 26.01% and this continues to be monitored for up to 12 months from case closure. An economic evaluation using a comparison cohort of this service is currently underway to determine impact of this intervention.



## Primary care access

### Key line of enquiry 2.4:

How has local data been analysed to better understand areas of inequality in access to primary care, and how have other triangulated sources of insight supported an understanding of the drivers of these?

Strata mapping suggests that significant areas of the trust catchment live in areas where they would have to travel more than 30 min by public transport to reach a GP practice.

## Patient reported measures

### Key line of enquiry 2.5:

How has qualitative information, such as patient reported outcomes measures (healthcare inequalities? PROMs) and patient reported experience measures (PREMs) been collected and analysed to address healthcare inequalities?

Patient reported experience and outcome measures are collected, analysed and reported for individual evaluation of services (e.g. Waiting Well Programme, social prescribing in cardiology) as well as through Friends and Family surveys. The [NHS Oversight Dashboard](#) also reports on patient experience measures, comparing the trust with other providers. Below is an example of

what the trust is doing to capture patient PROMs via social prescribing interventions with cardiology patients.

Qualitative information has been systematically collected and analysed within the cardiology social prescribing project to better understand patient outcomes, experiences and healthcare inequalities.

PROMs are gathered using the Health and Wellbeing Prism tool alongside the EQ-5D. This enables patients to self-assess key domains including mental wellbeing, lifestyle, social connectedness (family and friends) and wider determinants of health such as financial stability, housing, and transport. EQ-5D provides a validated, standardised measure of health-related quality of life. Data is collected at both entry and exit from the service, allowing for assessment of change over time and impact of the intervention on outcomes.

PREMs are also captured through structured feedback, including whether patients would recommend the service, alongside open-text responses to provide richer insight into patient experience. This qualitative feedback helps identify strengths of the service as well as areas for improvement.

In addition, the social prescriber produces monthly case studies to illustrate individual patient journeys, providing narratives on patient needs, interventions and outcomes. These case studies add depth to the quantitative findings and highlight the real-world impact of the service on patients facing complex social and health challenges. To further enhance the qualitative evidence base, a student from Teesside University has obtained ethical approval to undertake patient interviews, providing additional in-depth insight into patient experiences and outcomes.

All qualitative and quantitative data has been analysed alongside demographic information to assess reach and equity of access. This demonstrated that 51% of patients accessing the service are from the most deprived areas (Index of Multiple Deprivation deciles 1 and 2), compared to 6% from the least deprived areas (deciles 9 and 10). This indicates that the service is successfully engaging populations experiencing higher levels of socioeconomic disadvantage.

Together, these approaches have enabled a more holistic understanding of patient need, experience and outcomes, and have supported ongoing service development to address healthcare inequalities.

### 3. Improving data quality, collection and analysis

#### Key line of enquiry 3.1:

What actions have been taken to identify and improve the completeness and accuracy of coding and recording practices, including for ethnicity, other protected characteristics and socioeconomic factors such as housing status?

#### Completeness of ethnicity recording

Percentage of records within our key datasets where the patient's ethnicity is recorded as either not stated or not known.

| Dataset                 | 23/24 | 24/25 | 25/26 |
|-------------------------|-------|-------|-------|
| Community               | 11.1% | 9.7%  | 8.8%  |
| Emergency & Urgent care | 4.6%  | 6.4%  | 7.3%  |
| Outpatients             | 10.1% | 9.4%  | 9.7%  |
| Inpatients              | 7.4%  | 7.6%  | 8.0%  |
| Maternity               | 2.6%  | 3.6%  | 3.7%  |
| Cancer data             | 1.3%  | 1.9%  | 2.7%  |

Ethnicity recording has improved over time for community services from (11.1% incomplete recording in 23/24 to 8.8% 25/26). Some variation in ethnicity coding between departments has been identified and interventions to improve completeness and accuracy of coding are underway. Recording of other socio-economic factors such as housing status and employment status are being addressed through NIHR funded research project involving the Academic Centre Surgery in STFT exploring "Harms on Surgical Waiting List" project which is looking at a range of different data sets. The trust has implemented the reasonable adjustments digital flag information standard. There is a flag on clinical systems for veterans, learning disability, serious mental illness and alcohol/substance use.

#### Processing and linking data:

#### Key line of enquiry 3.2:

How is data processed and, where relevant, linked to identify population groups who are underrepresented in the NHS data sets and to understand pathways across services and patterns of access and demand among groups experiencing inequalities?

As NHS England notes, good quality data (i.e. complete, accurate, up-to-date, and consistently recorded across systems), is essential for carrying out effective service planning, quality improvement, and monitoring the equity of services. However, datasets do not always represent the whole population equally. Action based on incomplete data has the potential to widen health inequalities for people who are not represented in data.

As recommended by NHS England, performance, quality and patient outcomes within the trust are disaggregated by age, sex, ethnicity and deprivation and compared with the trust catchment or other comparator. This can identify disparities in care faced by population groups who face known health inequalities. Where possible and relevant, disaggregation of data by protected characteristics (such as disability status, sexual orientation, gender identity or broader socioeconomic measures, such as employment or housing status) is also considered.

## Addressing data gaps

### Key line of enquiry 3.3:

Where gaps in data quality affect the ability to carry out healthcare inequalities analysis, how is assurance undertaken on steps to address these?

We are continually taking steps to address gaps in data quality. For example, we will be looking to include the data from our community services in our updated Health Inequalities Dashboard, work to improve coding is underway and triangulation of data is used where feasible. Assurance is undertaken through Health Inequalities Oversight Group and regular reporting to the Quality Assurance Committee, Board, ICB and NHS England.

## 4. Action: Using information to take action on health inequalities

### Key line of enquiry 4.1:

How has information on health inequalities informed strategic commissioning decisions, pathway redesign or long-term strategies?

### Key line of enquiry 4.2:

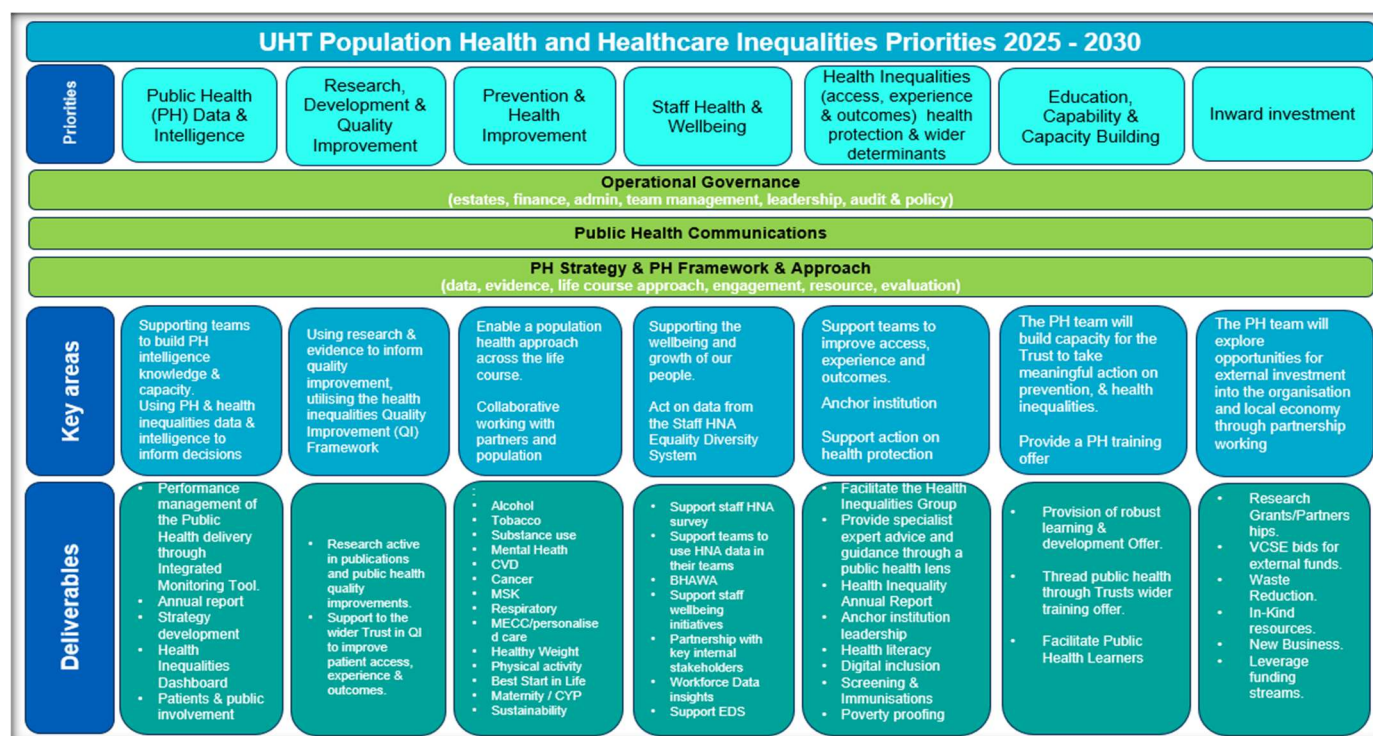
How has information on health inequalities informed quality improvement approaches in service delivery, including in neighbourhood health models?

### Key line of enquiry 4.3:

To what extent have inequalities in population health outcomes been used to inform decision making? Where trends exist, what ambitions have been set to target improvements?

## UHT Strategy for 'improving population health and reducing healthcare inequalities'

Information on health inequalities has informed the University Hospitals Tees strategy for improving population health and reducing healthcare inequalities. The infographic below shows the priorities within the strategy with deliverables reflecting local health inequalities and evidence based opportunities for action.



To implement the strategy, we will utilise a cross-cutting approach to embed the principles of population health, prevention and health inequalities across all our Clinical Service Units (CSU). The public health consultants will provide specialist leadership and advice to the executive, managers, and staff to ensure that we embed an equity lens in all our clinical pathways with the aim to reduce healthcare inequalities in access, experience, and outcomes. These interventions will enable primary, secondary and tertiary prevention to be embedded in our models of care.

The infographic below outlines our model for implementation. We will produce a bi-annual assurance report to the quality assurance committee on progress of implementation of the strategy.

| Reducing healthcare inequalities                          |                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Priorities                                                | How we will achieve this                                                                                                                                                                                                                                                                                                                            | Phase 1<br>2025 to 2026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Phase 2<br>2026 to 2030                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Phase 3<br>From 2030 onwards                                                                                                                                                                                                                                                                                         |
| Improve equity in access, diagnosis and management        | <ul style="list-style-type: none"> <li>Improve case finding of long-term health problems in core20plus population</li> <li>Improve access, uptake and optimisation of behavioural interventions for Core20Plus population</li> <li>Provide inclusive healthcare for people with low incomes</li> <li>Improve health and digital literacy</li> </ul> | <ul style="list-style-type: none"> <li>Develop UHT health inequalities dashboard</li> <li>Develop UHT MECC &amp; personalised care plan</li> <li>Develop a UHT pre - habilitation offer (cancer &amp; non -cancer)</li> <li>Stocktake current poverty proofing models by CSUs</li> <li>Stocktake UHT health and digital literacy offer</li> <li>Complete UHT baseline analysis against the patient safety health inequalities framework</li> <li>Stocktake UHT screening services for health inequalities plans</li> <li>Test modules from the access and attendance model</li> </ul> | <ul style="list-style-type: none"> <li>Pilot UHT prehab model with potential to embed as routine practice</li> <li>Test population health management model to implement the personalised care plan and quality improvements</li> <li>Start rolling out poverty proofing training and models for CSUs</li> <li>Implement UHT offer for health literacy and digital inclusion</li> <li>Start rolling out health inequalities models for all our screening programmes</li> <li>Roll our shared decision making training across CSUs</li> <li>Start rolling out access and attendance model across UHT</li> </ul> | <ul style="list-style-type: none"> <li>Embed poverty proofing models as routine practice</li> <li>Embed health inequalities quality improvement to all our screening pathways</li> <li>Establish a UHT prehab model for cancer and non-cancer patients</li> <li>Embed the UHT access and attendance model</li> </ul> |
| Empower patients, communities and organisation for equity | <ul style="list-style-type: none"> <li>Embed patient, public and people with lived experience engagement model</li> <li>Reduce inequalities in social determinants of health</li> <li>Empower staff to address inequalities</li> <li>Leverage quality improvement to address health care inequalities</li> </ul>                                    | <ul style="list-style-type: none"> <li>Confirm PPLE standards for UHT with patient experience and involvement leads</li> <li>Establish routes of participation with place based partnerships for neighbourhood health development</li> <li>Implement trauma informed training for staff</li> </ul>                                                                                                                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>Develop health inequalities ambassadors model for clinicians CSUs</li> <li>Agree health inequalities transformation/CIP quality improvement projects with priority CSUs</li> <li>Stocktake UHT inclusion health offer and develop support pathways e.g high intensity users</li> </ul>                                                                                                                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>Embed inclusion health pathways into routine practice</li> <li>Embed health inequalities and prevention offer in all transformation/CIP quality improvement projects with CSUs</li> </ul>                                                                                     |
| Financing for equity                                      | <ul style="list-style-type: none"> <li>Implement funding models to address health care inequalities</li> <li>Agree payment mechanism to improve prevention spending by UHT</li> </ul>                                                                                                                                                               | <ul style="list-style-type: none"> <li>Develop baseline of all public health funding work streams per Trust</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <ul style="list-style-type: none"> <li>Agree UHT budget arrangements for Population health and health inequalities delivery</li> <li>Identify CSUs with highest care expenditure as priority</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                       | <ul style="list-style-type: none"> <li>Embed a health economic equity lens in all UHT business case decisions for transformation projects</li> </ul>                                                                                                                                                                 |

Information on health inequalities has informed specific health inequalities programmes, service improvements and decision making across a wide range of areas (including but not limited to public health prevention provider services outlined below).

| South Tees NHS Foundation Trust Public Health and Prevention provider services                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Tobacco dependency treatment service – acute in patient and maternity</li> <li>Paediatric department stop smoking service</li> <li>Alcohol care team and recovery navigator</li> <li>Alcohol detox bed</li> <li>Waiting well</li> <li>Cancer prehab</li> <li>High intensity user case workers Emergency department</li> <li>Cardiology Social prescribing link worker</li> <li>Cervical screening – colposcopy</li> </ul> | <ul style="list-style-type: none"> <li>Diabetic eye screening</li> <li>Maternity vaccination</li> <li>Maternity vulnerabilities workers</li> <li>Digital inclusion worker (maternity)</li> <li>Access and attendance – Health inequalities care navigator</li> <li>BBV &amp; Syphilis testing in Emergency Department</li> <li>Lung health Checks</li> <li>Sexual health &amp; reproductive services</li> <li>Active Hospitals</li> </ul> |

## Our role as an Anchor institution and collaboration with partners

The Tees valley anchor institutions network is now well established. Our Deputy Chief Executive Officer is the UHT executive lead. We have agreed a partnership mission to 'reduce poverty' by using our levers as large organisations. A priority for the network is a multi-agency offer to tackle unemployment and ensure social value in procurement. Below is our promise to our communities across Tees Valley.



Members of the trust's Health Inequalities Oversight Group also collaborate with multiagency partners via local Health and Wellbeing Boards (aligning priorities across the trust's Footprint where feasible), Place Partnerships and topic specific partnerships (e.g. antipoverty, financial/digital inclusion and healthy weight/food). Community insights gathered at place during this year are being analysed by organisational partners and could help shape future action on health inequalities when available. Support available within the local community has been collated into the trust Directory of Services for use by staff and shared through staff training sessions.

## DNA – Access and Attendance

As part of the trust's commitment to reduce DNAs the trust is rolling out DrDoctor's DNA Predictor. DNA Predictor uses AI to identify patient risk of DNA based on approximately 50 metrics including attendance over the last 12 months and deprivation. The top 50% of patients at risk of DNA are asked to confirm their attendance 9 days before their appointment. The Health Inequalities Care Navigator contacts the top 10% of patients who are risk of DNA who do not confirm their attendance using DrDoctor Direct Messaging. Direct Messaging supports two-way text communication with the patient about their attendance and to support with the removal of any barriers to attendance. If the top 10% of patients at risk of DNA have not engaged with digital communication the Health Inequalities Care Navigator will call the patient and support

them by identifying the social, practical and communication barriers that limit their ability to access care, and by providing personalised, practical support to improve attendance and reduce health inequalities. There have been two phases to the pilot; Phase 1 commenced in December 2025 for respiratory, trauma & orthopaedics, neurology, ophthalmology and paediatrics: Phase 2 commenced in March 2026 for infectious diseases, gynaecology, cardiology, physiotherapy, and ear, nose & throat.

Early analysis is demonstrating a significant impact in addressing health inequalities, increasing appointment attendance, and reducing avoidable DNAs across the pilot specialties. Between December and March, the Navigator made 1,153 manual calls, achieving 562 successful patient conversations, leaving 315 voicemails, 264 patients who could not be reached. From these contacts, 322 tailored health inequality interventions were delivered, including transport and travel reimbursement support, social prescribing referrals, interpreter arrangements, safeguarding escalation, and flexible rescheduling and cancelling. This personalised and compassionate approach ensured that patients felt informed, prepared and supported ahead of their appointments, particularly those experiencing the greatest disadvantage.

The most common barriers identified included transport difficulties, low health literacy, language and communication challenges, unstable housing, safeguarding issues, caring responsibilities, anxiety or previous negative experiences, and work-related time constraints. A large proportion of support was provided to individuals from deprivation decile 1, highlighting the deep-rooted inequalities affecting marginalised groups.

## **Tobacco Dependency Treatment Service**

The trust provides smoking cessation services for adult acute inpatient and maternity settings. This service is provided by the Tobacco Dependency Treatment Service. Smoking cessation support is offered to all acute inpatients that are identified as a smoker. The trust aims to see all inpatients within 24 hours of administration.

During April 2025 – March 2026, 2946, inpatients were reviewed by the TDTS with 1249 patients accepting support to quit smoking.

To support our hospital to be a smoke free site the TDTS have been working with local primary schools across South Tees to deter smokers from smoking on hospital grounds 'Really' campaign launched last year uses heart felt pleas from children asking smokers not to light up on hospital grounds. Tannoy buttons have been installed across James Cook Hospital situated at entrance points where smokers congregate.



In recognition of a gap in support for patients under 18 and the parents of children presenting with respiratory or acute medical illness the trust is working in partnership with Public Health South Tees to provide specialist support to these patients and parents. From January 2025 specialist stop smoking advisors from Stop Smoking South Tees have been working in James Cook University Hospital to provide interventions and advice. Parents of children presenting with a known respiratory diagnosis such as asthma, cystic fibrosis, chronic lung disease etc or parents of children presenting with a respiratory illness are automatically referred for consultation with the tobacco dependency advisors. Patients aged 12 to 18 who disclose regular smoking /vaping irrespective of reason for hospital presentation are also referred to the service. Specialist advisors have trust honorary contracts and are working on the wards and across outpatients on a weekly basis. Positive feedback highlights a reduction in admissions among this cohort of children. A mid-way review has currently been undertaken and an action plan in place to increase referrals and roll out into neonatal department.

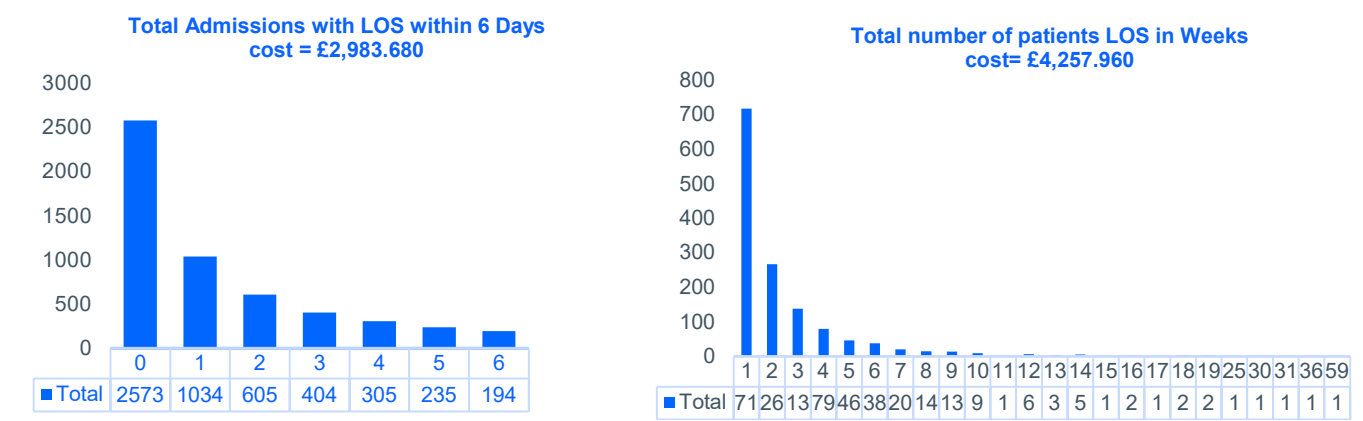
### Alcohol Care Team (ACT)

Alcohol significantly impacts population health and healthcare services, contributing to several diseases, as well as accidents, violence and self-harm. It places a significant financial burden on the NHS. South Tees faces some of the highest alcohol-related harm rates in England, with a disproportionate impact in deprived areas. The ACT was established in James Cook University Hospital in 2022 funded by the ICB and NENC NHS.

The team is comprised of nurses and recovery navigators who deliver a range of interventions aimed at reducing alcohol-related harm among high-risk or dependent drinkers which ensures that all patients referred to ACT have a full alcohol screening and IBA (Identification, Brief Advice) whilst supporting patients and ward staff with the management of alcohol withdrawals, relapse prevention interventions and seamless discharges into community alcohol services

In the last year (April 2024 to March 2025) the ACT have assessed 1,630 patients, identifying 1,125 as possibly dependent on alcohol and a further 216 as higher risk drinkers. Of those assessed 1,556 received brief advice or intervention with 401 referred to community services.

A recent service evaluation has been completed, which highlighted the inequalities in alcohol-related attendances and admissions, and identified the role that the ACT has in tackling alcohol-related harm including reducing length of stay and readmissions, the total cost for alcohol related hospital stays for 2024/25 has cost £7,241.640.



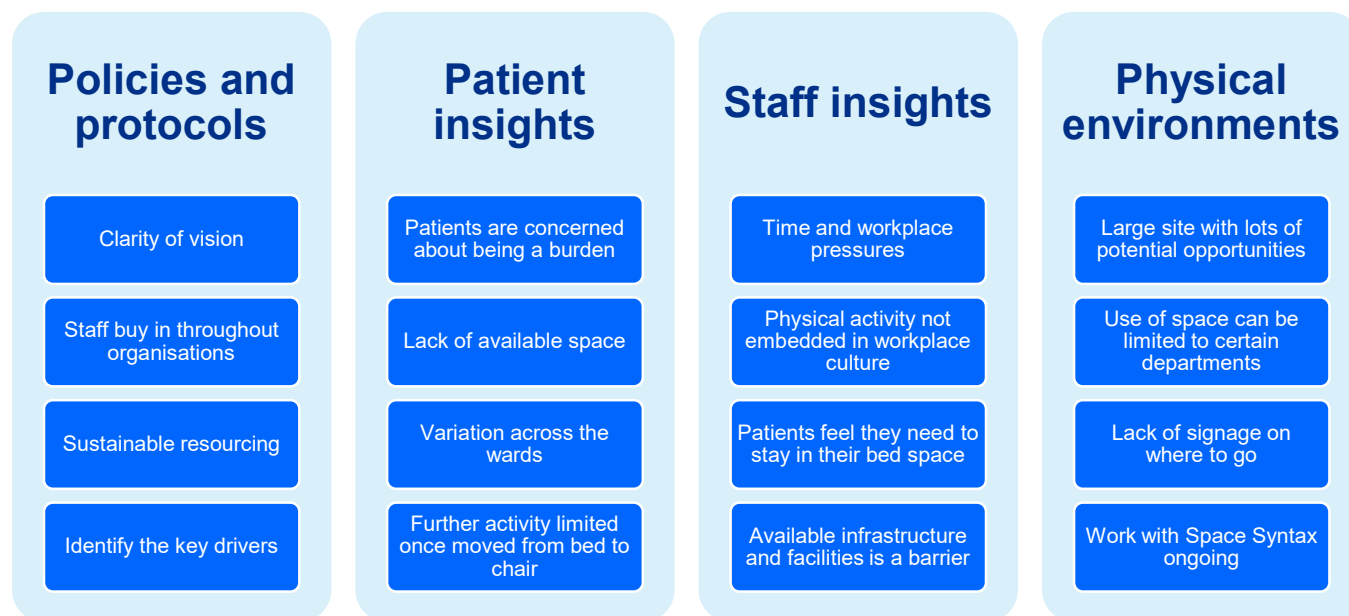
With the above cost highlighted, work is ongoing to implement the recommendations from the service review, including the implementation of an inpatient detoxification bed to provide safe efficient detoxification from alcohol allowing the opportunity to fully detox 52 people a year from the south tees area, with the aim to reduce hospital admissions, re-admissions and create pathways from hospital into community service for ongoing relapse prevention and support.

## Active Hospitals

Active Hospitals aims to change the physical activity culture in hospitals to encourage patients and staff to move more, improving wellbeing and patient outcomes. South Tees Hospitals NHS Foundation Trust are working in partnership with You've Got This (a local place-based Sports England funded partnership that works to reduced physical inactivity). As part of this work an insights-led approach explored:

- Staff culture – considering both staff and patient movement
- Policies and procedures
- Patients' insights
- Environment

### Key Findings from insight included:



An action plan is already in place to support the initiative, encompassing improvements to the physical environment, the development of suitable spaces to enable activity, the promotion of active travel, and the review and development of policies to support and encourage staff physical activity.

The staff pilot will provide an opportunity to evaluate what works well and to identify any challenges prior to wider rollout. Learning from this pilot areas will inform future implementation across the trust. For staff, planned actions include the promotion of walking meetings and the use of clear signage to highlight existing on-site walking routes. The trust has recently partnered with a local gym to introduce the Park Active scheme. This initiative enables staff to park off site at the gym rather than on Trust premises, thereby reducing parking demand and congestion on site. Participants undertake an approximately 15 minute walk to and from their workplace and benefit from access to a gym membership as part of the scheme. The programme supports the trust's objectives to promote physical activity among staff while also addressing onsite parking pressures. A total of 116 parking spaces is available for staff participation in the Park Active scheme.

## Shared Decision Making

Shared Decision Making (SDM) places patient autonomy at the centre of care by ensuring individuals are empowered to participate in decisions to the extent they choose. During 2025/26 the aim was to embed SDM as a sustainable, systemwide "business as usual" model by strengthening governance, leadership, and clinical resources. This included ratifying the SDM Improvement Plan with stakeholder input and implementing its core actions: preparing patients, developing staff, reviewing commissioned pathways, and enhancing supportive systems.

Over the past year significant progress has been achieved through integration of baseline assessment tools into existing audit pathways, empowering service users to participate in their care through patient-facing resources "Ask 3 Questions" that look at (Benefits, Risks, Alternatives, and doing Nothing) across clinical sites to prompt collaborative dialogue, we have trained the workforce through a cohort of accredited trainers who have facilitated the initial training of over 200 staff members across diverse clinical specialities.

To standardise this learning, we have developed a bespoke UHT SDM module and a co-produced educational video featuring senior leaders, clinicians, and service users. Accredited trainers continue to deliver monthly SDM sessions for the trust.

Going forward, the focus will be on achieving full maturity by expanding workforce skills, particularly in communicating risk and uncertainty, improving access to high-quality decision materials, and using collaboRATE data to inform clinician feedback and drive continuous improvement across services.



## Making Every Contact Count (MECC)

MECC continues to expand and embed across the trust. Hundreds of staff across the trust have completed training, supported by monthly awareness sessions with good attendance. MECC Champions have been recruited and are active on all wards, reinforcing best practice in everyday care.

MECC is being systematically embedded into workforce development processes, with training integrated into the Care Certificate programme for healthcare assistants, clinical skills training and ward manager training. The Education and Practice team is actively supporting integration into preceptorship and ESR learning modules, while work with IT continues to improve digital access to MECC resources via staff devices. MECC has also been incorporated into job descriptions and is being highlighted in Trac job vacancies, ensuring sustainability by embedding it into recruitment and professional expectations.

Promotion of MECC has taken place through Clinical Skills Days, international conferences, posters and case studies being prepared for intranet publication. Work is ongoing to align MECC with appraisal processes and staff wellbeing conversations, ensuring it is firmly embedded in workforce culture and practice. MECC is now added to STAQ accreditation framework and is now the trust priority.

## Secondary Care Social Prescribing: Cardiology

In July 2025, the trust launched an 18-month Secondary Care Social Prescribing pilot in cardiology, in partnership with Public Health South Tees. The programme targets patients with heart failure and those in cardiac rehabilitation, recognising that cardiovascular disease is the largest contributor to inequalities in life expectancy and that South Tees continues to experience higher rates of CVD admissions and mortality than the national average.

Since its launch social prescribing interventions have demonstrated strong early impact, high patient engagement and clear economic value, to date, 106 individuals have been referred, with 75% (86 individuals) accepting support. This high uptake reflects both the relevance of the intervention and the unmet need for non-clinical support alongside medical care. Most referrals relate to anxiety/low mood, social isolation, and challenges managing long-term conditions, often alongside wider issues such as finance and housing. Patients have been connected to a wide range of community services, including mental health support, social groups, exercise schemes, financial advice, and housing assistance.

Early outcomes show significant improvements in wellbeing, with 9 in 10 supported individuals reporting positive changes in EQ-5D measures. These include reduced anxiety and low mood, increased ability to carry out daily activities, improved confidence and stability, and an overall enhancement in quality of life.



The programme is also delivering wider system benefits. By providing holistic, non-clinical support, it enables clinicians to focus on medical care while ensuring individuals receive comprehensive support through strengthened links with community and voluntary sector services. This integrated approach is contributing to reduced pressure on acute services through earlier intervention and prevention.

Social prescribing in secondary care cardiology represents an effective, preventative approach that is improving outcomes for residents, reducing health inequalities and supporting more sustainable service delivery.

## CVD Prevention - Atrial Fibrillation Case finding in flu vaccination clinics in South Tees

This project represents a successful collaboration between primary care, public health and specialist cardiology services, working together to tackle AF health inequalities in one of the most deprived neighbourhoods in South Tees.

Aim of the project were to determine the effectiveness of embedding AF case finding into flu clinics including the number of patients screened and the number of new cases identified including lessons learned for future scaling of opportunistic AF case finding.

### Atrial Fibrillation results

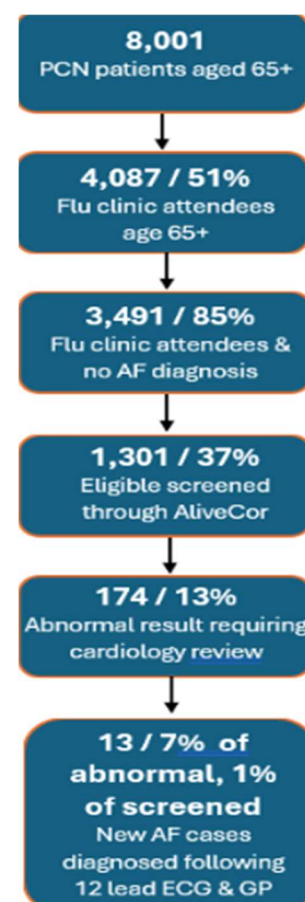
#### Outcomes and impact

Increased detection of undiagnosed AF – data shows that case finding was successfully implemented with 13 new diagnoses of AF (7% of abnormal results, 1% of those screened)

Improved management of AF – 174 patients with abnormal readings were identified. Those with previously undiagnosed AF were referred for a 12 lead ECG, blood tests and GP review. 13 new AF diagnosis started on anticoagulation

- Improved patient satisfaction - offering AF case finding alongside flu vaccination. Overall patient feedback shows that the initiative was well-received, easy to access and highly valued. 98% of patients found the heart rhythm check easy to have.
- Identification of underrepresented groups – demographic data showed 53% of those screened through Alivcor 42% were from IMD 1-3.

Recommendations for future work – the model has clear potential to scale across other PCNs and provides opportunities beyond flu clinics. However important to ensure any intervention does not create inequalities in access, experience and outcomes therefore future scaling will need to consider how best to reach groups at highest risk of CVD (core20plus patient search with risk factors hypertension, diabetes, smoking, alcohol, BMI)

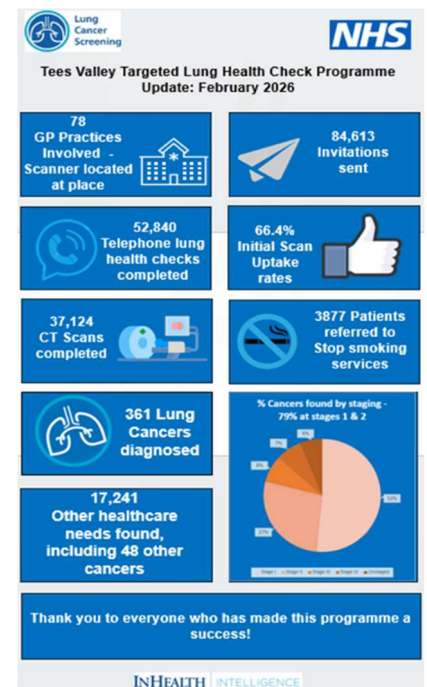


## Lung Health Screening

Lung Health Screening continues to demonstrate strong outcomes in the early detection of lung cancer, as well as the identification of a significant number of incidental cancers and other conditions. To date, the programme has detected at least 361 lung cancers, with 79% identified at curative stages 1 and 2. The service operates through mobile CT scanners located in accessible community settings, such as supermarket car parks, enabling patients to attend with a relative or carer if required and to park easily. The team makes reasonable adjustments wherever possible, and in exceptional circumstances can arrange taxi transport. In 2025, the scanner was deployed to Holme House Prison to ensure eligible individuals who would otherwise be unable to attend were offered screening.

A promotional video of the service, including British Sign Language (BSL), is being rolled out across GP practices. In addition, the team is planning a dedicated screening day for deaf patients, supported by enhanced communication resources.

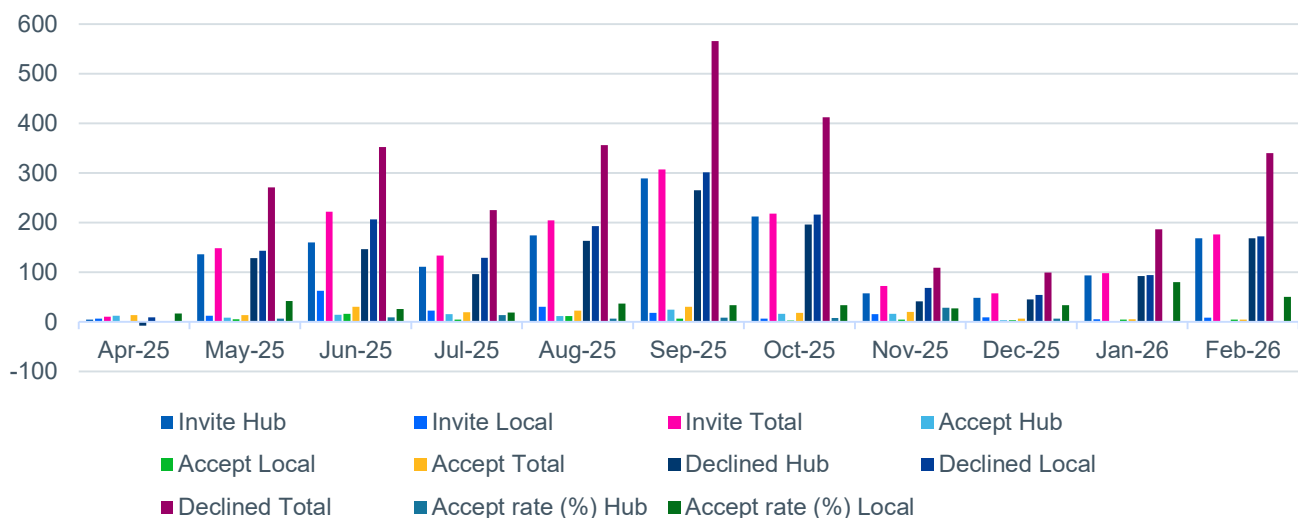
The Lung Screening Programme remains a key component of the national 10-year plan and represents a significant success in improving cancer survival through earlier diagnosis.



## Waiting Well

Waiting Well is a programme to support patients on long waiting lists to improve their health and wellbeing prior to surgery, it's a NENC ICB initiative. In South Tees it is delivered collaboratively through the trust and Local Authority. The initial focus was to invite patients on priority 4 surgical pathways living in IMD 1 and 2. In the last 12 months we have expanded the programme to include priority 3 patients as well as those in IMD 3 and 4.

**Waiting Well uptake April 25- March 26**



The graph above shows uptake rates from April 25 to March 2026 highlighting both central hub activity and local activity. Since October 2024 the invite process changed with most of the patients being invited via the regional central hub. Since this time uptake rate has reduced due to the same issues reported previously (inappropriate referrals including patients out of area. Uptake rates for patients invited locally were 38% while uptake rates for patients invited via the central hub were around 8%.

Further challenges relate to recruitment and retention of waiting well staff due to uncertainty around funding and short-term funding for the project.

Taper 3 Opioid Deprescribing project within Deep end practices was launched in October 2026 with specialist pain management support from STFT pharmacist. All practiced have signed up to the project.

We are now working collaboratively with the Optimise cancer prehab programme offering specialist exercise classes to patients who require that level of input. We are also offering cooking workshops delivered by Middlesbrough Environment City to help patients better support their nutritional needs prior to surgery. We are aiming to run 10 workshops over the next 12 months providing support to up to 100 patients who are engaging in either Optimise or Waiting Well programme.

## **Armed Forces/Veterans**

During 2025–2026, significant progress has been made in strengthening support for the Armed Forces Community (AFC) across University Hospitals Tees. A key milestone was the achievement of joint Veteran Aware accreditation, reflecting a continued commitment to delivering high-quality, inclusive care for veterans and their families. The previously vacant Help for Heroes nurse post has now been successfully filled, with the service supporting over 350 AFC patients, including 64 individuals referred into military charities or specialist veteran care pathways.



University Hospitals Tees also marked Armed Forces Day and Remembrance Week with group-wide celebrations and services, reinforcing recognition of the armed forces. To better understand the AFC patient population, a snapshot survey of more than 700 inpatients across all four hospitals was conducted; while 19 patients had been previously identified on the electronic patient record, an additional 113 were newly recognised as members of the AFC.

Furthermore, the National Training and Education Programme was launched in partnership with the Veterans Covenant Healthcare Alliance, equipping NHS staff with the knowledge to address the specific needs and health inequalities faced by the AFC, with over 250 staff trained to date. University Hospitals Tees also hosted the Career Transition Partnership, supporting service personnel leaving the forces on medical grounds and highlighting employment opportunities and the organisation's commitment through the Employer Recognition Scheme.

## Workforce health

Action to improve staff wellbeing is important for reducing health inequalities since staff are part of our local communities and may be facing health inequalities themselves, a healthier workforce is able to provide better care for patients and there can be additional health benefits for staff member's families and friends. Every year the trust health and wellbeing team undertake a staff health needs assessment to understand the health and wellbeing needs of different staff groups from across the trust. Findings from the 2025 needs assessment informed the following wellbeing initiatives:

- **Blood Pressure checks**, offering 30 minute appointments focused on blood pressure monitoring alongside personalised lifestyle advice.
- **Complementary therapies** including Sahaja Yoga Meditation and Pilates
- **Liver Checks**, offering staff access to liver fibroscan assessments. As a result of the high level of engagement and identification of fatty liver disease staff requiring specialist follow up, a monthly fibroscan clinic has now been established.
- **Menopause clinic** - the trust has now established a dedicated Menopause Clinic for staff. While the clinic nurses do not prescribe medication, they provide comprehensive advice and guidance, which can be shared with the staff member's GP and/or line manager, as appropriate, to support ongoing care and workplace adjustments.
- **Health Passport** - the trust has piloted a Health Passport across several departments. The passport includes a dedicated section outlining how an individual's condition may affect them when they are experiencing periods of both good and poor health as well as information that may not fall under a formally recognised disability or health condition. For example, caring responsibilities, or other factors that could impact an individual's working arrangements. Plans are now underway to pilot the Health Passport at departmental level, with the intention of supporting wider adoption across the trust.

To support the monitoring and analysis of workforce wellbeing a staff Health and Wellbeing Dashboard has been developed. The dashboard integrates three distinct data sources: Health Needs Assessment survey data, National Staff Survey data and Electronic Staff Record (ESR) workforce data.

The data available within the dashboard includes key demographic characteristics such as ethnicity, sex, and age, alongside health and lifestyle indicators including physical activity, sleep, and alcohol consumption. The dashboard allows for detailed analysis by variables such as job role, age group, and department, as well as enabling comparisons with organisational averages across the trust.

Postcode data from the 2025 Health Needs Assessment survey will also be incorporated. This enhancement is expected to support more targeted, preventative health and wellbeing initiatives and further inform the trust's approach to improving staff health outcomes.

## Public Health in Maternity

Smoking in Pregnancy Service continues to deliver intensive, personalised support to pregnant smokers, using a flexible and patient-centred model aimed at helping families move towards smokefree homes. The service offers; high intensity behavioural support offered through home visits, telephone reviews, and clinic-based appointments to ensure women can access help in a way that works for them. Nicotine Replacement Therapy (NRT) is provided flexibly, with combination products supplied once a woman expresses readiness to quit. Vaping is used as a harm reduction pathway. A financial incentive programme provides up to £400 per pregnancy, contingent on continued engagement and carbon monoxide (CO) validation throughout pregnancy and into the postnatal period. A new “significant other” incentive scheme will launch shortly, offering £100 to a partner, family member who quits smoking alongside the pregnant woman to support a smokefree household. During 2025/26, 317 referrals were received by the team with 122 women accepting support and 42 babies been born into newly smokefree homes, reducing the long term risk of respiratory illness, SIDS, and chronic health conditions.

Vaccination work continues to address preventable illness in pregnancy, particularly in high risk and deprived communities’ vaccination uptake is strong, demonstrating successful engagement with antenatal patients regarding newer immunisation programmes. Flu vaccination uptake remains low among both pregnant women and maternity staff, representing an ongoing challenge and a recognised priority for improvement. The maternity public health team successfully delivered outreach vaccination clinics in Family Hubs, targeting women in the most deprived areas with flexible, accessible vaccination opportunities.

The maternity unit provides onsite postnatal contraception, including coils (IUD/IUS) and implants, enabling women to leave hospital with reliable contraception in place. This reduces inequalities by eliminating dependence on community sexual health waiting lists, which can be lengthy and disproportionately disadvantage women in deprived communities.

Healthy Lifestyle clinics support pregnant women with a BMI >40, addressing health inequalities by improving access to specialist weight management advice during pregnancy. South Tees is currently the only Trust in the region providing a structured, pregnancy specific weight management service. Women attend a series of appointments with a midwife–dietitian team, focusing on safe weight gain, nutrition, physical activity, and personalised support. The service is undergoing formal evaluation with Newcastle University, exploring patient experiences, outcomes, and long term impact to inform future commissioning.

Following an in-depth poverty proofing review of the maternity pathway, several changes have been embedded to reduce financial barriers for women. Free scan photos are now provided to remove the cost burden for families, particularly those attending multiple scans. Digital access support is available for women unable to access BadgerNet maternity records due to lack of devices, data, or digital literacy. Staff have received training to recognise indicators of financial hardship, normalise conversations about poverty, and link women to available support services.

## 5. Publishing information on health inequalities

### Board reporting

#### Key line of enquiry 5.1:

How is health inequalities data incorporated into performance reporting at board level, and what has been the impact of this on reducing inequalities?

The trust actively monitors health inequalities information including using the Core20PLUS5 approach to ensure patients belonging to different age, gender, deprivation and ethnic groups have fair access to trust health services.

The board receives an Integrated Performance Report, produced monthly, which provides headline metrics aligned to the NHS Oversight Framework, CQC domains and local operational plans with trends and commentary. It includes measures of patient safety, clinical effectiveness, performance and access across emergency care, cancer and planned care (including analysis to highlight potential inequalities), workforce key performance indicators and our financial position.

Underpinning the metrics summarised to the board is information made available to the relevant committees, groups and services. The trust suite of interactive online reports has grown again this year, becoming more sophisticated and real-time, further supporting organisational leaders to make informed decisions that support high quality patient care.

### Action plan development and monitoring

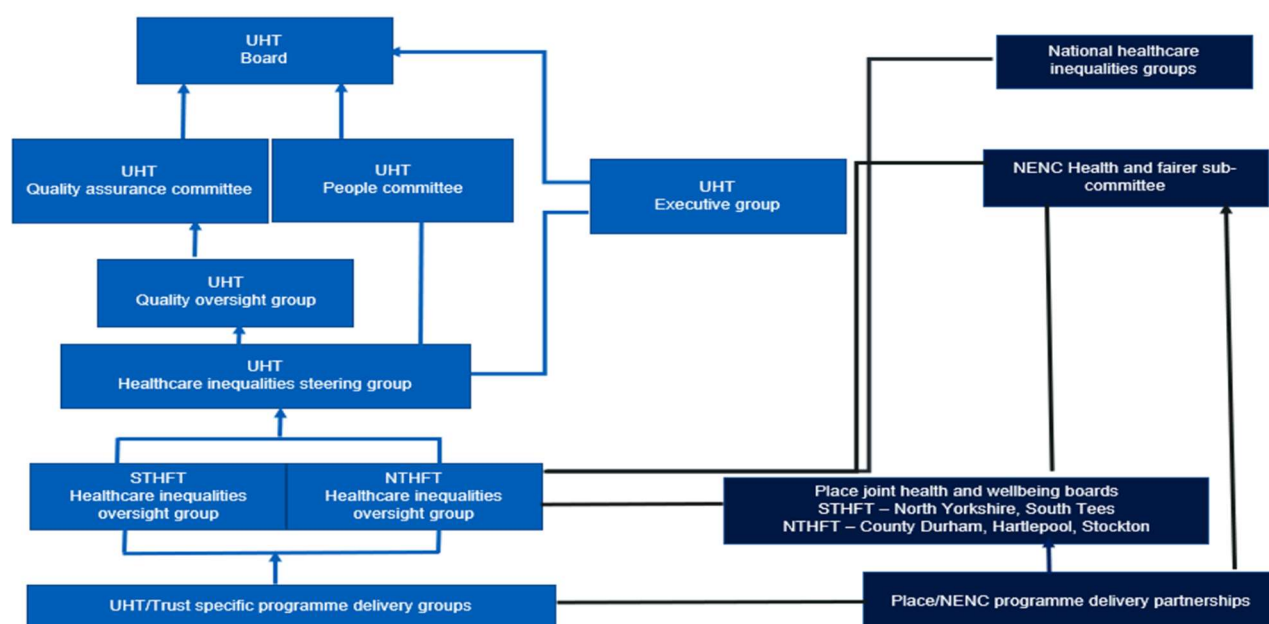
#### Key line of enquiry 5.2:

How have action plans to reduce inequalities in access and quality of care been developed and monitored across services and pathways?

At Trust level, a bi-annual implementation report to the North East and North Cumbria (NENC) integrated care board (ICB) commissioners is provided in fulfilment of the provider contractual obligations for the health inequalities activity plan. The trust also produces a population health and health inequalities annual report. Following the formation of University Hospitals Tees, health there is shared governance and leadership arrangement, to monitor implementation our University Hospitals Tees (UHT) strategy for 'improving population health and reducing healthcare inequalities' where bi-annual assurance reports are presented to the quality assurance committee on progress of implementation of the strategy.

The UHT healthcare inequalities group, chaired by the chief medical officer aims to align our response across both trusts. At place, oversight for trust action is led through the multi-agency healthcare inequalities oversight group (HIOG). As part of the group development, we will re-visit the board assurance framework (BAF) to ensure that the board is sighted on any anticipated risks to delivery of our mandate.

## Appendix 2: Governance arrangements - Statutory and mandated board assurance process



Below is the minimum dataset that will be reported through our organisations internal oversight arrangements. All indicators will be analysed to ascertain disparities for health inequalities indices – age, sex, ethnicity, deprivation as appropriate. In depth analysis will be undertaken to ascertain disparities for inclusion health groups.

| Domain                    | Indicator                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Elective recovery         | <ul style="list-style-type: none"> <li>Trend in elective activity vs pre-pandemic baseline levels for under 18s and over 18s – deprivation gap</li> <li>% of patients treated within 18, 52 and 65 weeks</li> </ul>                                                                                                                                                                                                |
| Urgent and emergency care | <ul style="list-style-type: none"> <li>Trend in emergency admissions for under 18s – deprivation gap</li> </ul>                                                                                                                                                                                                                                                                                                    |
| Cardiovascular disease    | <ul style="list-style-type: none"> <li>Trend in stroke rate of non-elective admissions (per 100,000 age-sex standardised) – deprivation gap</li> <li>Trend in myocardial infarction rate of non-elective admissions (per 100,000 age-sex standardised) – deprivation gap</li> </ul>                                                                                                                                |
| Cancer                    | <ul style="list-style-type: none"> <li>Trend in % of cancers diagnosed at stage 1 or 2, case mix adjusted for cancer site, age at diagnosis, deprivation, ethnicity and sex</li> </ul>                                                                                                                                                                                                                             |
| Oral Health               | <ul style="list-style-type: none"> <li>Trend in tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under</li> </ul>                                                                                                                                                                                                                                                 |
| Smoking                   | <ul style="list-style-type: none"> <li>% of eligible adult and maternity inpatients that are referred to the tobacco dependency treatment service</li> <li>% of eligible adult acute inpatients offered support to quit smoking</li> <li>% of eligible pregnant women who are offered support to quit smoking</li> <li>Trend in % of maternity patients who smoke at time of delivery – deprivation gap</li> </ul> |
| Maternity and neonatal    | <ul style="list-style-type: none"> <li>Trend in preterm births under 37 weeks – deprivation and ethnicity gap</li> </ul>                                                                                                                                                                                                                                                                                           |
| Prevention of ill health  | <ul style="list-style-type: none"> <li>Trend in % of people waiting for over 6 weeks for a diagnostic procedure</li> <li>% of patient facing staff to receive a flu vaccination</li> <li>Trend in % of obese patients that are either supported in-house, referred or signposted for community or digital support</li> </ul>                                                                                       |
| Reducing inequality       | <ul style="list-style-type: none"> <li>Trend in % of over 65s attending emergency departments to be admitted</li> </ul>                                                                                                                                                                                                                                                                                            |

|  |                                                                                                                                                                                                                                                                                                                                                                                                         |
|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <ul style="list-style-type: none"> <li>• Trend in % of under 18s attending emergency department to be admitted</li> <li>• Trend in DNAs in outpatient and community services for all patients vs core20 population</li> <li>• % of alcohol addicted patients identified – maternity, inpatients, A&amp;E and urgent care – that are supported and referred to community specialist services)</li> </ul> |
|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## 6. Our main challenges and constraints

We have made significant progress implementing our health inequalities programmes and achieved major successes. However, all the funding streams are fixed term. Therefore, it is difficult to make longer term plans for sustainable improvements in health inequalities. Funding uncertainty also poses a risk for loss of experienced staff, destabilisation of services and potential lost opportunities to develop further cost avoidance, e.g. through the DNA, waiting well and frequent attendance in A&E models.

## 7. Looking ahead – Our priorities for 2026-27

**In 2026-27, our priorities are:**

- Offer a board development session on health inequalities
  - Implementation of the UHT ‘Improving Population Health and Reducing Healthcare Inequalities Strategy’ e.g., Health inequalities ambassadors training to clinical service units (CSUs)
1. Strengthening our Health Inequalities Dashboard and utilising new local analysis (e.g. ethnicity recording by specialty, community services data) or planned national data releases (e.g. updated trust catchment populations) to identify opportunities identify opportunities to increase equity or target interventions
  2. Effective implementation and evaluation of ongoing priority health inequalities work (including securing long-term funding for interventions) – DNA, maternity and A&E - and continued collaboration with organisational partners; and
  3. Utilising “Key Lines of Enquiry” from the NHS Statement on Health Inequalities to prospectively plan data collection/analysis/improvement, local engagement, action on health inequalities and sharing of information for impact. This includes action through the Health Inequalities Oversight Group membership/forward plan, wider governance/partners and other mechanisms and use of national frameworks to maximise local health equity.

## Quality

Quality of care has remained central to the services we provide at South Tees Hospitals NHS Foundation Trust. Throughout 2025/26 we have focussed on building on previous achievements and maximising the opportunities offered by our new organisational structure. Despite operational pressures, the board has continued to maintain strong oversight of all quality matters through the Quality Assurance Committee QAC), a sub-committee of the board chaired by a Non-Executive Director.

Quality metrics are routinely monitored via the Integrated Performance Review (IPR) dashboard. These metrics are reviewed as part of the organisations Accountability and Governance Frameworks, supporting shared ownership, effective challenge and continuous improvement.

### Quality Objectives

In 2025 the organisation agreed nine quality priorities

These were:

| Patient Safety                                                                                                                                                                                                                                                                                                                                                                                                         | Clinical Effectiveness                                                                                                                                                                                                                                | Patient Experience                                                                                                                                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>**New QP 25/26**</b><br/>We will reduce the risk of acquiring healthcare associated infections in line with NHS England standard contract objectives such as Clostridioides Difficile, Metcillin Resistant Staphylococcus Aureus, Gram-Negative Blood Stream Infections (ECOLI, Klebsiella, and Pseudomonas) alongside other infections to improve outcomes for our patients whilst embedding IPC practices.</p> | <p><b>**Carried forward from 24/25**</b><br/>We will ensure continuous learning and improved patient outcomes following implementation of best clinical practice, using data from clinical audits of compliance against evidence-based standards.</p> | <p><b>**Carried forward from 24/25**</b><br/>We will develop and implement a Group Mental Health Strategy to improve care and share learning for our patients who are experiencing difficulties with their mental ill health.</p> |
| <p><b>**Carried forward from 24/25**</b><br/>We will continue to optimise the trust's ability to respond to and learn from incidents, safeguarding concerns, claims and inquests to improve outcomes for our patients and reduce the risk of reoccurrence.</p>                                                                                                                                                         | <p><b>**Carried forward from 24/25**</b><br/>We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes.</p>                                                                | <p><b>**Carried forward from 24/25**</b><br/>We will proactively seek patient feedback and ensure there is continuous improvement in care and treatment because of the feedback we receive</p>                                    |
| <p><b>**Carried forward from 24/25**</b><br/>We will improve medication safety and continue to optimise the benefits of ePMA and evaluate the impact on learning from medication incidents</p>                                                                                                                                                                                                                         | <p><b>**Carried forward from 24/25**</b><br/>We will develop and implement shared decision making and goals of care.</p>                                                                                                                              | <p><b>**Carried forward from 24/25**</b><br/>We will respond in a timely way to complaints, supporting patients and families through difficult circumstances and implement quality improvements as a result of the learning.</p>  |

Progress against these priorities is monitored through the Quality Assurance Committee. Further detail on how these have progressed over the year is outlined in our Quality Report.

## Finance

Each year the trust develops a financial plan which includes a cost improvement target to be achieved, a capital plan and a forecast outturn for the year end.

The 2025/26 period saw considerable investment in the South Tees Hospitals NHS Foundation Trust estate.

At James Cook, a further phase to complete waiting areas and reception associated with the new urgent treatment centre was completed, there was a major investment in the purchase and installation of a new CT machine within the cardiology department and Ward 5 was subject to a programme of remodelling and full refurbishment.

A significant programme of work was completed at Redcar Primary Care Hospital bringing the installation of additional CT and MRI diagnostic equipment to its new community diagnostic hub.

Extensive works have been completed on the £35.5million Friarage Surgical Centre which is now close to handover and is on target to be open to patients in June 2025.

Following our success in securing £18.95million of SALIX funding, detailed pre-start planning is in progress in connection with major carbon saving plant upgrades at James Cook and Friarage hospitals and installation of new enhanced glazing to improve thermal efficiency at the Friarage. The works are making significant progress towards our net zero carbon target.

Budgets are set in line with NHS planning guidance and the funding allocations assumed in the financial plan submissions. To align budgets to current operational delivery and expenditure levels, each Clinical Service Unit and Corporate Directorate have a budgetary 'control total', based on current expenditure run rates, inflation and efficiency requirements. This supports continuing focus on expenditure run-rate reductions and productivity. Budget control totals are affordable within the Trust's overall resource limit, as part of the plan to deliver break-even across the UHT Group.

A 5% CIP requirement will be allocated to the budget control total for all CSU's/Corporate Directorates, in line with the targets issued as part of the planning process for 2026/27. Each CSU leadership team and corporate director is required to review and formal sign-off their respective budget.

## Subsidiary undertakings

The Trust created a Limited Liability Partnership (LLP) in May 2016 to act a body through which research funds could be managed. The LLP is called South Tees Institute of Learning, Research and Innovation LLP. In 2022 the Trust also formed the Tees Valley Pathology Services LLP and the Tees Valley Laboratory Services LLP with North Tees and Hartlepool NHS Foundation Trust. The 3 LLP's all have a financial year end of 31 March in line with the Trusts, they were all dormant in 2025/26 and will not be consolidated as part of the Trust Group for the financial year to 31 March 2026.

Limited Liability Partnerships must always have two members (partners). To ensure compliance with this requirement, South Tees Hospitals NHS Foundation Trust also created a Limited Liability Company in May 2016. The LLC is called South Tees Healthcare Management Limited. Together, the Trust and South Tees Healthcare Management Limited are the members (partners) of South Tees Institute of Learning, Research and Innovation LLP. When setting up this arrangement in 2016, the Trust intended for South Tees Healthcare Management Limited to remain dormant and act as one of the members (partners) of South Tees Institute of Learning, Research and Innovation LLP. The Tees Valley Pathology Services LLP and the Tees Valley Laboratory Services LLP are jointly controlled by the Trust and North Tees and Hartlepool NHS Foundation Trust.

When changes to the provision of the Trust's outpatient pharmacy took place in 2019, South Tees Healthcare Management Limited was chosen to enable outpatient pharmacy services to be placed back under the control of the Trust as a wholly owned subsidiary. The operations of this company were consolidated and are reported in the Group position at 31 March 2026.

## 2. Accountability report

### Director's report

#### **The Board of Directors – role and responsibility**

The Board of Directors ('the board') functions according to corporate governance best practice and compliance with the standards and regulations set by the two main regulatory bodies, the Care Quality Commission (CQC) and NHS England (NHSE).

The board operates as a unitary board with collective accountability for all aspects of trust performance, from clinical quality to financial performance and sustainability. It ensures the trust has adequate systems and processes in place, necessary resources to meet its objectives, robust risk management and there is an effective workforce to be able to deliver the highest quality care for its patients. In addition, the board is responsible for establishing the vision and strategy of the trust, ensuring harmony with wider system plans and objectives.

Following changes to health legislation in 2022 through the Health and Care Act, organisations were able to work closer together across a broader geographical boundary and in making decisions, boards should meet the requirements of the 'Triple Aim':

- Better health and wellbeing for everyone
- Better quality of health services for all
- A sustainable use of NHS resources

The board is led by the Chair, Professor Derek Bell who was appointed in September 2021 and re-appointed in September 2024 as Chair, across both North Tees and Hartlepool NHS Foundation Trust (North Tees and Hartlepool) and South Tees Hospitals NHS Foundation Trust (the trust), operating under group arrangements

The Board of Directors is responsible for exercising all of the powers of the trust, however, the board has the option to delegate these powers to members of the Executive Team, and other committees. The board has several committees, which support the seeking of assurance in relation to quality, performance and risk management throughout the trust.

These committees are: Audit and Risk Committee, chaired by Kenneth Readshaw; Quality Assurance Committee chaired by Fay Scullion; Resources Committee, chaired by David Redpath (to January 2026) and Celia Weldon (from February 2026); People Committee, chaired by Mark Dias, Academic Committee, chaired by Professor Chris Day and Remuneration Committee, chaired by the Chair, Professor Derek Bell.

The trust has a Scheme of Delegation which outlines when approval for a decision is required from the board or one of its committees, such as for a high-value business case, and decisions which the Executive Team are permitted to make without further approval. The Board of Directors is jointly responsible for scrutinising and constructively challenging the performance of the trust to ensure we deliver our strategy, continuously improve and deliver high quality care.

Each of the board committees undertakes a performance evaluation on an annual basis using a standard template, excluding the Audit and Risk Committee. The output of the evaluation is reported to the individual committee and collectively to the Audit and Risk Committee, to ensure the Committees remain effective and fit for purpose.

In April 2024, the University Hospitals Tees (UHT) Group with North Tees and Hartlepool was established along with a Group Board, to realise the strategic intent of both organisations to secure the future of high quality, safe and sustainable healthcare across the population of the Tees Valley and North Yorkshire.

A Partnership Agreement between both trusts, NHSE and North East and North Cumbria Integrated Care Board (NENC ICB) was officially signed in February 2024 and provided the basis of both trusts being able to operate as a group model, which remains in place today. In addition, terms of reference were drafted setting out the functions that could be jointly exercised by the group board of UHT, those that could be delegated and those that must remain at unitary board level. The terms of reference are in accordance with the guidance Arrangements for Delegation and Joint Exercise of Statutory Functions – Schedule F, which was published by NHSE in February 2024.

The Non-Executive Directors of each trust, the Chair and members of the Executive Team both voting and non-voting were appointed into group roles during 2024. As the UHT group model has matured, reference to 'group board' has ceased and replaced with the Board of Directors or UHT Board.

The UHT board sets the strategic direction for the organisation and monitors performance against strategic objectives to ensure high quality services for our patients and population we serve in conjunction with key stakeholders and partners. The UHT Strategy: Caring Better Together was approved in May 2025 setting the direction for our services for the next 5-10 years, with six key strategic objectives and a number of enabling strategies to support delivery.

Following the establishment of the UHT board, the majority of the key committees were constituted as group committees to collectively scrutinise performance and gain assurance across both trusts, with the exception of the Audit Committee and Remuneration Committee, as it is a statutory requirement for each trust to have singular Audit and Remuneration Committees, however, during 2025-26 an increasing number of meetings were held 'in common'. It is proposed during 2026-27 to appoint a single chair for the Audit Committees of both trusts.

### **Board of Directors composition**

The UHT board comprises seven voting Executive Directors, including the Chief Executive and eleven Non-Executive Directors inclusive of the Chair. A review of the size of the board and the balance of skills and experience has regularly been undertaken as part of succession planning arrangements to ensure the statutory requirements and duties of the organisation are adequately being met.

Board members undergo an annual appraisal assessing their contribution aligned to the core values of the trust. The Chief Executive leads the annual evaluation of each Executive Director and the results are summarised and reported to the Non-Executive Directors at the Remuneration Committee. The Executive Directors are appointed by the Remuneration Committee on behalf of the Board of Directors.

The Chair and Non-Executive Directors are appointed for terms of office up to three years and may seek reappointment in line with the provisions set out in the NHS Foundation Trust Code of Governance (the Code). The appointment and re-appointment processes are led by the Nominations Committee on behalf of the Council of Governors. All the Non-Executive Directors are considered to be independent both in character and in judgement. Any proposal for a Non-Executive Director to serve longer than six years is subject to rigorous and robust review and approval by NHSE in line with the recommendations outlined in the code.

The composition of the UHT Board is set out below, including details of background, committee membership and attendance. The performance of the board as a whole is reviewed on an annual basis by undertaking an effectiveness self-assessment of the Board of Directors, subsidiary boards and board committees.

### **Board of Directors meetings**

There were eleven board meetings held during 2025/26, the majority comprising a public and private agenda including separate items to be considered by the unitary board of the trust as required. The majority of board business continues to be conducted in public, although there is a requirement for a small element to be conducted in private due to the confidential nature of the matters being discussed and during the year a number of extra ordinary meetings held in private were convened for urgent items of business.

### **Board of Directors' profiles**

#### **Professor Derek Bell OBE**

##### **Chair**



Derek has over 40 years' experience in the NHS and previously served as president of the Royal College of Physicians of Edinburgh. He was awarded an OBE in 2018 for services to unscheduled care and quality improvement.

- Appointed 1 September 2021
- Reappointed 1 September 2024

## Ann Baxter

### Vice Chair / Non-Executive Director

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Ann trained as a social worker and worked in local government for 45 years. Throughout her career, she worked in various teams in London, Devon, Cumbria and North Yorkshire. She joined Stockton Borough Council in 1996 and was the director of services for adults and children until 2008, when she became director in the London Borough of Camden.

Since retiring from a full-time role, she has worked as a regional advisor for the Local Government Association across the North East, Yorkshire and Humberside, advised on national reviews and chaired the Teesside and Darlington Safeguarding Adults Board. Ann currently is a Governor at a large comprehensive school.

She is the Board Maternity Champion

- Appointed 1 July 2019
- Appointed Vice Chair 1 April 2023
- Appointed Group Vice Chair 1 April 2024
- Re-appointed Group Vice Chair 1 April 2025
- Stood down 31 March 2026

## Ali Wilson

### Vice Chair / Non-Executive Director

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Ali has a long history of public service, having begun her NHS career as a nurse in the early 1980s. She has held a variety of clinical, managerial and academic positions, leading and evaluating service improvement, major service and organisational change. Before her retirement from a full-time senior leadership role in 2018, Ali was the chief executive officer for NHS Darlington and NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Groups and chair of the North East Leadership Academy.

Ali is passionate about leadership development and system working and committed to the delivery of high quality, personalised and effective care both within a hospital and community environment. She has a long-standing interest in harnessing the potential of patient, carer and public involvement, having undertaken a Fulbright Fellowship at the Institute of Public Affairs, University of Minnesota in 2001, which focused on patient and public engagement in the co-design of services.

She is the board Health and Wellbeing Champion

- Appointed 19 July 2022
- Appointed Vice Chair 1 June 2023
- Appointed Group Vice Chair 1 April 2024
- Re-appointed Group Vice Chair 1 April 2025
- Re-appointed 1 September 2025

## Ada Burns

### Non-Executive Director / Senior Independent Director

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Ada had a lengthy career in local government, in regeneration roles in London Councils, and until 2018 as chief executive of Darlington Borough Council. In this role, she worked across the Tees Valley with a particular interest in health inequalities. Ada was most recently chair of Teesside University, and a trustee of a community arts centre.

- Appointed 1 October 2019
- Reappointed 23 March 2023
- Appointed Group Non-Executive Director 5 April 2024
- Stood down 30 September 2025

## Chris Macklin

### Non-Executive Director / Senior Independent Director

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Chris has worked within finance in the NHS since 1975. He commenced his first director of finance role at the Queen Elizabeth Hospital in Gateshead in 1997. Chris has a wealth of experience working within a provider setting, and within the commissioning side of the NHS, holding the role of Director of Finance for Sunderland, Gateshead and South Tyneside. After retiring as a DoF in 2015, he was encouraged to remain in the NHS, taking up his first non-executive director post in 2015. Throughout his career as a DoF and a Non-Executive Director, Chris has sat on and chaired a number of national committees relating to NHS Accounting Standards and Governance / Audit.

- Appointed 1 January 2023
- Appointed Group Non-Executive Director 5 April 2024
- Stood down 30 April 2025

## David Redpath

### Non-executive Director

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With roots firmly in the North East, David has enjoyed over 20 years in technology leadership and advisory roles around the world. His most recent role as a senior executive partner at research and advisory company Gartner sees him act as strategic advisory to multiple public and private companies in the UK. Prior to this David performed several CIO roles in different industries and served as a Non-Executive Director at Newcastle Building Society and the Nation Union of Students.

He was chair of the Resources Committee until 31 January 2026

- Appointed 3 December 2020
- Appointed 1 August 2021
- Re-appointed 1 August 2024
- Appointed Group Non-Executive Director 5 April 2024

## Miriam Davidson

### Non-executive Director

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While Miriam is proud of her Australian heritage, she has lived and worked happily in the North East for over 35 years. Throughout her career in the NHS (1988 to 2014) and local government (2014 to 2020), she has held senior roles in health improvement and public health. Miriam is a registered specialist in public health and during her post as director of Public Health for Darlington, she was also vice chair of the north east branch of the Association of Directors of Public Health. More recently, Miriam has supported the North East Public Health Specialty Training Programme (HEE), as head of School of Public Health.

Miriam continues to coach, mentor and appraise specialists in public health. Her focus is on health inequalities and the challenge of why health appears to be for some, not all.

She is the Board Maternity Champion.

- Appointed 19 July 2022
- Appointed Group Non-Executive Director 5 April 2024
- Re-appointed 1 September 2025

## Mark Dias

### Non-executive Director

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Mark is a fellow of the Chartered Institute of Personnel and Development (CIPD) and an experienced human resource professional having worked at a senior level in a number of multi-national organisations. Mark's previous roles included EMEA employee relations director for Cummins, HR director for DS Smith and HR business partner at Nuffield Hospitals. A former serving police officer at Cleveland Police and commended for standing up for equality and integrity in policing. He is a self-employed consultant providing HR consultancy and mediation services to a range of clients.

He is chair of People Committee

- Appointed 19 July 2022
- Appointed Group Non-Executive Director 5 April 2024
- Re-appointed 1 September 2025

## Fay Scullion

### Non-Executive Director

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Fay is a registered nurse by background and has worked in a variety of settings across the North East in a range of senior posts.

Fay has an interest in the disease profile of the North East became involved in the care of cancer patients in general settings. She moved into the voluntary sector and worked in various regional and national development roles, latterly as director of partnerships for Macmillan Cancer Support. This work across the UK involved transforming cancer services with a range of partners, from local organisations, the NHS to National Governments. Since retiring from full time employment, Fay also works as a volunteer governor in a secondary school trust.

She was the board Freedom to Speak Up Champion up to 30 September 2025 and is chair of the Quality Assurance Committee.

- Appointed 1 January 2023
- Appointed Group Non-Executive Director 5 April 2024
- Re-appointed 1 January 2026

## Ken Readshaw

### Non-Executive Director / Senior Independent Director

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Ken is a chartered accountant with considerable experience of the chemical and power generation sectors, both in the UK and abroad. He was previously audit chair of NHS North Yorkshire Clinical Commissioning Group, has several charitable roles, and is passionate about helping to provide communities with the best possible public services.

He is chair of the Audit and Risk Committee (South Tees) and was appointed Senior Independent Director with effect 1 October 2025.

- Appointed 19 July 2022
- Appointed Group Non-Executive Director 5 April 2024
- Re-appointed 1 September 2025

## Alison Fellows

### Non-Executive Director

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Alison grew up on Teesside. After qualifying as a solicitor, she was a partner in a Newcastle law firm, working on commercial projects, including the procurement and construction of new hospitals. Alison then moved into the public sector and worked in regeneration at both Newcastle and Sunderland Councils, before becoming the Group Commercial Director of Tees Valley Combined Authority. At TVCA she held responsibility for a wide range of investment projects across the region. Alison also held a role as Commercial Director of Teesside Airport.

She is chair of the Audit Committee and was appointed Freedom to Speak Up Guardian with effect 1 October 2025

- Appointed 1 February 2023
- Appointed Group Non-Executive Director 5 April 2024
- Re-appointed 1 February 2026
- Stood down 31 March 2026

## Liz Barnes

### Non-Executive Director

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Liz has spent her career in higher education, working in four universities. She commenced at Teesside University where she was a lecturer in physiology. She also spent a number of years as Deputy Dean of Health and Social Care before becoming Dean of Social Sciences and Law. Liz finished her education career as Vice Chancellor of Staffordshire University. She has served as a trustee and Non-Executive Director with a number of organisations including schools, universities, a housing association, a private training provider. She most recently chaired a charity protecting children and their families from sexual exploitation.

- Appointed 1 February 2023
- Appointed Group Non-Executive Director 5 April 2024
- Stood down 30 June 2025

## Professor Chris Day

### Non-executive Director

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Chris has been vice-chancellor and president of Newcastle University since January 2017. A former consultant hepatologist, he has an international reputation in medical research and was awarded a CBE for Services to Health Research and Treatment in the 2023 New Year Honours.

He is currently board member of the Russell Group and a former president of the Association of Physicians of Great Britain and Ireland. Chris is also a Deputy Lieutenant of Tyne and Wear, reflecting his contributions to higher education and research.

He is chair of the Academic Committee.

- Appointed 1 July 2025

## Celia Weldon

### Non-executive Director

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Celia has 30 years' experience in senior corporate governance and expertise which has been gained in a variety of corporate roles. She is a fellow of the Corporate Governance Institute (formerly the Institute of Company Secretaries and Administrators) and a fellow of the Institute of Chartered Accountants in England and Wales.

Celia has been an executive and a non-executive board member in a number of organisations, including the roles of senior independent director, chair of audit and risk committee, and chair of finance and performance committee.

She is chair of Resources Committee.

- Appointed 1 February 2026

### Stacey Hunter

#### Chief Executive Officer



Stacey was previously CEO at Salisbury NHS Foundation Trust where she worked from September 2020 to January 2024. Prior to that, she worked for Bradford and Airedale Foundation Trusts, and spent some time seconded to the Nightingale Hospital Yorkshire during the COVID-19 pandemic. Stacey commenced her career in 1990 as a Nurse at Hull Hospitals and Leeds Teaching Hospital.

- Appointed on 1 February 2024

### Michael Stewart

#### Chief Medical Officer



Michael is a consultant cardiologist and was appointed Chief Medical Officer in 2021. Most recently, he served as director of cardiovascular services at Auckland District Health Board. Prior to this Michael worked as a cardiologist at South Tees Hospitals NHS Foundation Trust from 1996 to 2018 where he also held medical leadership roles.

- Appointed Group Chief Medical Officer 11 March 2024

### Emma Nunez

#### Chief Nursing Officer



Emma joined University Hospitals Tees from Harrogate and District NHS Foundation Trust where she was executive director of nursing, midwifery and AHPs and deputy chief executive.

Emma is a registered midwife; she undertook her clinical training in Northumbria in 1998 and spent the majority of career in the North East. She has held senior positions in provider, commissioning and regulatory organisations regionally and nationally with a particular focus on patient safety and quality improvement.

- Appointed Group Chief Nurse 1 April 2025

## Neil Atkinson

### Chief Delivery Officer

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Neil has extensive NHS experience at a senior level across a range of finance functions in provider and commissioning organisations. He joined the trust in 2018 from Leeds Teaching Hospitals.

- Appointed Group Managing Director 5 April 2024

## Rachael Metcalf

### Chief People Officer

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Rachael Metcalf is a Chartered CIPD professional with over 25 years' experience in the field of People Services who joined the Trust in 2004. Rachael has worked at a senior level leading several People functions and services. She became Director of Human Resources in September 2018. Prior to her NHS career Rachael worked in HR at North Yorkshire Police and started her HR career in an investment bank in Azerbaijan.

- Appointed Group Chief People Officer 5 April 2024

## Chris Hand

### Chief Finance Officer

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Chris is a qualified accountant with over 20 years' experience in NHS financial management, including 13 years at Northumbria Healthcare NHS Foundation Trust. Chris also served as the executive director of finance at Northumberland County Council. He was appointed as the Director of Finance in March 2021.

- Appointed Group Chief Finance Officer 5 April 2024

## Matt Neligan

**Deputy Chief Executive / Chief Strategy Officer**

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Matt joined University Hospitals Tees in 2024 from his role as director of commissioning development for NHS England where he had led national work to develop Integrated Care Systems. He has worked for nearly 30 years in the NHS with experience across acute hospitals, commissioning, primary care and national programmes.

- Appointed 14 October 2024

## Attendance at Board meetings 2024/25

| Non-executive Directors |                                                                                  | Total number attended | % attendance |
|-------------------------|----------------------------------------------------------------------------------|-----------------------|--------------|
| Professor Derek Bell    | Chair                                                                            | 8/11                  | 73           |
| Ali Wilson              | Non-Executive Director / Vice Chair                                              | 11/11                 | 100          |
| Ann Baxter              | Non-Executive Director / Vice Chair                                              | 10/11                 | 91           |
| Ada Burns               | Non-Executive Director / Senior Independent Director<br>(left 30 September 2025) | 1/3                   | 33           |
| Professor Chris Day     | Non-Executive Director<br>(appointed 1 July 2025)                                | 4/10                  | 40           |
| David Redpath           | Non-Executive Director                                                           | 9/11                  | 82           |
| Miriam Davidson         | Non-Executive Director                                                           | 11/11                 | 100          |
| Mark Dias               | Non-Executive Director                                                           | 10/11                 | 91           |
| Fay Scullion            | Non-Executive Director                                                           | 11/11                 | 100          |
| Ken Readshaw            | Non-Executive Director / Senior Independent Director                             | 9/11                  | 82           |
| Alison Fellows          | Non-Executive Director                                                           | 7/11                  | 64           |
| Elizabeth Barnes        | Non-Executive Director<br>(left 30 June 2025)                                    | 1/1                   | 100          |
| Celia Weldon            | Non-Executive Director<br>(appointed 1 Feb 2025)                                 | 4/4                   | 100          |
| Executive Directors     |                                                                                  |                       |              |
| Stacey Hunter           | Chief Executive                                                                  | 11/11                 | 100          |
| Dr Michael Stewart      | Chief Medical Officer                                                            | 10/11                 | 91           |
| Neil Atkinson           | Chief Delivery Officer                                                           | 9/11                  | 82           |
| Rachael Metcalf         | Chief People Officer                                                             | 10/11                 | 91           |
| Emma Nunez              | Chief Nursing Officer                                                            | 10/11                 | 91           |
| Chris Hand              | Chief Finance Officer                                                            | 10/11                 | 91           |
| Matt Neligan            | Deputy Chief Executive/Chief Strategy Officer                                    | 11/11                 | 100          |

\*attended the unitary board meetings of both trusts, in addition to group board

## Declaration of Interests of the Board of Directors

An annual review of the Board of Director's Register of Interests takes place alongside the annual review of the Fit and Proper Person Test requirements. In addition, at every key meeting of the trust including Board of Directors, Council of Governors and Board Committees, there is a standing agenda item, which requires members to declare any conflicts of interest in relation to agenda items or any changes to their registered interests, which is noted in the minutes of the meeting. The Register of Board interests is available for public inspection via the board papers on the trust's website.

## Better Payment Practice Code

Unless other terms are agreed, we are required to pay our creditors within 30 days of the receipt of goods or a valid invoice, whichever is later. This is to ensure that we comply with the Better Payment Practice Code. The trust's performance against this metric is shown as follows:

| Non NHS                 | NHS                     |
|-------------------------|-------------------------|
| Target: 95%             | Target: 95%             |
| Result by number: 97.9% | Result by number: 91.8% |
| Result by value: 94.7%  | Result by value: 95.6%  |

A detailed breakdown of the figures is shown below:

|                                                 | 2025/26 |         | 2024/25 |         |
|-------------------------------------------------|---------|---------|---------|---------|
|                                                 | Number  | £000    | Number  | £000    |
| Total non-NHS trade invoices paid in the year   | 102,864 | 621,077 | 104,950 | 603,222 |
| Total non-NHS trade invoices paid within target | 100,738 | 588,315 | 101,959 | 591,699 |
| % of non-NHS trade invoices paid within target  | 97.9%   | 94.7%   | 97.2%   | 96.4%   |
| Total NHS trade invoices paid in the year       | 2,919   | 104,498 | 2,944   | 76,925  |
| Total NHS trade invoices paid within target     | 2,681   | 99,916  | 2,707   | 71,494  |
| % of NHS trade invoices paid within target      | 91.8%   | 95.6%   | 92.0%   | 92.9%   |

No interest was paid under the Late Payment of Commercial Debts (Interest) Act 1998 in 2025/26.

## Income disclosures

In 2025/26, the trust met the requirement that income from the provision of goods and services for the purposes of the Health Service in England must be greater than its income from the provision of goods and services for any other purposes as defined under section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

All net income from the provision of goods and services for other purposes has been re-invested back into frontline healthcare for the benefit of patients.

## Statutory statement required within the Directors' Report

South Tees Hospitals NHS Foundation Trust has complied with the cost allocation and charging requirements set out in the HM Treasury and Office of Public Sector Information guidance.

A statement describing adoption of the Better Practice Code is included within the Annual Report. Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that income from the provision of goods and services for the purposes of the health service in England must be greater than its income for the provision of goods and services for any other purpose. The trust can confirm it has met these requirements. Note 3 to the accounts confirm that the trust does not have income from fees and charges where the full cost exceeds £1million.

All Directors of the trust have undertaken to abide by the provisions of the Code of Conduct for Board level Directors; this includes ensuring that, at the time that this Annual Report is approved:

- So far as each director is aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware; and
- Each director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.
- The provisions of the Code of Conduct also require each director to confirm, they have undertaken all the steps that they ought to have taken as a director in order to do the things mentioned above and:
- Made such enquiries of their fellow directors and of the company's auditors for that purpose; and
- Taken such other steps (if any) for that purpose, as are required by their duty as a director of the company to exercise reasonable care, skill and diligence.

## Foundation trust membership

The trust's membership was established following our authorisation as a foundation trust on 1 May 2009. Since that time, we have continued to engage with our members and the wider public to ensure that the views of local people and those across the wider populations that we serve are represented and help us to shape our services for the future.

We communicate with our members regularly through a variety of channels to keep them updated about our news and other developments, through social media, the trust website and our member's bulletin.

The membership consists of core public members across a variety of constituent areas, non-core public members and staff members. Public members must be at least 16 years of age and live within one of the constituencies:

- Middlesbrough
- Redcar and Cleveland
- Hambleton and Richmondshire
- Out of Trust Area / Rest of England (this is any other area outside of the core constituent areas within England)
- Patient / Carer

Staff members are any individuals who have been employed by the trust or subsidiary organisation for 12 months or more. When joining the trust, staff automatically become members unless they choose to opt out.

As of 31 March 2026, the trust had 12,326 members, comprising 1,379 public members, 164 patient members and 10,783 staff members. During the autumn round of elections, we undertook a data cleansing exercise to invite members to confirm how they wished to be communicated with going forward to reduce postal costs where possible and ensure the membership remained engaged and active.

The tables below provide details of the Trust's membership

| Constituency                | Number of members | Members as at 31 March 2026 |
|-----------------------------|-------------------|-----------------------------|
| Middlesbrough               | 369               | 1,146                       |
| Redcar and Cleveland        | 338               | 1,049                       |
| Hambleton and Richmondshire | 323               | 962                         |
| Patient                     | 349               | 345                         |
| Rest of England/Out of Area | 164               | 497                         |
| <b>Total</b>                | <b>1,543</b>      | <b>3,999</b>                |

Further information about the Trust membership can be found on our website:

<https://www.southtees.nhs.uk/about/membership/> or by emailing: [stees.foundation.trust@nhs.net](mailto:stees.foundation.trust@nhs.net)

## Council of Governors

The Council of Governors directly represents the interests of members, staff, and the wider population to ensure the needs of the population are met. The Council of Governors forms an integral part of our governance structure and supports the development of forward plans and services.

The Council of Governors has a number of statutory duties, which include:

- Appointment and removal of the Chairman and other Non-Executive Directors
- Approving the appointment of the Chief Executive
- Deciding the remuneration of the Chairman and Non-Executive Directors
- Appointment and removal of the trust's External Auditors
- Receiving the trust's Annual Report and Accounts
- Hold the Non-Executive Directors collectively to account for the performance of the board
- Approving amendments to the trust's constitution
- Approval of significant transactions
- Approval of any application for merger, acquisition, separation or dissolution.

The Council of Governors comprises 34 governors who represent the trusts' public, patient and staff constituencies and those stakeholder organisations who nominate individuals to become appointed governors.

The table below provides details of the trust's Council of Governors.

|                                              |                                                     |
|----------------------------------------------|-----------------------------------------------------|
| 5 Public Governors from Middlesbrough        | 5 Public Governors from Hambleton and Richmondshire |
| 5 Public Governors from Redcar and Cleveland | 2 Patient/Carer                                     |
| 1 Rest of England                            | 10 Appointed Governors                              |
| 6 Staff Governors                            |                                                     |

We have continued to engage with our partnership organisations and stakeholders, including local authorities, universities, Healthwatch and wider system partners as we deliver our strategic ambitions for the Tees Valley and North Yorkshire through the UHT Strategy: Caring Better Together to ensure we are delivering the best care and services to our population in the right place at the right time.

The Health and Care Act 2022 removed legal barriers for organisations to work closer together in partnership across a wider geographical footprint. To support this, the duties of Council of Governors were expanded to represent not only the interests of the trust's members but also the wider public and to support joint working between organisations.

To facilitate greater joint working and engagement between the Council of Governors of the trust and North Tees and Hartlepool, meetings of the Council of Governors during 2025/26 have been held 'in common', although each trust continues to remain as an individual statutory organisation with its own Constitution.

During 2025/26 details were published by the Centre regarding proposed changes to the structure of foundation trusts and the role of Governors as part of the 10 Year Health Plan for England. Final details including timescales are still awaited.

There were a number of changes to the Council of Governors during 2025/26, including elections that were held. Details of the changes that occurred are described in the following table:

| Governor                        | Constituency  | Term of office | Number of terms | Term due to end/ended | Council of Governor meeting Attendance |
|---------------------------------|---------------|----------------|-----------------|-----------------------|----------------------------------------|
| <b>Public elected governors</b> |               |                |                 |                       |                                        |
| Rebecca Hodgson                 | Middlesbrough | 3 years        | 3               | November 2025         | 0/2 0%                                 |
| Jean Milburn                    | Middlesbrough | 3 years        | 2               | November 2026         | 4/4 100%                               |
| Yvonne Bytheway                 | Middlesbrough | 3 years        | 3               | November 2028         | 4/4 100%                               |

|                                |                             |         |   |                                     |          |
|--------------------------------|-----------------------------|---------|---|-------------------------------------|----------|
| David Charlesworth             | Middlesbrough               | 3 years | 1 | November 2026                       | 1/4 25%  |
| Rachel Booth-Gardiner          | Middlesbrough               | 3 years | 1 | November 2025<br>(did not re-stand) | 2/2 100% |
| Bob Pitt                       | Middlesbrough               | 3 years | 1 | November 2028                       | 1/1 100% |
| Chris Pitcairn                 | Middlesbrough               | 3 years | 1 | November 2028                       | 1/1 100% |
| Zahida Mian                    | Redcar and Cleveland        | 3 years | 2 | November 2027                       | 4/4 100% |
| Robert Norton                  | Redcar and Cleveland        | 3 years | 1 | November 2027                       | 4/4 100% |
| Brian White                    | Redcar and Cleveland        | 3 years | 2 | November 2025<br>(did not re-stand) | 1/2 50%  |
| Brendan Smith                  | Redcar and Cleveland        | 3 years | 1 | November 2026                       | 4/4 100% |
| Lesley Addison                 | Redcar and Cleveland        | 3 years | 1 | November 2027                       | 1/4 25%  |
| Janet Crampton                 | Hambleton and Richmondshire | 3 years | 3 | November 2025                       | 2/2 100% |
| Graham Lane                    | Hambleton and Richmondshire | 3 years | 1 | November 2026                       | 3/4 75%  |
| Sue Young                      | Hambleton and Richmondshire | 3 years | 2 | November 2025 (did not re-stand)    | 1/2 50%  |
| Noel Beal                      | Hambleton and Richmondshire | 3 years | 1 | November 2025 (did not re-stand)    | 1/2 50%  |
| Patrick Cabbage                | Hambleton and Richmondshire | 3 years | 1 | November 2028                       | 0/1 0%   |
| Martin Reynolds                | Hambleton and Richmondshire | 3 years | 1 | November 2028                       | 0/1 0%   |
| Dr Olufemi Shoyemi             | Rest of England             | 3 years | 1 | November 2026                       | 1/4 25%  |
| <b>Staff elected governors</b> |                             |         |   |                                     |          |
| Len Collings                   |                             | 3 years | 1 | November 2028                       | 1/1 100% |
| Isaac Oluwatowoju              |                             | 3 years | 2 | November 2027                       | 3/4 75%  |

|                         |         |   |                                  |           |
|-------------------------|---------|---|----------------------------------|-----------|
| Julian Wenman           | 3 years | 1 | November 2025 (did not re-stand) | 1/2 50%   |
| Yirupaiahgari Viswanath | 3 years | 1 | November 2028                    | 1/1 100%  |
| Zamad Gillani           | 3 years | 1 | November 2028                    | 1/1 1000% |
| Dan Fawkes              | 3 years | 1 | November 2028                    | 1/1 100%  |
| Jane Passman            | 3 years | 1 | November 2026                    | 3/4 75%   |

## Appointed/Partnership Governors

| Governor              | Partner organisation           | Date appointed                     | Council of Governor meeting attendance |
|-----------------------|--------------------------------|------------------------------------|----------------------------------------|
| Cllr Ursula Earl      | Redcar and Cleveland Council   | June 2023                          | 1/4 25%                                |
| Cllr David Coupe      | Middlesbrough Council          | January 2022                       | 3/4 75%                                |
| Cllr Steve Watson     | North Yorkshire County Council | August 2022                        | 0/4 0%                                 |
| Carlie Johnston-Blyth | Teesside University            | May 2021                           | 2/4 50%                                |
| Prof Shaun Pattinson  | Durham University              | October 2022 Stood down 27/11/2026 | 0/2 0%                                 |
| Prof David Kennedy    | Newcastle University           | February 2024                      | 2/4 50%                                |
| Linda Sergeant        | Healthwatch                    | November 2024                      | 3/4 75%                                |
| Lee O'Brien           | Carers Together                | February 2020                      | 0/4 0%                                 |

The cost for Council of Governors meetings and expenses, including travel and subsistence was £194 for 2025/26 and £862 for 2024/25.

## Council of Governor meetings

Council of Governors meetings are meetings held in public, unless the items of business require a private discussion. During 2025/26, four Council of Governors meetings were held in common with North Tees and Hartlepool Council of Governors.

- 26 June 2025
- 11 September 2025
- 18 December 2025
- 19 February 2026

## Council of Governor committees

The Council of Governors delegates some of its powers to Committees and Working Groups to consider items of business on behalf of the Council of Governors, one of which is a statutory committee, the Nominations Committee. The work of the Nominations Committee is detailed further in this section. Other groups that met during the year included the Membership Engagement Committee and North Tees and Hartlepool Membership Committee, which met in common and the Quality Accounts Working Group with Governors from the trust and North Tees and Hartlepool.

## Governor development and engagement

During the year a programme of development and engagement sessions have been delivered for Governors to support them in undertaking their role and to keep them updated with key aspects of the trust's work and future plans. These have included formal induction sessions for new Governors, an externally facilitated session by NHS Providers, access to external events and development sessions covering a range of topics in advance of each Council of Governors meeting. The sessions during 2025/26 have all been held jointly with North Tees and Hartlepool Council of Governors.

The Governor Handbook is updated regularly to remain a useful reference guide, containing comprehensive information and resources to support all our Governors to undertake their role within the Council of Governors and wider communities.

One of the key roles of a Governor is to engage with and represent the interests of members and the public to gather their views and to communicate information about the trust. There are a number of ways members of the trust and members of the public can communicate with the Council of Governors:

Telephone: 01642 624506

Email: [stees.foundation.trust@nhs.net](mailto:stees.foundation.trust@nhs.net)

Write to your Governor at:

Membership Office

4th floor, North Wing

University Hospital of North Tees

Hardwick

Stockton on Tees

TS19 8PE

## The Board of Directors' relationship with the Council of Governors

The Board of Directors and Council of Governors continue to work together in order to fulfil their respective duties. To ensure Governors are kept informed of key matters of business and topical issues in a timely manner, the Lead Governors and Vice Chairs of both trusts have worked closely with the Chair and Company Secretary regarding the planning of the Council of

Governors meeting agendas and topics for development sessions. The role of the Non-Executive Directors in providing assurance to the Council of Governors regarding the work of the board and wider organisation is now well established. They attend all meetings and share the work of the committees including highlighting the challenge and oversight on key areas of performance through the committees' chairs Logs. In addition, the Chief Executive supported by other members of the Executive Team, attend the meetings as required, to provide valuable updates about the work of the trust and UHT to ensure governors are fully apprised regarding delivery of the Strategy and organisational development.

To further support gaining the appropriate level of assurance regarding the operation of the board and wider trust, governors are encouraged to attend the public Board meetings to develop a broader understanding of discussion and scrutiny taking place at board level, to observe the decision-making processes and challenge by the Non-Executive Directors.

## Declaration of Interests of the Council of Governors

All governors are required to comply with the Council of Governors Code of Conduct and to declare any interests that may result in a potential conflict in their role as governor of the trust, a process that is repeated annually and recorded on a register of interests. In addition, at every meeting of the Council of Governors there is a standing agenda item, which requires governors to declare any conflict of interest in relation to agenda items or any changes to their registered interests, which are noted in the minutes of the meeting. The Register of Governors' interests is held by the Company Secretary and is available for public inspection via the following address:

**Membership Office, University Hospital of North Tees,  
Hardwick, Stockton on Tees, TS19 8PE**

## Nominations Committee

The Nominations Committee is a statutory committee responsible for the recruitment, remuneration, terms and conditions, appointment/re-appointment or removal of the Chair and Non-Executive Directors. In addition, the committee has oversight of the annual appraisal process for the Chair and Non-Executive Directors and supports succession-planning proposals for the board.

The committee has a membership representative of public and staff elected governors and appointed governors, it is chaired by the chair, except when matters relating to their appointment or remuneration are being discussed. The Senior Independent Director and Vice Chairs are invited to the committee as required to provide support and advice along with the Company Secretary.

The committee acts on behalf of the Council of Governors and takes forward recommendations to the Council of Governors for formal ratification. During 2025/26, the committee met on four occasions under in common arrangements with the North Tees and Hartlepool Nominations Committee. Items of business considered included:

- Chair and Non-Executive Director Appraisal process and outcome
- Board Succession Plan updates;
- Non-Executive Director recruitment;

- Non-Executive Director appointments and re-appointments;
- Reviewed remuneration and terms of service for Non-Executive Directors;
- Received assurance on compliance with the Fit and Proper Person Test;

**Attendance information for the Nominations Committee meetings is below.**

| Members                   |                                                      | Total number attended | % attendance |
|---------------------------|------------------------------------------------------|-----------------------|--------------|
| Professor Derek Bell      | Chair                                                | 2/4                   | 50%          |
| Ada Burns                 | Non-Executive Director / Senior Independent Director | 2/2*                  | N/A          |
| Ann Baxter                | Non-Executive Director/Vice Chair                    | 2/4*                  | N/A          |
| Ali Wilson                | Non-Executive Director/Vice Chair                    | 1/4*                  | N/A          |
| Julian Wenman             | Elected Staff Governor                               | 0/2                   | 0%           |
| Janet Crampton            | Elected Governor / Lead Governor (ST)                | 1/2                   | 25%          |
| Zahida Mian               | Elected Public Governor                              | 4/4                   | 100%         |
| Sarah Moule               | Elected Public Governor (NT)                         | 1/4                   | 25%          |
| Rebecca Hodgson           | Elected Public Governor                              | 1/2                   | 25%          |
| David Russon              | Elected Staff Governor (NT)                          | 2/4                   | 50%          |
| Mike Scanlon              | Elected Public Governor (NT)                         | 2/4                   | 50%          |
| Lynda White               | Elected Public Governor (NT)                         | 2/4                   | 50%          |
| Angela Warnes             | Elected Public Non-Core Governor (NT)                | 2/3                   | 100%         |
| Allison Usher             | Elected Public Governor (NT)                         | 4/4                   | 100%         |
| Jean Milburn              | Elected Public Governor                              | 2/4                   | 50%          |
| Christopher Akers-Belcher | Appointed Governor (NT)                              | 2/4                   | 50%          |
| Bob Norton                | Elected Public Governor                              | 3/3                   | 75%          |
| Yvonne Bytheway           | Elected Public Governor                              | 1/1                   | 100%         |
| Brendan Smith             | Elected Public Governor                              | 1/1                   | 100%         |
| Daniel Fawkes             | Elected Staff Governor                               | 1/1                   | 100%         |
| Chris Pitcairn            | Elected Public Governor                              | 1/1                   | 100%         |
| Jane Passman              | Elected Staff Governor                               | 1/1                   | 100%         |
| Andy Simpson              | Appointed Governor                                   | 0/1                   | 0%           |

\* attendance is by invitation and not mandatory

## NHS England's Well Led Framework

The trust undertook a well led inspection by the Care Quality Commission in January 2023, which provided constructive feedback on leadership, governance and organisational culture providing a rating of Good. During 2025/26, the trust undertook a Provider Capability Assessment, where the trust achieved amber / green rating demonstrating developing and established scores across the well led domains, highlighting areas of strength and opportunities for further improvement. Actions arising are being taken forward through a clear improvement plan with board oversight. Building on this work, the trust is preparing for a developmental well led inspection planned for autumn 2026.

## Annual Remuneration Report

### Annual Statement on Remuneration

We present on behalf of the Board of Directors' Remuneration Committee the trust's Remuneration Report for the financial year ending on 31 March 2026. The Remuneration Committee is a committee of the board and is responsible for the recruitment, succession planning and remuneration of the Executive Directors and other Directors.

In accordance with the requirements of the HM Treasury Financial Reporting Manual (FRM) and NHS Improvement, we have divided this Remuneration Report into the following parts:

- An annual statement on remuneration from the Remuneration Committee;
- Senior Managers' Remuneration Policy; and
- Annual Report on Remuneration.

The process the trust uses for assessing the performance of its Chief Executive and Directors is determined by the Remuneration Committee and is reviewed annually to ensure it is fit for purpose and meets current good practice for Board Directors. The trust's policy on pay is that it will, for all staff groups, endorse any national proposals for pay, subject to the trust being able to afford to pay any changes/increases.

The trust Remuneration Committee aims to ensure that Executive Directors and Directors remuneration is set appropriately. the committee takes into account relevant market conditions to ensure Executive Directors and Directors are remunerated appropriately and that their pay is reasonable and comparable to other Executive Director and Director pay.

the committee was assured that salaries above the threshold displayed within the Remuneration table within the Accountability Report are reasonable and comparable to other Executive Director and Director pay.

The Chief Executive and Executive Directors receive a fixed salary which is reviewed annually and determined by independent benchmarking against NHS organisations throughout the country with the use of NHS Provider benchmarking information, NHS Annual Reports and Accounts and knowledge of job descriptions, person specifications and market pay.

Executive Directors and Directors are substantive employees and their contracts can be terminated by either party giving notice of three months.

For the purpose of this Remuneration Report only voting members of the board are considered as 'senior managers'.

Due regard is also given to the diversity and complexity of the roles undertaken by the Directors when reviewing and benchmarking pay against comparators. Any pay changes/increases will always be subject to formal review of both the individual director's performance and the trust's performance, taking cognisance of the national framework for pay.

The Remuneration Committee considers the key business objectives as set out in the trust Strategy allocated to each Director through the appraisal process. Performance is closely monitored and discussed through both an annual and on-going appraisal process. The Chief Executive takes a lead on the evaluation of Directors and the Chairman takes the lead on the Chief Executive's performance.

During 2025/26, appraisals were held with the Chief Executive and each director and all senior managers' remuneration is subject to satisfactory performance.

### Major decisions on remuneration in 2024/25:

- No South Tees Hospitals NHS Trust specific decisions were made.

### Major decisions on remuneration in 2024/25 made in common with North Tees and Hartlepool NHS Trust:

- Deputy Chief Executive role approved
- Group Director of Pharmacy approved
- Executive appraisals and objectives noted and strengthened
- National VSM pay framework noted
- VSM pay award approved
- Voluntary Redundancy policy approved
- Chief Executive appraisal noted
- Appointment approved: Chair of NTH Solutions LLP
- Chief Delivery Officer terms and salary approved

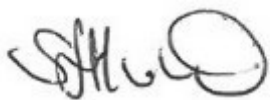
The committee met on three occasions during the period of 1 April 2025 to 31 March 2026 in common with the Remuneration Committee of North Tees and Hartlepool.

|                      |                                                      | Total number attended | % attendance |
|----------------------|------------------------------------------------------|-----------------------|--------------|
| Professor Derek Bell | Chair                                                | 2/3                   | 66           |
| Ali Wilson           | Non-Executive Director /Vice Chair                   | 3/3                   | 100          |
| Ann Baxter           | Non-Executive Director /Vice Chair                   | 3/3                   | 100          |
| Ada Burns            | Non-Executive Director / Senior Independent Director | 2/2                   | 100          |

|                     |                                                      |     |     |
|---------------------|------------------------------------------------------|-----|-----|
| Professor Chris Day | Non-Executive Director                               | 0/2 | 0   |
| David Redpath       | Non-Executive Director                               | 2/3 | 66  |
| Miriam Davidson     | Non-Executive Director                               | 3/3 | 100 |
| Mark Dias           | Non-Executive Director                               | 2/3 | 66  |
| Fay Scullion        | Non-Executive Director                               | 2/3 | 66  |
| Ken Readshaw        | Non-Executive Director / Senior Independent Director | 2/3 | 66  |
| Alison Fellows      | Non-Executive Director                               | 2/3 | 66  |
| Elizabeth Barnes    | Non-Executive Director                               | 1/1 | 100 |
| Celia Weldon        | Non-Executive Director                               | 1/1 | 100 |

The Remuneration Committee fulfil their responsibilities and report to the Board of Directors.

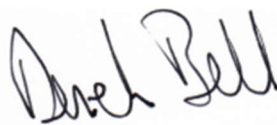
Signed:



**Stacey Hunter**

Chief Executive and Accounting Officer

Signed:



**Professor Derek Bell OBE**

Chair

## Senior manager remuneration and benefits

The Remuneration Committee is committed to ensuring the trust is able to offer proportionate and fair remuneration packages, reflective of the responsibility of working in a large and complex environment and to promote the long-term sustainable success of the trust by attracting, recruiting and retaining high calibre staff in a competitive marketplace.

It considers the prevailing market conditions, benchmarks pay and employment conditions against appropriate peer, national and regional comparators and the trust workforce. When appointing Directors and Executive Directors to the trust, the Remuneration Committee aligns with the trust's strategy to deliver Workforce Race Equality standards, Workforce Disability Equality Standards and increase inclusive leadership. The trust values and promotes diversity and is committed to equality of opportunity for all. The trust believes that the best boards are those that reflect the communities they serve, and applications are particularly welcomed from women, people from the local black and minority ethnic communities, and disabled people who we know are under-represented in senior manager roles.

The Remuneration Committee always considers the pay and terms and conditions of service of all Trust employees when making any decisions relating to the Executive Directors' pay and conditions. This is to ensure that levels of responsibility and experience are reflected appropriately, take account of pay surveys conducted by NHS Providers, as well as comparisons with other North East trusts and consider any national inflationary pay awards awarded to agenda for change/medical and dental staff.

NHS England outlined recommendations for the 2025/26 annual pay increase for very senior managers in June 2025. The Remuneration Committee agreed to award 3.25% for all very senior managers backdated to 1 April 2025 in line with the guidance.

Details of Directors' remuneration and pension entitlements for the year ending 31 March 2026 are published in this Remuneration Report and the Annual Accounts section.

The authority and responsibility for controlling major activities is retained by the statutory Board of Directors who have voting rights. This includes the voting Executive and voting Non-executive Directors (including the Chairman).

Pension arrangements for the Chief Executive and Executive Directors are in accordance with reference to NHS Pension Scheme, the Accounting Policies for Pensions and relevant benefits are set out in the following tables:

There are no components to senior manager salaries other than those disclosed within the tables in this report. Total remuneration includes salary, non-consolidated performance-related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions for 2025/26. There have been no special contractual compensation provisions attached to the early termination of a senior manager's contract of employment and there has been no payment for compensation for loss of office paid or receivable under the terms of an approved compensation scheme.

## Service contract obligations

Director and Executive Director service contracts do not include obligations on the Foundation Trust which could give rise to or impact on remuneration payments or payments for loss of office. The trust does not make payments for loss of office outside the standard contract terms included in the employment contracts of senior managers.

| Element of remuneration              | Description and operation                                                                                                                                                                                                                                | Future policy (VSM Framework aligned)                                                                                                                                                                                                                                                          |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Base salary                          | Base salary is determined by reference to the NHS Very Senior Managers (VSM) Pay Framework and reflects the scope, responsibilities, skills and experience required for each role. Salary levels are set within the relevant national pay range or band. | Base salaries will continue to be set in accordance with the NHS VSM Pay Framework and applicable national guidance. Any appointment salary or salary adjustment will be approved by the Remuneration Committee having regard to affordability, internal relativities and national pay policy. |
| Annual pay review / pay awards       | Annual pay reviews are conducted in line with national VSM guidance and any centrally mandated pay awards, subject to affordability and approval.                                                                                                        | Future pay awards will be applied strictly in line with national VSM pay guidance and Government policy. There is no automatic entitlement to pay increases beyond those nationally agreed or formally approved.                                                                               |
| Performance-related pay / bonuses    | The Trust does not operate bonus or performance-related pay schemes for Very Senior Managers. Performance is managed through appraisal and objective setting.                                                                                            | No performance-related pay or bonus arrangements will be introduced for VSMs unless required by national policy and fully disclosed in advance in the Remuneration Report.                                                                                                                     |
| Pension benefits                     | VSMs are eligible for membership of the NHS Pension Scheme, subject to scheme rules, or alternative arrangements where appropriate. The Trust does not offer enhanced pension benefits.                                                                  | Pension provision will remain in line with the NHS Pension Scheme or approved alternative arrangements. No discretionary or enhanced pension benefits will be provided outside national policy.                                                                                                |
| Benefits in kind                     | Benefits in kind are limited and may include access to standard NHS schemes (e.g. lease car scheme) and reimbursement of legitimate business expenses in accordance with Trust policy.                                                                   | Benefits in kind will remain modest, transparent and compliant with HMRC and NHS guidance. No new benefits will be introduced without Remuneration Committee approval.                                                                                                                         |
| Recruitment and retention premia     | Recruitment and retention premia are exceptional and only applied where there is a clear operational need.                                                                                                                                               | Any future recruitment or retention premia will be applied strictly in accordance with NHS VSM guidance, supported by a clear business case, and approved by the Remuneration Committee.                                                                                                       |
| Contractual terms and notice periods | VSM contracts include notice periods that reflect NHS norms for senior roles.                                                                                                                                                                            | Notice periods will continue to align with NHS best practice and VSM guidance, ensuring they are reasonable, proportionate and do not expose the Trust to undue financial risk.                                                                                                                |

|                      |                                                                                                                                       |                                                                                                                                                                                       |
|----------------------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Termination payments | Termination payments are made in line with contractual terms, statutory requirements and NHS guidance, including any applicable caps. | Any future termination payments will comply with the NHS VSM Framework, national severance guidance and statutory limits, and will be subject to appropriate approval and disclosure. |
| Other allowances     | Any additional allowances are rare and subject to approval.                                                                           | Additional allowances will only be used where explicitly permitted by the NHS VSM Framework and approved by the Remuneration Committee.                                               |

## Policy on payment for loss of office

The members of the executive team are appointed on permanent contracts with a notice period of three months for them to serve and a period of six months for the trust to serve.

The Chief Medical Officer's salary is in accordance with the terms and conditions of the National Health Service Consultant Contract plus a responsibility allowance payable for the duration of office which is three years.

Early termination by reason of redundancy is in accordance with the provision of the NHS redundancy arrangements and in accordance with the NHS pension scheme. Employees above the minimum retirement age that request termination by reason of early retirement are subject to the normal provisions of the NHS pension scheme.

## Directors' costs table 2025/26 (subject to audit)

Figures below are for the 12-month period from 1 April 2025 to 31 March 2026 for comparison purposes a table showing figures for the prior year is also included.

| Name and Title                                                                                                           | Salary & fees (£000) | Taxable benefits (£) | Performance-related bonuses (£000) | Long-term performance bonuses (£000) | Pension-related benefits (£000) | Total (£000) |
|--------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------|------------------------------------|--------------------------------------|---------------------------------|--------------|
| <b>Derek Bell</b><br>Chair                                                                                               | 40-45                | 600                  | -                                  | -                                    | -                               | 40-45        |
| <b>Ali Wilson</b><br>Non-Executive Director/Vice Chair                                                                   | 10-15                | -                    | -                                  | -                                    | -                               | 10-15        |
| <b>Ann Baxter</b><br>Non-Executive Director/Vice Chair                                                                   | 10-15                | -                    | -                                  | -                                    | -                               | 10-15        |
| <b>Ada Burns</b><br>Senior Independent and Non-Executive Director                                                        | 0-5                  | -                    | -                                  | -                                    | -                               | 0-5          |
| <b>Christopher Macklin</b><br>Senior Independent and Non-Executive Director                                              | 0-5                  | -                    | -                                  | -                                    | -                               | 0-5          |
| <b>Celia Weldon</b><br>Non-Executive Director                                                                            | 0-5                  | -                    | -                                  | -                                    | -                               | 0-5          |
| <b>David Redpath</b><br>Non-Executive Director                                                                           | 5-10                 | -                    | -                                  | -                                    | -                               | 5-10         |
| <b>Kenneth Readshaw</b><br>Non-Executive Director                                                                        | 5-10                 | -                    | -                                  | -                                    | -                               | 5-10         |
| <b>Mark Dias</b><br>Non-Executive Director                                                                               | 5-10                 | -                    | -                                  | -                                    | -                               | 5-10         |
| <b>Miriam Davidson</b><br>Non-Executive Director                                                                         | 5-10                 | -                    | -                                  | -                                    | -                               | 5-10         |
| <b>Alison Fellows (Care)</b><br>Non-Executive Director                                                                   | 5-10                 | -                    | -                                  | -                                    | -                               | 5-10         |
| <b>Christopher Day</b><br>Non-Executive Director                                                                         | 5-10                 | -                    | -                                  | -                                    | -                               | 5-10         |
| <b>Elizabeth Barnes</b><br>Non-Executive Director                                                                        | 0-5                  | -                    | -                                  | -                                    | -                               | 0-5          |
| <b>Fay Scullion</b><br>Non-Executive Director                                                                            | 5-10                 | -                    | -                                  | -                                    | -                               | 5-10         |
| <b>Stacey Hunter</b><br>Chief Executive Officer                                                                          | 135-140              | -                    | -                                  | -                                    | 47.5-50                         | 180-185      |
| <b>Neil Atkinson</b><br>Chief Delivery Officer                                                                           | 100-105              | 2200                 | -                                  | -                                    | 17.5-20                         | 120-125      |
| <b>Chris Hand</b><br>Chief Finance Officer                                                                               | 95-100               | 1000                 | -                                  | -                                    | 32.5-35                         | 130-135      |
| <b>Matthew Neligan (3)</b><br>Chief Strategy Officer                                                                     | 95-100               | -                    | -                                  | -                                    | 122.5-125                       | 220-225      |
| <b>Mike Stewart</b><br>Chief Medical Officer                                                                             | 125-130              | -                    | -                                  | -                                    | 20-22.5                         | 145-150      |
| <b>Rachael Metcalf</b><br>Chief People Officer                                                                           | 80-85                | 700                  | -                                  | -                                    | 25-27.5                         | 105-110      |
| <b>Emma Nunez</b><br>Chief Nurse                                                                                         | 90-95                | 500                  | -                                  | -                                    | 90-92.5                         | 180-185      |
| <b>Band of Highest Paid Director's Total Remuneration (excluding redundancy payments and payments in lieu of notice)</b> | <b>£270-275k</b>     |                      |                                    |                                      |                                 |              |

## Notes:

1. Ms Stacey Hunter, Chief Executive of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Ms Hunter's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary is £271,031 and the recharge is £135,516
2. Mr Neil Atkinson ,Chief Delivery Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mr Atkinson's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary is £200,346 and the recharge is £100,173
3. Mr Chris Hand, Chief Finance Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Mr Hand's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary is £196,362 and the recharge is £98,181
4. Dr Mike Stewart, Chief Medical Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Dr Stewart's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary is £253,892 and the recharge is £126,946. The element of Dr Stewart's salary that relates to his clinical role is £29,095.61.
5. Ms Emma Nunez, Chief Nurse Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 01.04.25. South Tees Hospitals NHS Foundation Trust pay Ms Nunez' salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary is £185,850 and the recharge is £92,925
6. Mrs Rachael Metcalf, Chief People Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Mrs Metcalf's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary is £162,565 and the recharge is £81,282
7. Mr Matt Neligan, Chief Strategy Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mr Nelligan's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary is £193,342 and the recharge is £96,671
8. Prof Derek Bell, Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Prof Bell's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary is £80,000 and the recharge is £40,000
9. Ms Ann Baxter, Vice Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Ms Baxter's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary is £26,000 and the recharge is £13,000
10. Ms Ali Wilson, Vice Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Ms Wilson's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary is £26,000 and the recharge is £13,000

11. Mr Christopher Macklin, Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust to 30.04.25. North Tees and Hartlepool NHS Foundation Trust pay Mr Macklin's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary is £1,535 and the recharge is £768
12. Mrs Alison Fellows (Care), Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mrs Fellows' salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary is £15,000 and the recharge is £7,500
13. Prof Elizabeth Barnes, Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust to 30.06.25. North Tees and Hartlepool NHS Foundation Trust pay Prof Barnes' salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary is £3,750 and the recharge is £1,875
14. Mrs Fay Scullion, Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mrs Scullion's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary is £15,000 and the recharge is £7,500
15. Ms Ada Burns, Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust to 30.09.25. South Tees Hospitals NHS Foundation Trust pay Ms Burns' salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary is £7,500 and the recharge is £3,750
16. Ms Miriam Davidson, Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Ms Davidson's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary is £15,475 and the recharge is £7,737
17. Mr David Redpath, Non-Executive Director and Subsidiaries Chair for North Tees and Hartlepool Solutions LLP and Optimus Health Ltd from 01.10.25. of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Mr Redpath's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary is £15,787 and the recharge is £7,793
18. Mr Ken Readshaw, Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Mr Readshaw's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary is £15,000 and the recharge is £7,500
19. Mr Mark Dias, Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Mr Dias' salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary is £15,000 and the recharge is £7,500
20. Professor Chris Day, Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 01.07.25. North Tees and Hartlepool NHS Foundation Trust pay Mr Day's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary is £11,250 and the recharge is £5,625

21. Ms Celia Weldon, Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 01.02.26. North Tees and Hartlepool NHS Foundation Trust pay Ms Weldon's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary is £2,500 and the recharge is £1,250
22. 2024/25 remuneration report included non-voting Directors. They are not included in the 2025/26 report.

## Directors' costs table 2024/25

| Name and Title                                                                    | Salary & fees (£000) | Taxable benefits (£) | Performance-related bonuses (£000) | Long-term performance bonuses (£000) | Pension-related benefits (£000) | Total (£000) |
|-----------------------------------------------------------------------------------|----------------------|----------------------|------------------------------------|--------------------------------------|---------------------------------|--------------|
| <b>Derek Bell</b><br>Group Chair                                                  | 40–45                | 400                  | -                                  | -                                    | -                               | 40–45        |
| <b>Ali Wilson</b><br>Group Non-Executive Director/Vice Chair                      | 10–15                | -                    | -                                  | -                                    | -                               | 10–15        |
| <b>Ann Baxter</b><br>Group Non-Executive Director/Vice Chair                      | 10–15                | -                    | -                                  | -                                    | -                               | 10–15        |
| <b>Ada Burns</b><br>Group Senior Independent and Non-Executive Director           | 5–10                 | -                    | -                                  | -                                    | -                               | 5–10         |
| <b>Christopher Macklin</b><br>Group Senior Independent and Non-Executive Director | 5–10                 | -                    | -                                  | -                                    | -                               | 5–10         |
| <b>David Redpath</b><br>Group Non-Executive Director                              | 5–10                 | -                    | -                                  | -                                    | -                               | 5–10         |
| <b>Kenneth Readshaw</b><br>Group Non-Executive Director                           | 5–10                 | -                    | -                                  | -                                    | -                               | 5–10         |
| <b>Mark Dias</b><br>Group Non-Executive Director                                  | 5–10                 | -                    | -                                  | -                                    | -                               | 5–10         |
| <b>Miriam Davidson</b><br>Group Non-Executive Director                            | 5–10                 | -                    | -                                  | -                                    | -                               | 5–10         |
| <b>Alison Fellows (Care)</b><br>Group Non-Executive Director                      | 5–10                 | -                    | -                                  | -                                    | -                               | 5–10         |
| <b>Elizabeth Barnes</b><br>Group Non-Executive Director                           | 5–10                 | -                    | -                                  | -                                    | -                               | 5–10         |
| <b>Fay Scullion</b><br>Group Non-Executive Director                               | 5–10                 | -                    | -                                  | -                                    | -                               | 5–10         |
| <b>Rudy Bilous (1)</b><br>Group Associate Non-Executive Director                  | 0–5                  | -                    | -                                  | -                                    | -                               | 0–5          |
| <b>Alyson Gerner (2)</b><br>Group Associate Non-Executive Director                | 0–5                  | -                    | -                                  | -                                    | -                               | 0–5          |
| <b>Stacey Hunter</b><br>Group Chief Executive Officer                             | 130–135              | -                    | -                                  | -                                    | 195–197.5                       | 325–330      |
| <b>Neil Atkinson</b><br>Group Managing Director                                   | 95–100               | 1500                 | -                                  | -                                    | 102.5–105                       | 200–205      |
| <b>Chris Hand</b><br>Group Chief Finance Officer                                  | 95–100               | 1500                 | -                                  | -                                    | 77.5–80                         | 170–175      |
| <b>Matthew Neligan (3)</b><br>Group Chief Strategy Officer                        | 40–45                | -                    | -                                  | -                                    | 25–27.5                         | 65–70        |
| <b>Mike Stewart</b><br>Group Chief Medical Officer                                | 120–125              | 500                  | -                                  | -                                    | -                               | 120–125      |
| <b>Rachael Metcalf</b><br>Group Chief People Officer                              | 75–80                | 1500                 | -                                  | -                                    | 80–82.5                         | 160–165      |
| <b>Susannah Cook (4)</b><br>Group Chief People Officer                            | 25–30                | -                    | -                                  | -                                    | 0–2.5                           | 25–30        |

| Name and Title                                                                                                           | Salary & fees (£000) | Taxable benefits (£) | Performance-related bonuses (£000) | Long-term performance bonuses (£000) | Pension-related benefits (£000) | Total (£000) |
|--------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------|------------------------------------|--------------------------------------|---------------------------------|--------------|
| <b>Maurya Cushlow (5)</b><br>Group Chief Nurse                                                                           | 10–15                | -                    | -                                  | -                                    | -                               | 10–15        |
| <b>Hilary Lloyd (6)</b><br>Group Chief Nurse                                                                             | 75–80                | -                    | -                                  | -                                    | 17.5–20                         | 90–95        |
| <b>Band of Highest Paid Director's Total Remuneration (excluding redundancy payments and payments in lieu of notice)</b> | <b>£260–265k</b>     |                      |                                    |                                      |                                 |              |

1. Prof Derek Bell, Group Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Prof Bell's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary value is £80,000.04 and the recharge to South Tees Hospitals NHS Foundation Trust for 2024/25 is £40,000.02. Expenses are also split 50:50.
2. Ms Ann Baxter, Group Vice Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Ms Baxter's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary value is £26,358.09 and the recharge to South Tees Hospitals NHS Foundation Trust for 2024/25 is £13,179.05.
3. Ms Ali Wilson, Group Vice Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Ms Wilson's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £25,715.11 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £12,857.55.
4. Ms Ada Burns, Group Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Ms Burn's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £14,835.62 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £7,417.81.
5. Mr Christopher Macklin, Group Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mr Macklin's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary value is £15,109.23 and the recharge to South Tees Hospitals NHS Foundation Trust for 2024/25 is £7,554.62.
6. Mr David Redpath, Group Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mr Redpath's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £14,835.62 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £7,417.81.
7. Mr Ken Readshaw, Group Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mr Readshaw's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £14,835.62 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £7,417.81.

8. Mr Mark Dias, Group Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mr Dias's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £14,857.40 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £7,428.70.
9. Ms Miriam Davidson, Group Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Ms Davidson's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £14,857.40 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £7,428.70.
10. Mrs Alison Fellows (Care), Group Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mrs Fellows's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary value is £14,977.77 and the recharge to South Tees Hospitals NHS Foundation Trust for 2024/25 is £7,488.89.
11. Prof Elizabeth Barnes, Group Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Prof Barnes's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary value is £15,349.47 and the recharge to South Tees Hospitals NHS Foundation Trust for 2024/25 is £7,674.74.
12. Mrs Fay Scullion, Group Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mrs Scullion's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary value is £14,977.77 and the recharge to South Tees Hospitals NHS Foundation Trust for 2024/25 is £7,488.89.
13. Prof Rudy Bilous, Group Associate Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24 to 31.08.24. South Tees Hospitals NHS Foundation Trust pay Mrs Gerner's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £3,468.75 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £1,734.38.
14. Mrs Alyson Gerner, Group Associate Non-Executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24 to 31.08.24. South Tees Hospitals NHS Foundation Trust pay Mrs Gerner's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £3,468.75 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £1,734.38.
15. Ms Stacey Hunter, Group Chief Executive of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Ms Hunter's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary value is £262,500.00 and the recharge to South Tees Hospitals NHS Foundation Trust for 2024/25 is £131,250.00. In addition, the full pension related benefit value for the year amounted to £390,151.00 and the 50% proportion for South Tees Hospitals NHS Foundation Trust amounts to £195,075.50.

16. Mr Neil Atkinson, Group Managing Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. From 01.04.24 to 04.04.24 was Managing Director for North Tees and Hartlepool NHS Foundation Trust only. North Tees and Hartlepool NHS Foundation Trust pay Mr Atkinson's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary value is £194,040.00 and the recharge to South Tees Hospitals NHS Foundation Trust for 2024/25 is £97,020.00. Expenses are also split 50:50. In addition, the full pension related benefit value for the year amounted to £206,448.00 and the 50% proportion for South Tees Hospitals NHS Foundation Trust amounts to £103,224.00.
17. Mr Chris Hand, Group Chief Finance Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mr Hand's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £190,181.20 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £94,048.55. In addition, the full pension related benefit value for the year amounted to £155,181.00 and the 50% proportion for South Tees Hospitals NHS Foundation Trust amounts to £77,590.50.
18. Mr Matthew Neligan, Group Chief Strategy Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 04.10.24. North Tees and Hartlepool NHS Foundation Trust pay Mr Nelligan's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. Full salary value is £83,012.10 and the recharge to South Tees Hospitals NHS Foundation Trust for 2024/25 is £41,506.05. In addition, the full pension related benefit value for the year amounted to £53,997.00 and the 50% proportion for South Tees Hospitals NHS Foundation Trust amounts to £26,998.50.
19. Dr Mike Stewart, Group Chief Medical Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Dr Stewart's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £242,391.12 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £121,195.56. Dr Stewart is not in the NHS pension.
20. Mrs Rachael Metcalf, Group Chief People Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mrs Metcalf's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £157,447.50 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £77,861.05. In addition, the full pension related benefit value for the year amounted to £161,087.00 and the 50% proportion for South Tees Hospitals NHS Foundation Trust amounts to £80,543.50.
21. Dr Susannah Cook, Group Chief People Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. Moved to Group role 05.04.24 and left 31.08.24. Include as voting member of North Tees and Hartlepool NHS Foundation Trust from 01.04.24 - 04.04.24. From 05.04.24 to 31.08.24 North Tees and Hartlepool NHS Foundation Trust paid Dr Cook's salary in full and recharged 50% to South Tees Hospitals NHS Foundation Trust. Full salary value is £56,808.62 and the recharge to South Tees Hospitals NHS Foundation Trust for 2024/25 is £27,679.17. In addition, the full pension related benefit value for the year amounted to £2,163.00 and the 50% proportion for South Tees Hospitals NHS Foundation Trust amounts to £1,081.50.

22. Ms Maurya Cushlow, Interim Group Chief Nurse of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 13.01.25. South Tees Hospitals NHS Foundation Trust pay Ms Cushlow's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Full salary value is £29,301.85 and the recharge to South Tees Hospitals NHS Foundation Trust for 2024/25 is £14,650.93. Ms Cushlow is not in the NHS pension.
23. Dr Hilary Lloyd, Group Chief Nurse of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 05.04.24 to 31.01.25. South Tees Hospitals NHS Foundation Trust pay Ms Lloyds's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust from 05.04.24. Full salary value is £151,288.57 and the recharge to North Tees and Hartlepool NHS Foundation Trust for 2024/25 is £62,587.87. In addition, the full pension related benefit value for the year amounted to £38,034.00 and the 50% proportion for South Tees Hospitals NHS Foundation Trust amounts to £9,017.00.

\* In accordance with NHS England's NHS Foundation Trust Annual Reporting Manual s2.40, disclosures are provided for all senior managers. Every senior manager salary is approved by the remuneration committee has been appropriately externally benchmarked and salary levels set to ensure we are attracting the right skills and competencies.

\*\* In accordance with NHS England's NHS Foundation Trust Annual Reporting Manual s2.53, where the calculations for Pension-Related Benefits result in a negative value the result should be reported as zero.

The information included above for pension benefits has been supplied by NHS Pensions.

## Pension information

The figures below are for the 12-month period from 1 April 2025 to 31 March 2026

| Executive Directors                       | Real increase in pension at pension age (Bands of £2,500) | Real increase to pension lump sum at pension age (Bands of £2,500) | Total accrued pension at pension age at 31 March 2026 (Bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2026 (Bands of £5,000) | Cash equivalent transfer value at 1 April 2025 (£000s) | Real increase in cash equivalent transfer value (£000s) | Cash equivalent transfer value at 31 March 2026 (£000s) | Employer's contribution to stakeholder pension (£000s) |
|-------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------|
| Stacey Hunter<br>Chief Executive Officer  | 5-7.5                                                     | 2.5-5                                                              | 95-100                                                                  | 230-235                                                                               | 2,022                                                  | 106                                                     | 2,197                                                   | 39                                                     |
| Neil Atkinson<br>Chief Delivery Officer   | 2.5-5                                                     | 0                                                                  | 65-70                                                                   | 155-160                                                                               | 1,400                                                  | 45                                                      | 1,491                                                   | 25                                                     |
| Chris Hand<br>Chief Finance Officer       | 2.5-5                                                     | 2.5-5                                                              | 60-65                                                                   | 145-150                                                                               | 1,167                                                  | 64                                                      | 1,273                                                   | 27                                                     |
| Mike Stewart<br>Chief Medical Officer     | 2.5-5                                                     | 0                                                                  | 0-5                                                                     | 0                                                                                     | 0                                                      | 36                                                      | 46                                                      | 16                                                     |
| Matthew Neligan<br>Chief Strategy Officer | 10-12.5                                                   | 25-27.5                                                            | 75-80                                                                   | 185-190                                                                               | 1,344                                                  | 253                                                     | 1,644                                                   | 28                                                     |
| Emma Nunez<br>Chief Nurse                 | 7.5-10                                                    | 17.5-20                                                            | 50-55                                                                   | 135-140                                                                               | 852                                                    | 160                                                     | 1,049                                                   | 25                                                     |
| Rachael Metcalf<br>Chief People Officer   | 2.5-5                                                     | 0-2.5                                                              | 50-55                                                                   | 115-120                                                                               | 960                                                    | 51                                                      | 1,047                                                   | 22                                                     |

Notes:

1. Ms Stacey Hunter, Chief Executive of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Ms Hunter's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
2. Mr Neil Atkinson , Chief Delivery Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mr Atkinson's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
3. Mr Chris Hand, Chief Finance Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Mr Hand's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
4. Dr Mike Stewart, Chief Medical Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Dr Stewart's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
5. Ms Emma Nunez, Chief Nurse Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 01.04.25. South Tees Hospitals NHS Foundation Trust pay Ms Nunez' salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
6. Mrs Rachael Metcalf, Chief People Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Mrs Metcalf's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
7. Mr Matt Neligan, Chief Strategy Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mr Nelligan's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
8. 2024/25 remuneration report included non-voting Directors. They are not included in the 2025/26 report.

The comparative figures for the 12-month period from 1 April 2024 to 31 March 2025 are as follows:

| Executive Directors                                    | Real increase in pension at pension age (Bands of £2,500) | Real increase to pension lump sum at pension age (Bands of £2,500) | Total accrued pension at pension age at 31 March 2026 (Bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2026 (Bands of £5,000) | Cash equivalent transfer value at 1 April 2025 (£000s) | Real increase in cash equivalent transfer value (£000s) | Cash equivalent transfer value at 31 March 2026 (£000s) | Employer's contribution to stakeholder pension (£000s) |
|--------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------|
| <b>Stacey Hunter</b><br>Group Chief Executive Officer  | 17.5-20                                                   | 40-42.5                                                            | 85-90                                                                   | 220-225                                                                               | 1,481                                                  | 409                                                     | 2,022                                                   | 38                                                     |
| <b>Neil Atkinson</b><br>Group Managing Director        | 10-12.5                                                   | 20-22.5                                                            | 60-65                                                                   | 155-160                                                                               | 1,090                                                  | 216                                                     | 1,400                                                   | 25                                                     |
| <b>Chris Hand</b><br>Group Chief Finance Officer       | 7.5-10                                                    | 12.5-15                                                            | 55-60                                                                   | 140-145                                                                               | 939                                                    | 142                                                     | 1,167                                                   | 26                                                     |
| <b>Matthew Neligan</b><br>Group Chief Strategy Officer | 2.5-5                                                     | 2.5-5                                                              | 60-65                                                                   | 155-160                                                                               | 1,127                                                  | 55                                                      | 1,344                                                   | 12                                                     |
| <b>Hilary Lloyd</b><br>Group Chief Nurse               | 2.5-5                                                     | 0-2.5                                                              | 70-75                                                                   | 195-200                                                                               | 1,624                                                  | 58                                                      | 1,824                                                   | 22                                                     |
| <b>Susannah Cook</b><br>Group Chief People Officer     | 0-2.5                                                     | 0                                                                  | 40-45                                                                   | 100-105                                                                               | 785                                                    | 2                                                       | 860                                                     | 8                                                      |
| <b>Rachael Metcalf</b><br>Group Chief People Officer   | 7.5-10                                                    | 15-17.5                                                            | 45-50                                                                   | 115-120                                                                               | 738                                                    | 154                                                     | 960                                                     | 21                                                     |

Note: In the tables above, the benefits and related CETVs do not allow for any potential future adjustment arising from the McCloud judgment.

## Notes to senior managers' remuneration and pension benefits (subject to audit)

A Cash Equivalent Transfer (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 the disclosure applies.

The CETV figures, and from 2004/05 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.

## Fair pay multiple (subject to audit)

As an NHS Foundation Trust, the Trust is required to disclose the relationship between the remuneration of the highest paid Executive Director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce (this excludes one-off

severance payments and pension related benefits). For this Trust, Executive Directors are deemed those with voting rights on the Board, as disclosed in the salary table above. In 2025/26 the highest paid Director is the Chief Executive Officer (in 2024/25 the highest paid Director was the Chief Executive Officer).

The banded remuneration of the highest paid Director at the Trust in 2025/26 was £272,500 (2024/25 £262,500). The increase in remuneration between years for the Group Chief Executive Officer was 3.4%. The remuneration was 7.2 times (2024/25 7.0 times) the median remuneration of the workforce, which was £37,796 (2024/25 £37,338). In line with the Department of Health and Social Care Group Accounting Manual (DHSC GAM) the Trust is required to disclose the above based on the Trusts share of remuneration as the highest paid Director provides services to both the Trust and North Tees and Hartlepool NHS Foundation Trust. In this case, the Trusts share of the banded remuneration of the highest paid Director was £137,500 and the remuneration was 3.6 times the median remuneration of the workforce.

This exercise has included all staff employed by the Trust during the financial period, regardless of whether they were still employed at 31 March 2026. The remuneration figures used are based on Trust employees including locum staff, the Trust's in-house nurse, clerical bank staff and excludes external agency staff.

In 2025/26, nine employees received remuneration in excess of the highest paid Director (nine employees in 2024/25). In line with the DHSC GAM requirement, 191 employees received remuneration in excess of the Trusts share of the highest paid Director. Remuneration ranged from £24,464 to £317,695 (2024/25 £23,614 to £361,691). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 4.0%. Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The starting point for the ranges for the financial periods is based on the minimum agenda for change pay scales.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

|                                                   | 2024/25         |         |                 | 2023/24         |         |                 |
|---------------------------------------------------|-----------------|---------|-----------------|-----------------|---------|-----------------|
|                                                   | 25th percentile | Median  | 75th percentile | 25th percentile | Median  | 75th percentile |
| Total pay and benefits excluding pension benefits | 29,123          | 37,796  | 49,780          | 29,015          | 37,338  | 47,554          |
| Banded remuneration of highest paid director      | 272,500         | 272,500 | 272,500         | 262,500         | 262,500 | 262,500         |

|                                                                                                           |     |     |     |     |     |     |
|-----------------------------------------------------------------------------------------------------------|-----|-----|-----|-----|-----|-----|
| Ratio of total pay and benefits and the mid-point of the banded remuneration of the highest paid director | 9.4 | 7.2 | 5.5 | 9.1 | 7.0 | 5.6 |
|-----------------------------------------------------------------------------------------------------------|-----|-----|-----|-----|-----|-----|

Note: in line with the requirement of the DHSC GAM the ratio of pay using the mid-point of the Trusts share of the highest paid director would equate to 4.7 for the 25th percentile, 3.6 for the median and 2.8 for the 75th percentile.

The change in median remuneration during the years is mainly due to the change in the banded remuneration of the highest paid director. The Trust believes that the median pay ratio for the relevant financial year is consistent with pay, ward and progression policies for the entire employee population.

### Expenditure on consultancy

In 2025/26, expenditure on consultancy was £1.578 million (2024/25 £0.282 million). Consultancy expenditure in the year related mainly to support in developing and delivering the trust's Financial Improvement Programme with support from NHS England.

### Staff exit packages

In 2025/26, the trust agreed an exit package with 38 members of staff (there were 3 instances in 2024/25) which cost £0.537 million. Further information to support the exit packages is included in Note 5.3 and Note 5.4 of the Financial Statements.

### Governors' expenses

In accordance with the trust's constitution, governors are eligible to claim expenses for travel at rates determined by the trust. Out of the Council of Governor membership there were six Governors who claimed expenses which totalled £194.

### Directors' expenses

In 2025/26, expenses paid to those holding the office of director at the trust totalled £1,432. All costs paid related to the reimbursement of travel, subsistence costs and course expenses. Details of remuneration and benefits in kind can be found within the remuneration table.

### Analysis of staff costs (subject to audit)

Details of the costs of our workforce are available within Note 5 of the Financial Statements. The note includes information to support employee expenses and details of the monthly average of people employed by the trust.

### Off-payroll engagements

Executive Director approval is required for all off-payroll engagements and the trust reports to NHS England as required in line with national requirements. Board approval via

recommendations from the Remuneration Committee is required by any off-payroll board member engagement.

| Highly paid off-payroll worker engagements as of 31 March 2026 earning £245 per day or greater: |   |
|-------------------------------------------------------------------------------------------------|---|
| Number of existing engagements as of 31 March 2025 of which:                                    | 0 |
| Number that have existed for less than one year at time of reporting                            | 0 |
| Number that have existed for between one and two years at time of reporting                     | 0 |
| Number that have existed for between two and three years at time of reporting                   | 0 |
| Number that have existed for between three and four years at time of reporting                  | 0 |
| Number that have existed for four or more years at time of reporting                            | 0 |

| All highly paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater: |   |
|-------------------------------------------------------------------------------------------------------------------------------|---|
| Number of off-payroll workers engaged during the year ended 31 March 2025:                                                    | 0 |
| Of which:                                                                                                                     |   |
| Not subject to off-payroll legislation                                                                                        | 0 |
| Subject to off-payroll legislation and determined as in-scope of IR35                                                         | 0 |
| Subject to off-payroll legislation and determined as out-of-scope of IR35                                                     | 0 |
| Number of engagements reassessed for compliance or assurance purposes during the year                                         | 0 |
| Of which: number of engagements that saw a change to IR35 status following review                                             | 0 |

| Any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024:                                                                     |   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year                                                                              | 0 |
| Number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements | 0 |

## The audit committee

The membership of the Audit and Risk Committee consists of three independent directors. The board should satisfy itself that the membership of the committee has sufficient skills to discharge its responsibilities effectively and ensure that at least one member of the committee has recent and relevant financial experience.

The committee is chaired by Mr Readshaw.

There were six (6) meetings held during 2025-26. Overall attendance was good throughout the year.

| Non-executive Directors | Total number attended | % attendance |
|-------------------------|-----------------------|--------------|
| Mr K Readshaw           | 6/6                   | 100          |
| Ms M Davidson           | 2/3                   | 66.6         |
| Mr D Redpath            | 3/3                   | 100          |
| Ms A Fellows            | 2/3                   | 66.6         |
| Ms C Weldon             | 1/1                   | 100          |

The committee remains responsible for providing the board with advice and recommendations on matters which include the effectiveness of the framework of controls in the trust, the adequacy of the arrangements for managing risk and how they are implemented, the adequacy of the plans of our auditors and how they perform against them, the impact of changes in accounting policy and the committee's review of the Annual Accounts.

The committee ensured a focus on the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these met the NHS Counter Fraud Authority's requirements standards.

#### **The committee met its responsibilities during 2025/26 by:**

- Reviewing the Board Assurance Framework
- Reviewing risk and internal control-related disclosures, such as the Annual Governance Statement
- Reviewing the work and findings of Internal Audit, including the Internal Audit annual plan
- Reviewing the work and findings of External Audit
- Reviewing the work and findings of the Local Counter Fraud Officer and other fraud reports
- Reviewing the process by which clinical audit is undertaken in the organisation
- Reviewing the process by which staff are able to speak up in the organisation
- Monitoring the extent to which our external auditors undertake non-audit work having reference to the Auditors Guidance Note 1 (AGN01) 'General Guidance Supporting Local Audit'
- Reviewing the 2025-26 Financial Statements and Annual Report, prior to submission to the board and NHS England
- Seeking assurance that the financial statements have been appropriately compiled on a going concern basis
- Reviewing and approving the trust's Standing Financial Instructions and Scheme of Delegation

- Reviewing Trust policies such as standing financial instructions, accounting policies and BAF standard operating procedure
- Approving the Register of Interests for the trust Board of Directors
- Seeking assurance in relation to the trust's compliance with regulatory changes
- Reviewed the schedule of losses and compensations, the annual fraud report and provided assurance to the board following each of its meetings
- Received a report on compliance with the Provider License and recommended this to the board
- Received a report on the decisions regarding matters reserved to the unitary Board and delegated to the Group Board as part of the joint single committee established with North Tees and Hartlepool NHS Trust in 2025-26.

A review of the committee effectiveness was undertaken in May 2025, based on a survey of members and attendees. Members were satisfied with the way the committee was operating and a small number of considerations are identified in the report.

In the review of internal audit and management assurance reports, Audit and Risk Committee identified 10 High, 29 Medium and 12 low risk findings to improve weaknesses in the design of controls and/or operating effectiveness. Eight High risk rated findings have been identified across the reviews carried out during the year. These have been summarised in the annual governance statement.

### **Significant issues considered by the Audit Committee**

During the year, the Audit Committee considered a number of significant issues in relation to the financial statements, focusing on areas such as going concern status and financial sustainability, taking into account the wider NHS financial context.

The Committee addressed these issues through detailed review of reports from management and the external auditor, challenge of key assumptions and methodologies, and consideration of benchmarking and sector guidance where appropriate. The external auditor presented its audit findings, including identified risks and how they were addressed, and confirmed whether it considered management judgements to be reasonable. The Committee was satisfied that the significant issues had been appropriately addressed and that the financial statements, taken as a whole, were fair, balanced and understandable.

### **Assessment of external audit independence, effectiveness and appointment**

The Audit Committee is responsible for overseeing the effectiveness and independence of the external audit process. During the year, the Committee assessed the external auditor's performance by reviewing the quality and clarity of its audit plan, the robustness of its risk assessment, the execution of the audit, and the quality of reporting to the Committee. This assessment drew on feedback from Committee members and senior management, as well as the auditor's own transparency reporting and adherence to professional standards. The Committee concluded that the external audit remained effective and provided the appropriate level of assurance to the Board.

The external auditor is appointed in accordance with the relevant statutory and NHS sector requirements. The Committee keeps under review the auditor's independence, including consideration of partner rotation and safeguards in place within the audit firm. The length of tenure of the current audit firm, the timing of the most recent audit tender process and any forthcoming retendering plans are monitored to ensure compliance with regulatory expectations and to support audit quality and independence. Where a retender is due, the Committee will oversee a fair and transparent procurement process, making recommendations to the Council of Governors as appropriate regarding appointment or reappointment.

### **Safeguards relating to non-audit services**

The Audit Committee also monitors the provision of non-audit services by the external auditor to ensure that independence and objectivity are not compromised. The Trust has an established policy governing the engagement of the external auditor for non-audit work, which sets out the types of services that are permitted, those that are prohibited, and the approval thresholds applicable. All non-audit engagements are subject to prior approval by the Committee (or its Chair under delegated authority), with careful consideration given to the nature of the work, the level of associated fees, and whether the engagement could create a self-review or advocacy threat.

In addition, the Committee reviews the total fees paid to the external auditor for audit and non-audit services each year, assessing these against relevant ethical standards. The external auditor provides confirmation of its independence and compliance with applicable professional and ethical requirements. Where appropriate, alternative providers are used for non-audit services to avoid conflicts of interest. Based on these safeguards, the Committee is satisfied that the external auditor's independence and objectivity have been maintained throughout the year.

### **Charitable Funds Committee**

The Charitable Funds Committee has continued to meet during 2025/26 for the on-going management of charitable funds on behalf of the Corporate Trustees

# Staff report

Information relating to workforce statistics (staff sickness) can also be found at <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>

## Staff experience and engagement

### Staff experience and engagement

The trust recognises the importance of true and meaningful engagement with our people. The annual staff survey plays a critical part in this however, is not the only means of engagement with our staff. This is supported by various methods, including quarterly pulse surveys (something we are looking to develop further as part of our University Hospitals Tees Group model over the next year), regular briefings from our executive and senior leaders across the trust and Group, active social media presence and regular 'Hearing it' sessions with the Group Chief Executive Officer. These online sessions are open to every member of staff across the group and provide the opportunity to ask questions on a wide range of subjects.

### Staff survey

The NHS staff survey is conducted annually. The survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. All indicators are based on a score out of 10 for specific questions where a higher score is more positive than a lower score. The response rate to the 2025 survey was 29% which is a reduction of 1%, from the 2024 survey (30%), nationally there was a 3% decline in uptake.

Scores for each indicator for 2025, 2024 and 2023 together with that of the survey benchmarking group for each year (acute and acute and community Trusts) are presented below:

| Indicators<br>(‘People Promise’<br>elements and<br>themes) | 2022/25     |                             | 2023/24     |                             | 2022/23     |                             |
|------------------------------------------------------------|-------------|-----------------------------|-------------|-----------------------------|-------------|-----------------------------|
|                                                            | Trust score | Benchmarking<br>group score | Trust score | Benchmarking<br>group score | Trust score | Benchmarking<br>group score |
| <b>People Promise:</b>                                     |             |                             |             |                             |             |                             |
| We are<br>compassionate<br>and inclusive                   | 7.14        |                             | 7.28        | 7.24                        | 7.29        | 7.34                        |
| We are<br>recognised and<br>rewarded                       | 5.63        |                             | 5.87        | 5.80                        | 5.92        | 5.83                        |
| We each have a<br>voice that counts                        | 6.46        |                             | 6.60        | 6.59                        | 6.67        | 6.70                        |
| We are safe and<br>healthy                                 | 5.81        |                             | 6.07        | 5.99                        | 6.13        | 6.06                        |
| We are always<br>learning                                  | 5.25        |                             | 5.57        | 5.39                        | 5.64        | 5.45                        |
| We work flexibly                                           | 5.70        |                             | 6.22        | 5.83                        | 6.24        | 5.90                        |
| We are a team                                              | 6.48        |                             | 6.75        | 6.54                        | 6.75        | 6.65                        |
| Staff engagement                                           | 6.55        |                             | 6.74        | 6.78                        | 6.84        | 6.90                        |
| Morale                                                     | 5.59        |                             | 5.84        | 5.84                        | 5.93        | 5.93                        |

The NHS annual staff survey was carried out in Autumn 2025. The survey mode was mixed, and the sample type was a census with a response rate of 29% (3,008 members of staff).

The questions in the NHS Staff Survey are aligned to the People Promise (from 2021 onwards). This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

The 2025 results for the above seven areas are as follows and include the results for additional themes of staff engagement and morale.

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## We are compassionate and inclusive

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Key indicators in the section relate to care of our patients, raising concerns and recommending the trust as a place to work and for this indicator the trust benchmarks above the national average.

The sub-score trends indicate lower scores in comparison to 2024 and 2023 for Compassionate Culture, Diversity and Equality and Inclusion. We have shown an increase in the sub-theme Compassionate Leadership. The trust remains above the national average for Diversity and Equality. An increased percentage of staff responded positively to the question “My immediate manager cares about my concerns”.

Throughout 2025/26 we have:

- Continued to develop our staff networks, with executive support, encouraging membership and positive engagement including those from protected characteristics;
- EDI calendar of events launched with EDI engagement sessions ran throughout the year;
- Embedded civility in the workplace training;
- Cultural Ambassadors programme embedded;
- Developed and promoted new Group Values and our Values into Action;
- Development of Health and Wellbeing Passport with an associated Managers toolkit.

## Raising concerns and issues

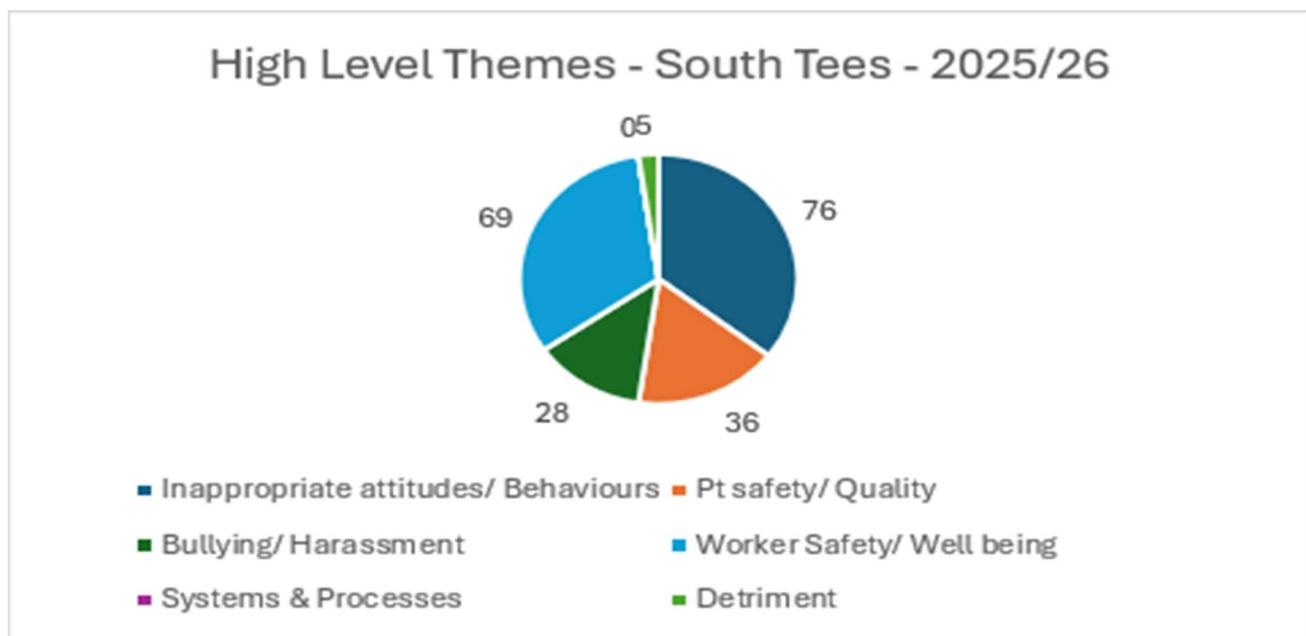
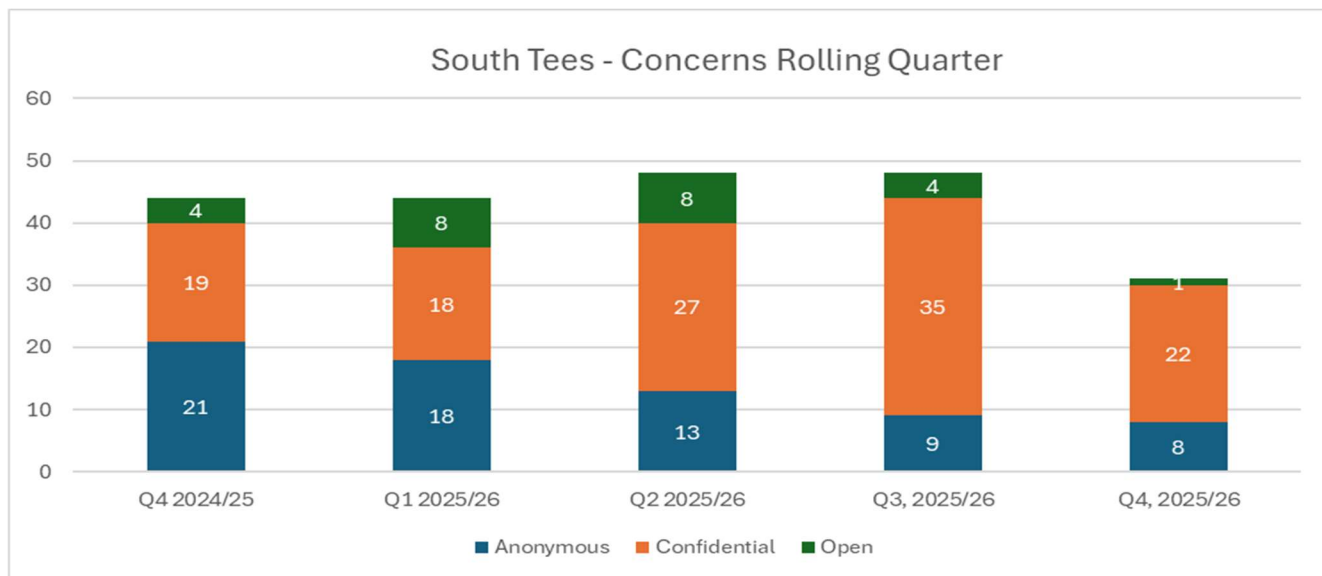
We continue to embed a restorative just and learning culture across UHT. This approach recognises that whilst mistakes may occur, accountability must be upheld, with a focus on learning, supporting staff and repairing trust following incidents.

Across STHFT Freedom to Speak up Guardians provide 82.5 hours of support weekly, Between 1 April 2025 and 31 March 2026:

- **170 concerns** were raised at South Tees (a **14.8% increase** from 148 in 2024/25).

Anonymous reporting decreased:

- South Tees: **28.2% (48 cases)**, down from 42.67% (65 cases) in 2024/25.



The most reported theme across both trusts in 2025/26 was inappropriate attitudes/behaviours, mirroring the national picture reported by the National Guardian's Office for the second consecutive year.

As we continue to embed a culture of making speaking up "business as usual", the FtSUG's continue with the proactive work to encourage all workers to speak up and report their concerns by helping them to feel empowered and psychologically safe. Over the next twelve months the FtSUG's have identified several opportunities, including:

- A single reporting system that can be utilised across the group model.
- Implementing the detriment standard operating procedure across the Clinical Support Units, to support in tackling barriers of detriment for workers speaking up.

- Continued engagement with group networks, to help build relationships with the network leads.
- The FtSUG continues to expand their Freedom to Speak Up Champion (FtSUC) network, through a fair recruiting process, as per National Guidance. The FTSUC's are trained, can attend quarterly network meetings, have informal bi-annual 1-2-1 and are asked to support staff and signpost and collect high level themed data for triangulation.

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## We are recognised and rewarded

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This theme includes recognition for good work, feeling valued and satisfaction with level of pay and for this indicator we benchmark above the national average. Our results are lower than last year; however, we did see an increase in the positive scoring for 'My immediate manager values my work (68.43%)'.

Throughout 2025/26 we have:

- Engaged with staff to understand how they would like reward and recognition to look in the future
- Group recognition events (such as Love Admin event and AHP awards hosted across both sites in 2025;
- Developed a new Group recognition strategy covering differing levels of appreciation ranging from day-to-day to the larger scale recognition events.

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## We each have a voice that counts

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This theme explores how colleagues feel about their work environment with opportunities to use initiative, are trusted to do their role and can make suggestions. For this indicator we benchmark below the national average for both theme and related sub themes. Our overall score is lower than last year with staff reporting they feel less involved in deciding on changes within their work area / team / department.

Throughout 2025/26 we have:

- Encouraged regular discussions between all staff to provide opportunity to share ideas, innovations and improvements across teams and services
- Freedom to Speak up Guardians, policy and processes actively in place, Speak Up champions identified and shared across the group
- Freedom to Speak up present at our Group Welcome for new staff
- Staff networks active and linked with Cultural Development team
- Hearing it sessions with Group Chief Executive
- Staff Facebook Groups

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## We are safe and healthy

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This theme covers staffing, health and wellbeing and bullying. For this indicator we benchmark above the national average. In comparison to 2024, a higher percentage of staff report there are not enough staff at the organisation for them to do their job properly.

Throughout 2025/26 we have:

- Set up Active Hospitals Steering Group to encourage staff to be more active in the workplace.

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## We are always learning

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This theme focuses on development opportunities and appraisals. For this indicator we have shown a decline from 2024 to 2025. We are below the national average for this theme and both sub themes. However, a higher percentage of staff report that they have had an appraisal within the past 12 months.

Throughout 2025/26 we have:

- Refreshed the appraisal documentation and policy across the group
- Proactive approach to responding to incidents and near misses across teams to promote just culture and Patient Safety Incident Response Framework (PSIRF)
- Management and Leadership training in place across the group (internal and external)
- Apprenticeships widely available
- Clinical skills training (simulation training)
- Further development of the Health and Social Care Academy at University Hospital of Hartlepool

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## We work flexibly

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This theme relates to home life balance and flexible working. For this indicator we benchmark below the national average and have shown a decline from the 2024 score. A lower percentage of staff report achieving a balance between my work and home life however, a higher percentage of staff feel they can approach their immediate manager to talk openly about flexible working.

Throughout 2025/26 we have:

- Awareness and education around flexible working
- Toolkits provided for staff and managers to access for visual aids
- Supported colleagues and managers with reasonable adjustments through the development of a Health and Wellbeing passport and reasonable adjustment training

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## We are a team

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This theme looks at the support, respect and encouragement from line managers and team working. For this theme and related subthemes 'Team working' and line management' the trust is below the national average. However, there has been an improvement in staff reporting whether disagreements are dealt with constructively within the team, where in 2024, this question showed our biggest decline.

Throughout 2025/26 we have:

- Encouraged team meetings and regular meetings with staff and leaders
- Trained insights facilitators in place and active approach to team development and coaching
- Developed a group approach to request organisation development support for team building
- Provided group wide leadership training
- Implemented the TED tool to support line managers taking ownership of their team building

### Future priorities and targets

Following the publication of the 2025 NHS staff survey, the group's CSU's will develop their People Plans guided by the staff survey data, with progress monitored through the senior management teams.

Our cultural development team will be running masterclasses across the group to support team leads in engaging and actioning their result findings. The team will also be offering individual support to all team leads and those with the lowest average result scores and those who did not achieve an individual department report will be supported to engage with the TED tool.

In collaboration with the communication team, the trust will develop a 'Changes Inspired by You' response using the survey results.

### Occupational Health and Wellbeing Services

Wellbeing team continues to provide essential day-to-day clinical services and wellbeing support for colleagues across the trust. These services include ensuring colleagues are medically fit to carry out their roles, delivering mental health support, musculoskeletal (MSK) physiotherapy, and a range of evidence-based health and wellbeing initiatives. The team also leads on vaccination programmes and provides dedicated menopause support—an area in which the trust has been recognised as one of the first to offer specialist menopause clinics.

The trust has recently been awarded Better Health at Work Ambassador Status, acknowledging our long-standing commitment to colleague wellbeing. This achievement reflects the significant efforts made to go beyond basic requirements and continually evolve our approach to meet both immediate and emerging needs.

By working closely with regional occupational health teams, the trust will continue to participate in wider workstreams, share learning, and review best practice to ensure our colleagues receive the highest standard of support

## Developing a sustainable workforce

We experience some difficulties recruiting to specific roles, particularly where there are national shortages or where demand outstrips supply. However, our retirement policies enable us to offer flexibility in the working arrangements for our experienced staff which has assisted in our turnover rate remaining lower than the national average, ensuring that we sustain a developed and experienced workforce.

Our objectives for developing a sustainable workforce are:

- To further triangulate our workforce planning, performance improvement and financial planning needs to develop a workforce plan which identifies any fragile services, and which facilitates the alignment of services and the progression of University Hospitals Tees.
- Continue to focus on understanding voluntary turnover and progress plans to address turnover hotspots such as early 'check ins' for newly recruited colleagues and an improved onboarding journey along with continuation of 'itchy feet' and 'stay' conversations with colleagues expressing a wish to leave.
- Introducing a digital solution to enable talent management and succession planning.
- Promoting the trust as an employer of choice within the local communities and developing a social media presence which showcase the available career and job opportunities to increase candidate reach.
- Continue with and develop recruitment and selection training for managers to ensure we appoint colleagues who demonstrate the abilities and values of the trust.
- Continue to promote the trust within the local community and as an employer of choice to promote vacancy and support the long-term unemployed.
- Redesign and reposition career opportunities so that they feel accessible and within the reach of our local community.
- Continue to build our relationships with higher education and further education sectors which will provide an opportunity to develop a talent pipeline and enable our colleagues to develop into new roles.

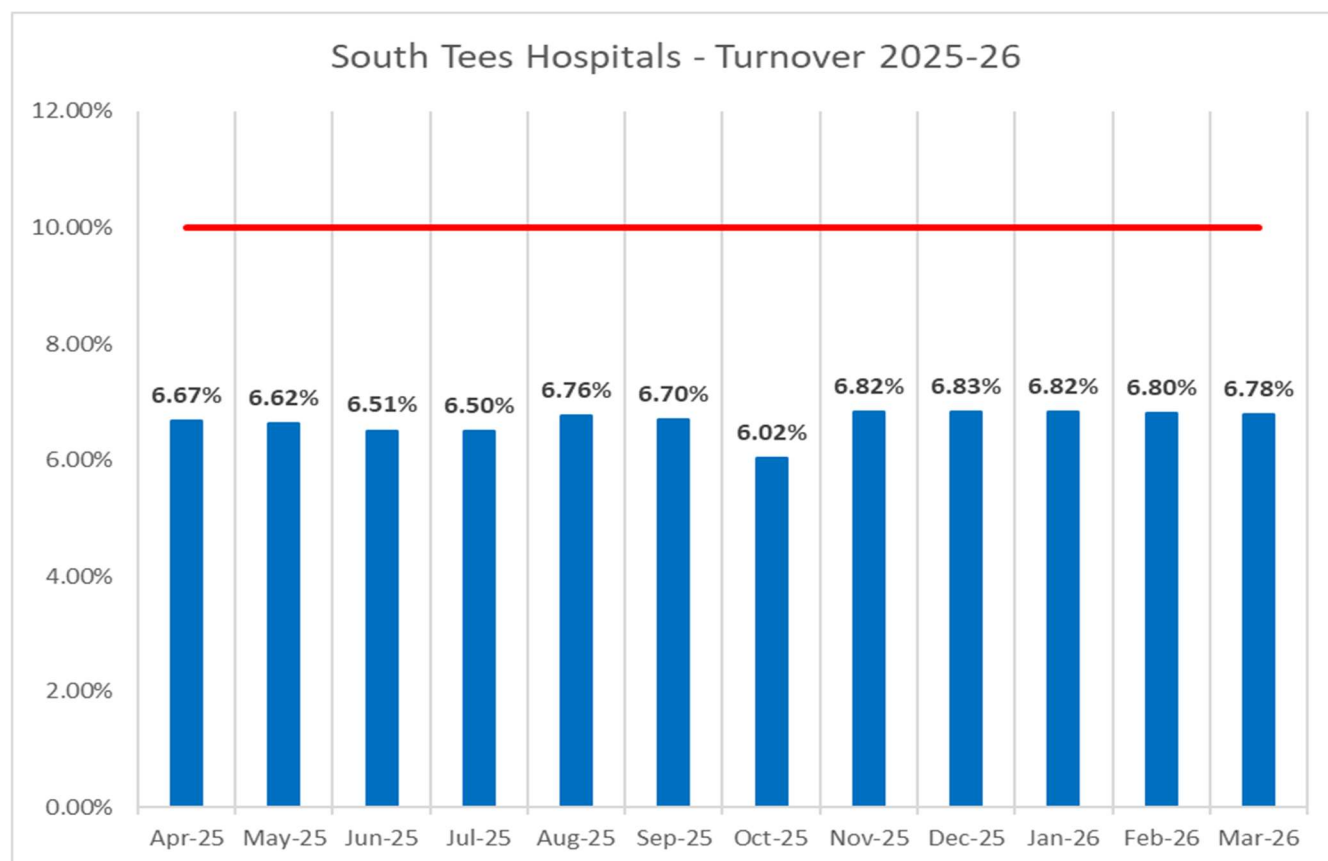
## Staff turnover

Staff turnover is reported within NHS Hospitals and Community Health Services (HCHS): Summary statistics for HCHS staff in England through NHS Digital. The series utilises data from the Electronic Staff Record (ESR) data warehouse and is an official statistics publication complying with the UK Statistics Authority's Code of Practice.

The turnover section within the organisation benchmarking tool, NHS Workforce Statistics dashboard is updated on a quarterly basis, in monthly reports, accessible through the following link: Microsoft Power BI. Staff turnover is reported within NHS Hospitals and Community Health Services (HCHS): Summary statistics for HCHS staff in England through NHS Digital. The

series utilises data from the Electronic Staff Record (ESR) data warehouse and is an official statistics publication complying with the UK Statistics Authority's Code of Practice.

The trust turnover continues to remain below the 10% threshold throughout the year, indicating a stable yet healthy turnover across the organisation.



## Staff consultation

We continue to work in close partnership with Trade Union colleagues, with a Partner Agreement which:

- Provides opportunities for joint problem solving in relation to the issues affecting the health and wellbeing of employees and the continued efficient operation of the organisation
- Provides staff with an additional mechanism of support through potentially challenging situations
- Promotes the co-operation of staff and managers within the trust by providing a culture in which matters affecting staff can be discussed
- Supports consultation in relation to key changes on HR policies
- Supports consultation on operational changes within the organisation, including final performance, key Trust service changes

The Joint Partnership Council (JPC) is held monthly and attended by both management and local Staff Side colleagues. The agenda items include both local, regional and national topics and the relationship between Staff Side and management is a productive and positive partnership. There is also a Committee-in Common in place for both Noth Tees and Hartlepool Hospital Foundation Trust and South Tees Hospitals NHS Foundation Trust where consistent topics across University Hospitals Tees are discussed.

## Staff Policies

The trust continues to operate its suite of HR policies to ensure a fair, equitable and compassionate approach to its people practices. These policies include: Recruitment and Selection, Equality and Diversity, Effective Management of Mandatory Training, Health and Safety, Sickness Absence, Management of Capability, Dignity at Work, Code of Conduct, Grievance, Disciplinary, Avoidance of Redundancies & Change Management and Pay Protection

As part of its good governance processes, a cycle of review and refresh of policies has continued during the year to ensure that the staff policies remain fit for purpose and in accordance with best HR and employment practice. The key focus has been to develop, in full, a suite of University Hospitals Tees policies to ensure equity and fairness. Management, Trade Unions and HR representatives have worked together collectively in order to effectively develop these new policies.

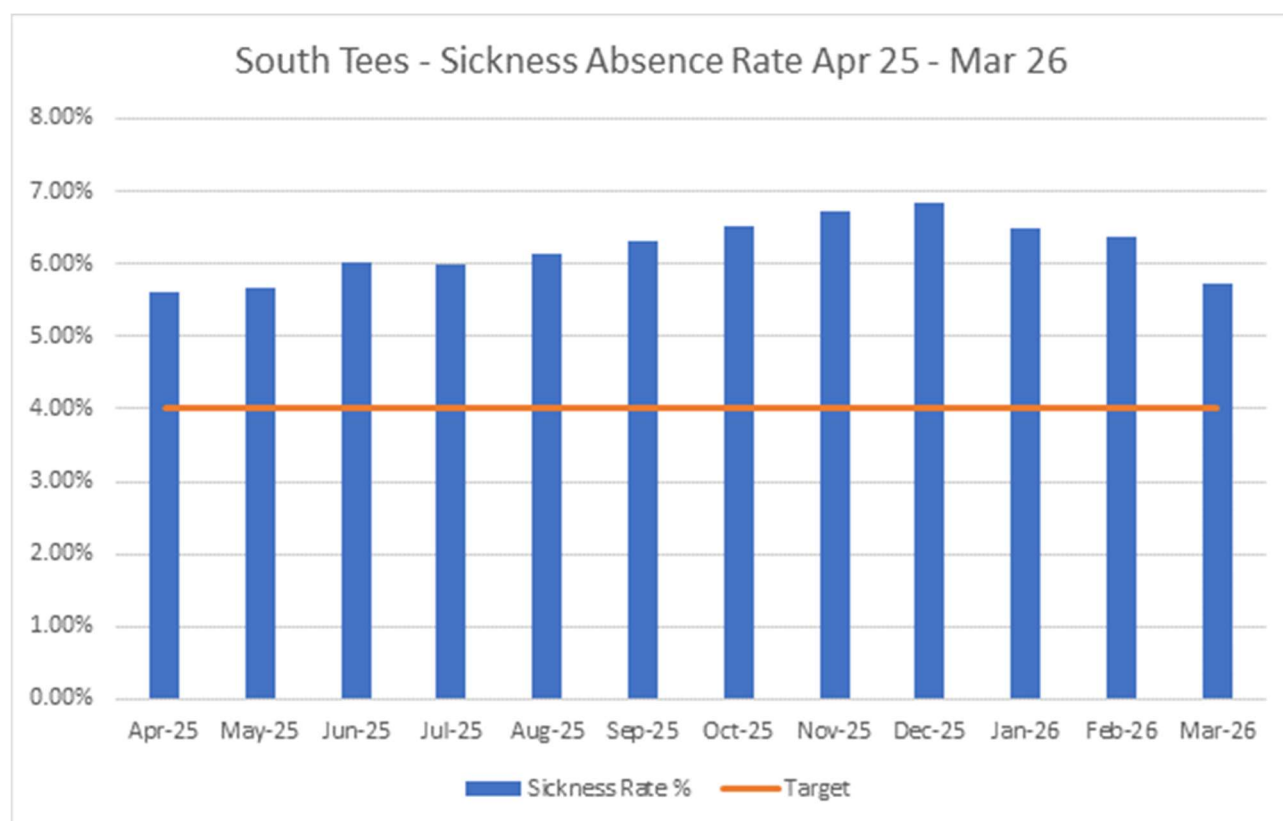
Several policies have already been developed and approved including: Recruitment & Selection, Disciplinary, Absence Management, Capability and MHPS. Further policies are under development, and it is anticipated that Mandatory Training, Sexual Safety and Time Away from Work will be approved by the end of April 2026. Once completed, further policies will be worked on, and this cycle will continue until all policies in place are University Hospitals Tees policies. Following implementation of all policies, a cycle of review will be implemented to ensure timely review and update of policies to ensure that they remain legally compliant and appropriate.

## Staffing analysis

The Trust employs circa 6360 staff and the table below shows staff numbers as at 31 March 2026.

| Headcount and WTE (as at 31 <sup>st</sup> March 2026) |           |      |        |      |
|-------------------------------------------------------|-----------|------|--------|------|
|                                                       | Headcount |      | WTE    |      |
| Category                                              | Female    | Male | Female | Male |
| Directors (inc non execs and chairman)                | 6         | 8    | 6      | 7.8  |
| Senior Managers                                       | 408       | 123  | 377    | 120  |
| Employees                                             | 8468      | 2214 | 7076   | 1776 |

## Absence Data



The Department of Health and Social Care Group Accounting Manual requires the sickness absence data for NHS bodies to be reported in the annual report on a calendar year basis. The most current data for the Trust for the Calendar year 2025 can be found below and at:

[Digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates)

### Staff exit packages

In 2025/26, the trust agreed an exit package with 38 members of staff (there were 3 instances in 2024/25) which cost £0.537 million.

In 2025/26, the trust agreed to settlement payments in relation to Employment Tribunal Claims for two individuals, which cost £15,571.99.

### Apprenticeships

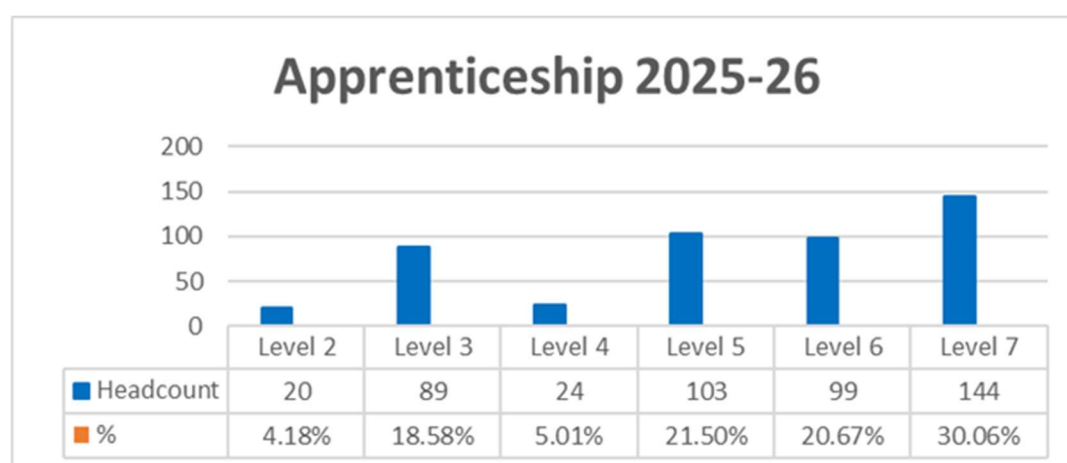
During 2025–26, the apprenticeship teams from North Tees & Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust continued their integration under the newly established University Hospitals Tees (UHT) Career and Development Hub. Work focused on streamlining and aligning internal systems and processes in preparation for the launch of a fully unified UHT apprenticeship offer in April 2026.

Alongside this internal development, the team has closely monitored national apprenticeship reforms to ensure the organisation remains informed of potential impacts on current programmes and future levy utilisation. Key reforms under review include:

- the transition to the Growth and Skills Levy
- the removal of funding for Level 7 apprenticeships for learners aged 21 and over
- the planned withdrawal of several leadership and management apprenticeship standards at Levels 3–6
- the introduction of shorter-duration apprenticeship units
- a reduction in levy fund expiry from 24 to 12 months
- the removal of the 10% government apprenticeship levy top-up

With the introduction of Clinical Service Units, the UHT apprenticeship team continue to work closely with stakeholders to ensure that levy funding is deployed strategically, aligned to workforce plans, and targeted toward addressing priority skills gaps across the organisation.

UHT currently works in partnership with 44 regional and national training providers, supporting 479 live apprentices across a wide range of clinical and non-clinical apprenticeship standards.



In addition to delivering internal apprenticeship programmes, UHT continues to support workforce development across the wider health and care system through apprenticeship levy transfers. These transfers enable partner organisations—particularly smaller employers—to access high-quality apprenticeship training that may otherwise be financially prohibitive. This supports system-wide capacity building, helps address shared skills shortages and contributes to the development of a flexible, sustainable workforce across the region.

During 2025–26, UHT supported 31 new apprenticeship starts through levy transfers, benefitting partners including ambulance services, local councils, dental practices, GP surgeries and nursing homes. A further 71 levy transfers have been committed for initiation from April 2026 onwards.

## Public Sector Equality Duty

Our workforce remains our most valuable asset. Their commitment to delivering safe, compassionate and high-quality patient care underpins all organisational priorities. In line with NHS People Plan and NHS Equality, Diversity and Inclusion (EDI) Improvement Plan expectations, we continue to focus on creating a culture where colleagues feel they belong, are treated fairly, and have equitable access to development and progression. Our breakdown of workforce by protected characteristic is below;

### South Tees

| Gender | Headcount | Sum of FTE |
|--------|-----------|------------|
| Female | 8724      | 7394.26    |
| Male   | 2162      | 1842.59    |
| Trust  | 10886     | 9236.85    |

| Ethnicity  | Headcount | Sum of FTE |
|------------|-----------|------------|
| BME        | 1748      | 1492.15    |
| Not Stated | 147       | 116.06     |
| White      | 8991      | 7628.64    |
| Trust      | 10886     | 9236.85    |

| Religion                | Headcount | Sum of FTE |
|-------------------------|-----------|------------|
| Atheism                 | 2007      | 1770.77    |
| Buddhism                | 57        | 45.06      |
| Christianity            | 5160      | 4398.61    |
| Do not wish to disclose | 1970      | 1613.93    |
| Hinduism                | 207       | 181.76     |
| Islam                   | 499       | 392.99     |
| Jainism                 | 2         | 1.00       |
| Judaism                 | 5         | 4.28       |
| Other                   | 19        | 10.03      |
| Sikhism                 | 943       | 805.50     |
| Unspecified             | 17        | 12.92      |
| Trust                   | 10886     | 9236.85    |

| Sexual Orientation                  | Headcount | Sum of FTE |
|-------------------------------------|-----------|------------|
| Bisexual                            | 138       | 119.77     |
| Gay or Lesbian                      | 199       | 179.94     |
| Heterosexual or Straight            | 9118      | 7783.33    |
| Not stated                          | 1406      | 1132.05    |
| Other sexual orientation not listed | 20        | 16.96      |
| Undecided                           | 5         | 4.80       |
| Trust                               | 10886     | 9236.85    |

| Disability                     | Headcount    | Sum of FTE     |
|--------------------------------|--------------|----------------|
| Learning disability/difficulty | 196          | 174.69         |
| Long-standing illness          | 196          | 163.80         |
| Mental Health Condition        | 81           | 71.81          |
| No                             | 8853         | 7530.25        |
| Not Declared                   | 1220         | 1017.54        |
| Other                          | 56           | 47.35          |
| Physical Impairment            | 53           | 42.12          |
| Prefer Not to Answer           | 0            | 0.00           |
| Sensory Impairment             | 33           | 27.70          |
| Yes - Unspecified              | 144          | 115.12         |
| Do not wish to disclose        | 54           | 46.46          |
| <b>Trust</b>                   | <b>10886</b> | <b>9236.85</b> |

| Staff group                      | Headcount    | Sum of FTE     |
|----------------------------------|--------------|----------------|
| Add Prof Scientific and Technic  | 231          | 206.13         |
| Additional Clinical Services     | 2280         | 1902.61        |
| Administrative and Clerical      | 1874         | 1618.77        |
| Allied Health Professionals      | 1096         | 969.81         |
| Estates and Ancillary            | 356          | 296.07         |
| Healthcare Scientists            | 278          | 251.57         |
| Medical and Dental               | 1227         | 851.27         |
| Nursing and Midwifery Registered | 3542         | 3138.61        |
| Students                         | 2            | 2.00           |
| <b>Trust</b>                     | <b>10886</b> | <b>9236.85</b> |

| Staff group                                     | Headcount    | Sum of FTE      |
|-------------------------------------------------|--------------|-----------------|
| Administration and estates                      | 3562         | 2992.86         |
| Ambulance staff                                 | 18           | 15.83           |
| Healthcare assistants and other support staff   | 3957         | 3289.50         |
| Healthcare science staff                        | 386          | 350.12          |
| Medical and dental                              | 1785         | 1196.63         |
| Nursing, midwifery and health visiting learners | 2            | 2.00            |
| Nursing, midwifery and health visiting staff    | 5387         | 4769.60         |
| Scientific, therapeutic and technical staff     | 1991         | 1730.50         |
| <b>Trust</b>                                    | <b>17088</b> | <b>14347.04</b> |

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We remain committed to addressing inequalities experienced by colleagues across diverse protected groups. To achieve this, we ensure that our action plans take full account of intersectionality and the varied experiences of our workforce. Through our equality, diversity and inclusion (EDI) programme, we continue to promote our organisational values and behaviours, with a particular emphasis on cultivating a strong sense of belonging by recognising and embracing individual differences.

The Cultural Development Team implement and provide a range of training, awareness sessions/events and developmental opportunities. These initiatives are designed to enhance staff understanding of inclusive practice and ensure colleagues have the knowledge and support required to uphold an inclusive culture across the organisation. In Autumn 2025, the trust hosted their annual Equality, Diversity and Inclusion (EDI) Conference, highlighting our ongoing commitment to fostering a more inclusive and culturally competent organisation. The event brought together colleagues from across University Hospitals Tees (UHT), partner organisations, and members of our staff networks to engage in learning, reflection and meaningful dialogue around workplace inclusion.

We are also continuing to embed a restorative, just and learning culture. This approach ensures that when things go wrong, staff are supported, learning is prioritised and the focus remains on understanding 'what' happened rather than attributing blame. At the same time, we remain clear that behaviours falling short of our organisational values, including any form of discrimination or prejudice, will not be tolerated.

We continue to hold Disability Confident Employer status, demonstrating our commitment to removing barriers, promoting fairness, and ensuring equity within recruitment and employment practices

We comply with the Public Sector Equality Duty and Equality, Diversity and Inclusion legislation and NHS contract requirements and align our legal obligations with the NHS Standard Contract and frameworks like the Equality Delivery System (EDS2/EDS2022), WRES and WDES. Our annual Equality and Diversity report demonstrates our commitment to this and can be viewed on the website at [Equality and diversity report 2024 – 2025 - South Tees Hospitals NHS Foundation Trust](#).

**Our 2025/26 Equality, Diversity and Inclusion objectives are:**

- Ensure open and transparent opportunities for all;
- Review people policies and procedures;
- Create diverse and inclusive culture;
- To keep our colleagues safe and well at work.
- Work is underway to review and bring the Equality Objectives together as one across the group for 2026/27, with the national EDI High Impact Actions in mind.

## Gender pay gap report

In 2024-25 we reported a mean gender pay gap of 30.44% and a median gender pay gap of 21.14%.

The table below shows our gender pay gap data for the period 31 March 2024 to 31 March 2025.

| South Tees | Average <b>Mean</b> Gender Pay Gap – Whole Workforce |           | Average <b>Median</b> Gender Pay Gap – Whole Workforce |           |
|------------|------------------------------------------------------|-----------|--------------------------------------------------------|-----------|
|            | 2024/2025                                            | 2023/2024 | 2024/2025                                              | 2023/2024 |
| Male       | £25.35                                               | £16.42    | £14.89                                                 | £14.11    |
| Female     | £17.64                                               | £23.15    | £18.88                                                 | £17.96    |
| Difference | £7.72                                                | £6.73     | £3.99                                                  | £3.84     |
| Pay gap %  | 30.44%                                               | 29.08%    | 21.14%                                                 | 21.41%    |

As reported in previous years, there is a greater proportion of male workers within the categories of medical and dental (M&D) and very senior manager (VSM). These roles are the highest paid workers of the organisation and equate to 6.57% of the total workforce.

Our actions to improve the Gender Pay Gap align with University Hospitals Tees strategic objectives as well as support our commitments to the NHS People Plan. Our Gender Pay Gap report can be access through the following website address [Search and compare gender pay gap data - Gender pay gap service - GOV.UK](#)

## Workforce Race Equality Scheme and the Workforce Disability Equality Scheme

We continue to progress and strengthen our workforce culture and inclusion agenda, with oversight and assurance provided through the People Committee. Our 2025 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports are published on the trust website. [NHS Workforce Race Equality Standard annual report - South Tees Hospitals NHS Foundation Trust](#) and [NHS Workforce Disability Equality Standard annual report - South Tees Hospitals NHS Foundation Trust](#)

Our Race Equality Network and Disability Staff Network remain actively engaged in improving staff experience and contributing to strategic cultural development. Both networks play a key role in shaping and supporting new and emerging initiatives, including the implementation of the Generic Staff Passport, development of the trust's Anti-Racism Framework, and participation in policy reviews to ensure our approaches remain equitable, inclusive and reflective of colleagues' diverse needs.

## Staff Networks

The role of our Staff Networks in embedding Equality, Diversity, and Inclusion (EDI) across the organisation remains central to creating a workplace where all colleagues feel valued, respected, and able to thrive. Our networks continue to act as powerful drivers of cultural improvement—providing a voice for under-represented groups, championing inclusion, and influencing positive organisational change. We are now exploring opportunities to bring networks together where beneficial, with the aim of creating stronger, more resilient, and dynamic groups capable of having greater collective impact on the promotion of equality and inclusion.

A key function of our staff networks is to offer a safe and supportive environment where employees can share experiences, raise concerns, and access peer support. These spaces are particularly important for colleagues from communities who may face additional barriers or discrimination.

Our current staff networks include:

- Ethnic Minority/Racial Equality Network (REN)
- Childless Not by Choice (CNBC) Group
- Ability/ Disability and Long-Term Health Group
- Interfaith and Culture Network
- LGBTQ+ Network
- Menopause Group
- Neurodiversity Network
- Carers Network
- Younger and Older Worker Networks
- Women's and Men's Network
- Volunteers Network

By fostering a strong sense of belonging, the networks contribute to increased engagement, improved wellbeing, and better retention of staff across the trust.

Our staff networks continue to play a key advisory role, sharing lived experiences and providing honest insight into challenges faced by under-represented groups. This feedback informs leadership and People Services teams, supporting the development of fairer, more inclusive policies and practices.

The networks' contributions help ensure our policies reflect the realities faced by our workforce and support equity in practice, not only in principle.

Awareness-raising continues to be a core part of the networks' work. They lead and support a wide range of educational activities, workshops, and events that challenge bias, develop cultural understanding, and celebrate diversity. Annual events—such as Black History Month, International Women's Day, Disability History Month, and Pride Month—play a key role in amplifying diverse voices and enhancing staff understanding.

Staff networks continue to strengthen cross-trust engagement through monthly meetings, drop-in sessions, and collaborative events. These drop-in sessions offer colleagues an informal opportunity to meet network leads, learn about the support available, and find out how to get involved in shaping a more inclusive workplace.

Network leads have developed stronger relationships with multiple departments and leaders, enabling more frequent dialogue about barriers, challenges, and opportunities for improvement. This ongoing engagement helps maintain momentum and ensures that issues raised lead to meaningful action.

Recognising that many colleagues experience overlapping identities and forms of discrimination, our networks increasingly collaborate on shared priorities. This intersectional approach enables them to identify common themes, reduce duplication, and strengthen collective impact. For example, the Women's Network and LGBTQ+ Network have worked together on promoting gender-inclusive leadership pathways.

This year marks a significant step forward with the establishment of our new Cultural Development Team, who work across the group to support and develop inclusive cultural practices. The team is working closely with all staff networks, providing regular communication, strategic alignment, and practical support. Their involvement is helping to strengthen the networks' visibility, coordination, and impact.

In March, we held a dedicated Staff Network and Senior Leadership Team meeting, which represented a positive and forward-thinking step in our journey toward a more inclusive culture. This meeting provided an important platform for networks to be heard, acknowledged, and responded to directly by senior leaders. Feedback from the session has been highly positive and will help shape future engagement.

Work is underway to allocate Executive Sponsors to each staff network. This will enhance senior-level visibility, support escalation of issues, and embed stronger governance around inclusion activity. These partnerships will help ensure each network has a clear advocate at Board level, strengthening their influence and aligning their work with wider organisational priorities.

## NHS Oversight Framework

### Oversight Framework

NHS England NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. The framework looks at five national themes:

- quality of care, access and outcomes
- preventing ill health and reducing inequalities
- finance and use of resources
- people
- leadership and capability.

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

### Segmentation

Across the themes of the NOF (quality of care, finance and use of resources, operational performance, strategic change, leadership and improvement capability) the trust is placed in segment 3, mandated support for significant concerns, under the NHSE Regulatory Approach (Support Regime).

### EPRR assurance

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations must meet for emergency preparedness and response. The trust is required to undertake an annual self-assessment against the core standards to provide assurance to NHS England that robust and resilience EPRR arrangements are maintained within the trust.

For 2025-26 the EPRR core standards assessment provides assurance that the trust is partially compliant with 49 out of 62 standards, allowing us to declare partial compliance (79%) with the required EPRR core standards.

### EPRR activity and priorities

2025 has been another challenging year for EPRR, particularly with ongoing response to industrial action and the short-term challenges faced as the trusts move forward a group operating model. The Head of EPRR and EPO continued to work closely together and with Group / Trust management and clinical colleagues, the wider NHS and other stakeholders to develop and update the trusts EPRR arrangements in line with local risks, national policy and lessons identified from recent events.

### Application of the Modern Slavery Act

The Modern Slavery and Human Trafficking Act 2015 established a duty for commercial organisations to prepare an annual slavery and human trafficking statement to include the steps the organisation has taken during the year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business.

South Tees Hospitals NHS Foundation Trust provides more than 37 specialties to 1.5 million patients across Teesside, North Yorkshire and beyond. Care is delivered from two main acute hospital sites, The James Cook University Hospital and the Friarage Hospital in Northallerton and a number of community facilities across the area including Redcar Primary Care Hospital, East Cleveland Primary Care Hospital and the Friary Community Hospital.

We provide a large number of specialist services – delivering world-class cancer, cardiothoracic, spinal, cochlear implant, neurosciences, gynaecology vascular and urology care for patients across our region.

The trust supports and is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the trust to adhere to the same ethical principles. We have internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking.

We have zero tolerance for slavery and human trafficking and are fully aware of our responsibilities towards our service users, employees and local communities. We expect all the companies we do business with to share the same ethical values.

We also have an impartial Freedom to Speak up Guardian who supports staff to raise any concerns.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain, the trust and its subsidiary companies operates and adheres to a robust recruitment process including compliance with the National NHS Employment Checks / Standards (this includes employees UK address, right to work in the UK and suitable references) and employ agency staff (where appropriate) from agencies on approved frameworks so that we are assured that pre-employment clearance has been obtained to safeguard against human trafficking or individuals being forced to work against their will. If there is not an available worker from a framework agency, this is escalated to senior managers and local pre-employment checks, including the right to work in the UK, are sought.

We adhere to the principles inherent within both our safeguarding children and adults' policies. These provide clear guidance so that our employees are clear on how to raise safeguarding concerns, and by ensuring representation via the safeguarding team, on the Modern Slavery Network and the Vulnerable, Exploited, Missing, Trafficked strategic and operational groups, we provide a level of compliance with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment and access to training and development opportunities.

Our purchasing and procurement are governed by the NHS 'Supplier Code of Conduct' and standard NHS Terms and Conditions. High value contracts are effectively managed and relationships built with suppliers through frameworks which have been negotiated under the NHS Standard Terms and Conditions of Contract with anti-slavery and human trafficking policies and processes in place. All of our suppliers must comply with the provisions of the UK Modern Slavery Act (2015).

The trust upholds professional codes of conduct and practice relating to procurement and supply, including through our Procurement Team's membership of the Chartered Institute of Procurement and Supply

### **Disclosures set out in the Code of governance for NHS provider trusts**

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

There are other disclosures and statements (mandatory disclosures) that we are required to make, even where we are fully compliant. The mandatory disclosures have already been made within the main text of the Annual Report.

NHS Foundation Trusts are required to provide (within their Annual Report) a specific set of disclosures in relation to the provisions within Schedule A of the Code of Governance. We are compliant with these provisions and in compliance with the Code.

### **Statement of the Chief Executive's Responsibilities as the Accounting Officer of South Tees Hospitals NHS Foundation Trust**

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require South Tees Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

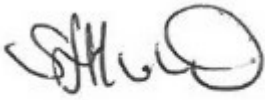
- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the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

- 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 trust's performance, business model and strategy.
- Prepare the financial statements on a going concern basis.

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

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

Signed:



**Stacey Hunter**

Date: 25 June 2026

Chief Executive and Accounting Officer

# Annual Governance Statement

## Scope of responsibility

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

## The 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 South Tees Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South Tees Hospitals NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

## Capacity to handle risk

Within the trust, overall responsibility for risk management is held by the Chief Executive in line with the trust Scheme of Reservation and Delegation. The Chief Executive discharges this responsibility in line with the Risk Management Policy as follows:

The Chief Nurse and Chief Medical Officer are responsible for clinical risk management and this is discharged within the Quality and Safety Team.

The Director of Risk, Assurance and Compliance is responsible for non-clinical risk management.

Executive Directors and Directors who attend the board have delegated responsibility for managing risks in accordance with their portfolios as reflected in their job descriptions. For example, the Chief Finance Officer has executive responsibility for financial governance and associated financial risks.

The Risk Management Group oversees the operation of the trust's risk management process. Membership of the group includes clinical and non-clinical representation across the Collaboratives and subsequently Clinical Service Units (CSUs) along with director level input. The Risk Management Group is chaired by the Director of Risk, Assurance & Compliance and is accountable to the Site Leadership Team who report into the group management team.

In November 2025, site-based leadership arrangements were replaced as part of a wider leadership and management restructure. This resulted in the establishment of 10 Clinical Service Units (CSUs) across University Hospitals Tees, replacing the previous Collaborative

and Care Group model. The CSU structure provides clearer clinical and operational accountability, aligns leadership more closely to specialty-based pathways, and brings decision making closer to patients, clinical teams and frontline services. By devolving responsibility to CSU level, the model supports more timely, informed decisions, strengthens clinical ownership of performance and quality, and improves alignment between strategic priorities and day-to-day operational delivery across the trust

The Audit and Risk Committee is tasked with reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

All staff are responsible for health and safety and the effective management of risks within their teams, services or departments and must keep themselves and others safe. All staff have a duty of care to provide safe services and do no harm.

Staff training and development needs with regards to risk recognition and safety is included in the trust induction policy, staff receive appropriate training relevant to their post requirements in the local induction. Training includes an introduction to the organisation and core training is provided (health and safety, equality and human rights, information governance, safeguarding and infection control). Specific training is provided, dependent upon the individual's job role or work location, and includes incident reporting and investigation, Safeguarding Adults and Children, Mental Health Act, Mental Capacity Act, First Aid and Life Support (including resuscitation), Clinical Risk Assessment and Management, Medicines Management and Respect (managing violence and aggression) and Risk Management. Development and training needs will be reflected in personal development plans (PDPs) over and above mandatory training.

## **The risk and control framework**

The Risk Management Policy provides a framework for managing risks across the trust and is consistent with best practice and Department of Health and Social Care guidance. The policy has been reviewed and updated and provides a clear, structured and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation. The policy sets out the role of the trust Board and its committees together with the individual responsibilities of the Chief Executive, Executive Directors, Directors and all staff, in managing risk.

Risk management by the trust board is underpinned by five (5) interlocking systems of internal control:

- The Board Assurance Framework
- Risk Register (informed by CSUs, corporate directorates and team)
- Board Committees (1<sup>st</sup> line)
- Audit and Risk Committee (2<sup>nd</sup> line)
- Annual Governance Statement

The Board Assurance Framework (BAF) sets out the strategic risks to delivery of the trust's strategic objectives together with the controls in place to mitigate the risks and the assurance that can be evidenced relating to their control. The BAF was reviewed during 2025/26 and the BAF is reported at each committee meeting and quarterly to the Audit and Risk Committee and Board.

The board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate risks which may threaten the achievement of the trust's objectives.

The board achieves this primarily through the work of its committees, through use of Internal Audit and other independent inspection and by systematic collection and scrutiny of performance data to evidence the achievement of the objectives. It does this by using a model of assurance which shows the boundaries between different roles and responsibilities in the management and assurance of risks. This helps to avoid duplication and gaps in its risk management, performance management, governance and control arrangements. By setting out roles and responsibilities relating to risk management and assurance, the model links to the trust's assurance framework using a three lines of defence model, with assurance sources mapped to risks. This model is fully adopted by the committees who have been able to measure quality of assurance not just its quantity.

The BAF is designed to provide the board with a simple but comprehensive method for the effective and focussed management of strategic risks to trust objectives. The board, through its committee structure, defines the strategic risks and ensures that each is assigned to a lead director as well as to a lead committee:

- The lead director is responsible for assessing any strategic risks assigned to them by the board and for providing assurance as to the effectiveness of primary risk controls to the lead committee.
- The role of the lead committee is to review the lead director's assessment of their strategic risks, consider the range of assurances received as to the effectiveness of primary risk controls, and to recommend to the lead director any changes to the BAF to ensure that it continues to reflect the extent of risk exposure at that time.
- The Audit and Risk Committee is responsible for reviewing the whole BAF in order to provide assurance to the board that strategic risks are appropriately rated and are being effectively managed; and for advising the board as to the inclusion within the BAF of additional risks that are of strategic significance.

During 2025/26, the board approved the strategic objectives, refreshed the strategic risks within the BAF and approved the risk appetites. The trust board has received and reviewed the Board Assurance Framework in full four times throughout the year with monthly reports on assurance. The three main board committees have received and reviewed the Board Assurance Framework relevant to their area on a monthly basis, with the Audit and Risk Committee receiving quarterly updates.

The board and its committees are not involved in operational management and delivery, but exercise oversight of the management of the organisation. The board and its committees require assurance from management (and other sources) in order to carry out their role in corporate governance. A front sheet template for board and its committees provide them with a recommendation on the level of assurance to reflect the conclusion of the report being

presented. There have been good examples of challenge and reflection of the level of assurance at committee level.

The proforma Board Assurance Framework document complies with HM Treasury Guidance on Assurance Frameworks and is reflective of regional and national benchmarking.

The strategic risks identified and monitored through the BAF during the year related to:

- **Quality and Safety** – Failure to protect people from abuse or avoidable harm; failure to provide care that is compassionate, kind and inclusive; failure to provide clinical effectiveness treatment in line with best practice.
- **Digital** – failure to adequately maintain and upgrade current hardware and software systems and implement planned digital programmes and infrastructure projects through lack of adequate funding; failure to prevent a cyber attack or data breach; failure to protect information / data we hold as a result of non-compliance with legislation and / or non-compliance with trust policy; conflicting demands of maintaining BAU and supporting new programmes within digital teams poses a risk to the timely and effective delivery of the digital strategy
- **Trust estate** – Failure of trust infrastructure (including buildings); Insufficient capital funding to maintain Trust estate; Trust estate does not allow for the provision of optimal clinical services; Reduction of system capacity if the trust is unable to provide services; Non-compliance with legal and regulatory standards of the trust's estate.
- **People** – a workforce that doesn't have the required knowledge, skills and experience to provide services now and in the future; culture that doesn't promote positively, respect, inclusion and a focus on belonging recognising and rewarding achievements; not having a health and wellbeing offer that positivity supports organisational efficiency and our colleagues ability to delivery quality patient care; workforce planning and people practices don't support the Trust to deliver its services.
- **Performance and compliance** – Risk that the A&E 4-hour standard is not met; Risk that the referral-to treatment 18-week NHS Constitution standard is not met; Risk that the diagnostic 6-week NHS Constitution standard is not met; Risk that the cancer referral to treatment 62-day NHS Constitution standard is not met
- **System Working & External Threats** – The trust isn't strategically positioned locally and regionally to deliver the UHT strategy; The trust doesn't reform clinical services to meet local and regional need in line with planned timescales.
- **Research & Innovation** – Lack of integration of research with digital infrastructures prevents the delivery of effective research; Growth research is constrained by infrastructure, capacity and culture; Over-reliance on external income leads to R&D financial uncertainty and limits growth; Innovation growth is limited by investment and resource constraints; Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture.
- **Finance** – adverse financial impact due to system working requirements; Insufficient funding in existing contract arrangements for services provided to the population; Inability to control costs within allocated resources; Inability to deliver the required savings (recurrent/nonrecurrent) within the annual financial plan

The trust's risk register contains all operational risks and can identify those risks identified as being the high-level risks to the trust, as set out in the Risk Management Policy. These are the operational risks of 15 and above. Each CSU and Corporate Directorate has in place risk registers which collectively are overseen by the Risk Management Group, Clinical Policy Group (subsequently replaced by the Clinical Strategy Council) and the Audit and Risk Committee. It directs management focus to the mitigation of risks and the planned mitigating actions.

The Audit and Risk Committee is responsible for scrutinising the overall systems of internal control (clinical and non-clinical) and for ensuring the provision of effective independent assurance via internal audit, external audit and local counter-fraud services.

The Audit and Risk Committee reports to the board via a chair's log after every meeting and annually on its work via the Annual Report of the Audit and Risk Committee in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the BAF, the completeness and extent to which risk management is embedded in the trust and the integration of governance arrangements. It has fulfilled the role by using the assurance provided in the Board Assurance Framework which it receives in full at each meeting.

The Audit and Risk Committee has also assessed its own effectiveness, what it has accomplished and whether it has fulfilled its responsibilities along with that of the board sub committees during 2025/26 and has concluded it is content with the scrutiny it, and committees, have provided.

The trust board and its committees have taken an active role in the improvement of risk management processes. This has included the review, refresh and alignment of the Board Assurance Framework to the board committees and agreed schedules of review of the risks at each meeting.

The trust board is responsible for approving the risk appetites that are proposed from the committees, which sets the risk appetite of the organisation and is described in the Risk Management Policy. Risk appetite is defined as 'the amount of risk the organisation is prepared to accept, tolerate, or be exposed to at any point in time.' It allows the board to take considered risks and to seek assurance that risks of any grade in areas of low tolerance are being managed, rather than focussing predominately on high rated risks. During 2025/26 the Board considered its risk appetite in June 2025 at a board development session.

## Quality governance arrangements

The trust maintains robust and effective quality governance structures. Key features include:

- The chief nursing officer and chief medical officer are jointly responsible for the quality governance arrangements across UHT, this is discharged within the Quality and Safety Team.
- The Quality Assurance Committee, chaired by Ms Fay Scullion, Non-Executive Director has oversight of the Quality Governance Framework, with sub-groups focussing on patient experience, patient safety, clinical effectiveness, infection prevention and control, Safeguarding adults and children, safer medication and health and safety.
- An annual clinical audit programme is in place which is approved at Quality Assurance Committee and the Audit and Risk Committee.

- A new electronic risk management (Healthcare Guardian provided by Ideagen) was introduced at South Tees in March 2026 replacing the Datix system. This mirrors the system already in place at North Tees thus an enhanced opportunity to work at pace across UHT. All staff are encouraged to report incidents and learning is shared across the organisation.
- Patient Safety Incident Investigations (PSII) occurring within the organisation are subject to human factors and systems-based investigations and are reported to the Quality Assurance Committee for discussion and understanding of the learning from the event. This is in addition to the weekly Patient Safety and Quality Panel where learning is triangulated with clinical negligence claims, coroner cases and any learning identified from our mortality reviews.
- The board receives a report from the chair of the Quality Assurance Committee, and private discussions around key issues that are emerging.

The trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. The equality impact assessment (EQIA) process is embedded as part of our business planning and service re-design. The process safeguards quality whilst enabling the organisation to deliver changes to service delivery, acknowledging the impact of the change either negatively or positively on any groups of patients, communities and staff which may be affected.

### **Well-Led**

The trust Board Development Programme sets out the process by which the board will assess itself against NHS England's Well Led Framework, forming a core part of the trust's ongoing journey of improvement and leadership development.

During 2024/25, the trust continued to receive routine quality monitoring and regulatory oversight from the Integrated Care Board (ICB) and the Care Quality Commission (CQC). This included regular Quality Review Group meetings and engagement sessions held throughout the year, providing ongoing assurance and constructive challenge.

To further support this improvement journey, the trust will undertake a formal tendering exercise during the summer to commission an independent provider to deliver a developmental Well Led Review in the autumn. This review will provide an objective assessment of leadership, governance and organisational culture, and will be explicitly developmental in focus.

The Provider Capability Assessment for South Tees was undertaken in line with NHS England's National Oversight Framework, which is designed to provide a consistent view of provider leadership, governance and improvement capability. The assessment rated the trust as Amber/Green overall, indicating that core well led arrangements are in place and operating, but that further development is required to ensure consistency, resilience and sustainability. Within the framework, an Amber/Green rating reflects a provider that is delivering required standards but would benefit from targeted support and challenge to strengthen leadership maturity and governance effectiveness. The PCA provides an important evidence base to inform ongoing oversight, supports proportionate regulatory engagement, and helps focus the trust's Board Development Programme and planned developmental Well Led Review on priority areas for improvement

The outcomes of the developmental Well Led Review will triangulate these findings and support the development of a prioritised improvement plan.

The trust was last subject to a CQC Well Led inspection in January 2023, resulting in the trust's rating being uplifted from 'Requires Improvement' to 'Good', providing a strong platform on which to build further leadership maturity and system confidence

### **Compliance with NHS Provider Licence**

The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future.

An annual audit of compliance against the Code of Governance is undertaken to ensure compliance with the NHS provider licence by way of a second line of assurance assessment.

In March 2023, NHS England updated NHS Provider Licence and subsequently the organisation is only required to self-certify on the following:

Condition CoS7 - for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS).

The trust board confirmed that it has a reasonable expectation that required resources will be available to deliver designated services Condition CoS7(3).

### **Workforce**

The Trust has established arrangements to ensure safe, sustainable and effective staffing across all services, aligned to the NHS People Plan. The Workforce Strategy and Annual Plan set out how workforce capacity and capability are managed, including recruitment, retention, workforce optimisation and leadership.

The People Committee receives regular assurance through the monthly safe staffing report, which meets National Quality Board (NQB) requirements. The report provides triangulated assurance using workforce and productivity metrics, Nurse Sensitive Indicators, quality outcomes and patient experience.

Clear escalation processes are in place for staffing risks, with significant issues escalated to the Chief Nurse and Director of Nursing. Staffing establishments are reviewed at least twice yearly, informed by evidence based workforce planning tools, professional judgement and review of workforce sensitive indicators. Outcomes are reviewed through monthly CSU specific workforce assurance meetings.

Monthly assurance includes nursing fill rates and Care Hours per Patient Day, with exception reporting for areas below agreed thresholds and reports to the People Committee.

Arrangements are in place for consistent escalation of staffing incidents across inpatient and community. Workforce staffing information is published in line with national transparency requirements. Equality and quality impact assessments are undertaken for changes to roles or skill mix and approved by the Chief Nurse.

Nursing is the largest collective workforce across South Tees. The contribution of this highly specialised group enables South Tees to deliver value-based care with pride and passion. The supply of staff is diverse and enables us to develop a safe and sustainable workforce.

## Care Quality Commission

South Tees Hospitals NHS Foundation Trust is registered with the Care Quality Commission (CQC) with no conditions applied to its registration. The CQC did not take any enforcement action against the trust during 2025/26, and the trust did not participate in any special reviews or investigations during this period.

In October 2025, the CQC completed an IR(ME)R inspection of the Radiotherapy Department. No breaches meeting the threshold for enforceable action were identified. Areas for improvement were highlighted, and the trust developed and submitted an action plan. The CQC subsequently confirmed it was assured by the actions taken and closed the inspection file



The CQC took no enforcement action against the trust during 2025/26, and the trust did not participate in any special reviews or investigations during the period.

## CQC Contact and Communication

STHFT maintains regular joint engagement meetings with the CQC through scheduled meetings and routine communication. Informal visits to clinical areas are facilitated upon request when CQC staff are on site.

All reports are available at: <https://www.cqc.org.uk/provider/RTR>

| Overall trust quality rating |  | Good ● |
|------------------------------|--|--------|
| Are services safe?           |  | Good ● |
| Are services effective?      |  | Good ● |
| Are services caring?         |  | Good ● |
| Are services responsive?     |  | Good ● |
| Are services well-led?       |  | Good ● |

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

## Register of Interests

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 12 months as required by the Managing Conflicts of Interest in the NHS guidance.

## Pension

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 foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. 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 financial plan is approved by the Board of Directors and submitted to NHSE, our independent regulator (in exercising its powers originally conferred by Monitor). The process for approving the plan involves the Integrated Care Board (ICB) and the regional NHSE team to create a coordinated strategic and transformational submission from the North East and North Cumbria ICB. This plan includes forward projections and is monitored by the Resources Committee with key performance indicators and financial sustainability metrics also reviewed monthly by the Senior Leadership Team, Group Management Team and the Board of Directors at each of its meetings.

The Integrated Care System (ICS) has an overall requirement to deliver the agreed plan with NHSE at the end of the 12-month period. During 2025/26 ICS partners continued the work undertaken in 2024/25 whereby two audit partners, Audit One and PWC, undertook a review of financial controls and arrangements for financial plans and arrangements for CIP and PMO. A number of development actions were identified and the implementation of the actions in 2025/26 have been overseen by the Financial Recovery Group and Resources Committee.

The group (excluding the South Tees Hospitals Charity) recorded an adjusted financial performance deficit in 2025/26 of £4.1 million as agreed in discussions with the ICS and NHS England (NHSE). On 31 March 2026 the trust's closing cash position amounted to £86.4 million.

The group's (excluding the charity) deficit within the annual accounts of £4.1 million reconciles to the financial performance deficit of £39.1 million by adjusting for the impairment of assets £54.6 million, donations towards capital expenditure £14.1 million, depreciation on donated assets £1.4 million, the addition of the net increase in cost from the change in treatment

between IFRS16 and UK GAAP on the PFI, £7.0 million. Access to available capital funding in 2025/26 represented a risk to the trust in relation to essential replacement and priority investment in the estate. The programme was mainly funded internally by the trust and Capital support although the trust sought capital funding, in the form of Public Dividend Capital, to cover specific investment in the Medical Equipment. The trust will continue in 2026/27 to review and prioritise all capital expenditure bids to minimise clinical and organisational risk.

Financial governance arrangements are managed within the corporate governance framework which includes Standing Orders, Standing Financial Instructions and a Scheme of Delegation. Financial governance is supported by internal and external audit to ensure economic, efficient and effective use of resources and is monitored by the Audit and Risk Committee.

The trust's Internal Auditor (PwC) has drafted the Audit Opinion on the adequacy and effectiveness of governance, risk management and control. Their annual opinion for the year ending 31 March 2025 is 'Reasonable assurance / moderate assurance' which sets out that governance, risk management and control in relation to business-critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk.

Their annual plan, agreed with the Audit and Risk Committee, focussed on key BAF risks and Trust strategic priorities, including known areas of weakness. In 2024/2025 PWC identified 10 high, 29 medium and 12 low risk rated findings to improve weaknesses in the design of controls and/or operating effectiveness. 10 high risk rated findings have been identified across the reviews carried out during the year. These are Data security and Protection Toolkit, Medical Devices Management / Training, Compliance with Regulatory Standards (CQC Must do actions), Procurement Contract Assurance / VFM, Sickness & Absence and Complaints with full details discussed at the Audit and Risk Committee and management actions in place to address the gaps.

## Information governance

### Incident Reporting

The confidentiality and security of information regarding patients and staff is monitored and maintained through the implementation of our Governance Framework which encompasses the elements of law and policy from which applicable information Governance (IG) standards are derived.

Personal information is increasingly held electronically within secure digital systems, it is inevitable that in complex NHS organisations, especially where there is a continued reliance upon manual paper records during a transitional phase to paperless or a paper light environment, that a level of data security incidents can occur.

Any incident involving loss or damage to personal data is comprehensively investigated by the trust in line with its Data and Cyber Breach Management Policy and graded in line with the NHS Digital 'Guide to the Notification of Data Security and Protection Incidents'.

All incidents are graded using the NHS Digital breach assessment criteria and our risk assessment tool according to the significance of the breach and the likelihood of those serious consequences occurring. The incidents are also graded according to the impact on the

individual or groups of individuals rather than on the trust. Those incidents deemed to be of a high risk are reportable to the Information Commissioners Office (ICO) via the Data Security Protection Toolkit within 72 hours of being reported to the trust.

We actively encourage staff to report any suspected data protection and cyber breaches irrespective of their severity in line with its reporting policy.

## Incidents

We reported five incidents to the ICO during the reporting period, an increase from four in the previous year. The reported incidents related to two 'inappropriate access on clinical systems', two 'information provided to the incorrect person in error', and one 'information found in a public place. Two of the incidents have since been closed without action by the ICO and the trust has taken appropriate action to mitigate, at time of writing this report three incidents remain open and awaiting ICO outcome.

| Incident ID | Reported Date | Brief Description                                                                                 | Outcome                                                                 |
|-------------|---------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| 111055      | 27/5/2025     | Disclosure of information in error. Non-compliance with Trust policy. Impact on one data subject. | Incident Closed by ICO<br>Additional staff training given               |
| 111945      | 6/6/2025      | Inappropriate access of data. Non-compliance with trust policy                                    | Still open with ICO<br>HR disciplinary                                  |
| 114341      | 5/8/2025      | Inappropriate access of data. Non-compliance with trust policy                                    | Incident closed by ICO<br>HR disciplinary                               |
| 124991      | 5/11/2025     | Disclosure of information in error. Non-compliance with trust policy. Impact on one data subject. | Still open with ICO<br>Additional staff training offered                |
| 39900       | 26/3/2026     | Patient information found in a public place. Non-compliance with trust policy.                    | Still open with ICO<br>Investigation ongoing with another organisation. |

As in previous years, in order to further strengthen existing trust policy and to prevent repeat incidents in areas where incidents have occurred during 2025/26 the following key actions were undertaken or are planned:

- Review of IG policies and standard operating procedures to ensure they reflect the specific needs and practicalities of each internal department and they reflect the changing needs of legislation and national guidance.
- Continued programme of comprehensive quality assurance and spot checks to ensure all departments are complying with trust policies relating to the protection of personal data.
- Continue to provide annual Data Security Training inclusive of Cyber Security and the provision of targeted training in areas of non-compliance.
- Robust monitoring of departmental action plans following incidents to ensure appropriate actions have been implemented via the Digital Governance Committee.

- Full annual review of information assets and information flows through the trust within a redesigned framework to comply with GDPR requirements.
- Regular staff awareness campaigns run via communications team targeting areas of non-compliance.
- HR processes followed where repeated non-compliance has been found.

### **Data Protection Officer (DPO)**

In accordance with UK GDPR Article 37, the trust has an appointed Data Protection Officer (DPO) who provides support, advice and assurance to the board in respect of obligations pursuant to legislation, monitors compliance and acts as a point of contact for data subjects and the supervisory authority (ICO).

### **Data Protection Assurance**

Assurance continues to be provided to the board of directors that systems and processes are being constantly assessed and improved to ensure that information is safe. In accordance with UK GDPR Article 37, we have an appointed Data Protection Officer (DPO) who provides support, advice and assurance to the board in respect of obligations pursuant to legislation, monitors compliance and acts as a point of contact for data subjects and the supervisory authority (ICO).

The Data Security and Protection Standards for health and care are set out in the National Data Guardian's (NDG) ten standards and are measured through the completion of the Data Security Protection Toolkit (DSPT). All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

The DSPT is now aligned to the Cyber Assessment framework (CAF). The Cyber Assessment Framework provides a systematic and comprehensive approach to assessing the extent to which cyber and information governance risks to essential functions are being managed

### **Assurance**

The trust submitted its 2025 DSPT submission on the 30 June 2025. The trust has self-assessed compliance with all standards and all mandatory evidence items were evidenced, meeting all mandatory assertions; therefore, the trust scored as all 'Standards Met' for the DSPT.

The 2025 DSPT was also subject to external audit where 12 outcomes across the five objectives in the Cyber Assessment Framework were externally assessed by External Price Waterhouse Cooper (PWC) during May 2025 prior to the DSPT submission.

The trust's independent risk audit assessed the overall risk across all five objectives as **Very High** and the confidence level of the Independent Assessor in the veracity of the self-assessment as **Low**. An action plan to address the risk level identified has since been fully actioned.

At the time of writing, the status of the 2026 DSPT is that the trust has provided baseline information on all outcomes. The trust is gathering evidence to support the final submission. The final submission date is 30 June 2026.

### Assessment Outputs

|                                | Overall risk rating across all five CAF objectives | Confidence level of the Independent Assessor in the veracity of the self-assessment |
|--------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------|
| Independent Assessment Outputs | Very High                                          | Low                                                                                 |

## Data Quality and Governance

The quality reporting structure is fully embedded within the organisation with the quality dashboard and alternative sources of benchmarking data and assurance (North East Quality Observatory Service, NHS Digital and Healthcare Evaluation Data) are used to validate conclusions and recommendations. Internal controls are in place to ensure the accuracy of data and the reporting of measures of performance.

Mandatory training is provided to raise awareness of information governance and control with employees. Internal audits are undertaken.

## Review of effectiveness

As Accounting 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 Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on 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 and Risk Committee, the Resources Committee, the Quality Assurance Committee and People Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

## Trust Board

During 2025/26 there were five (5) changes to the Board of Directors:

Leavers included Ann Baxter, Non-executive Director and Vice Chair, Ada Burns, Non-executive Director, Chris Macklin, Non-executive Director, Alison Fellows, Non-executive Director and Elizabeth Barnes, Non-executive Director.

Emma Nunez was appointed as Chief Nursing Officer along with Christopher Day and Celia Weldon as Non-executive Directors.

The changes were approved by the Nomination Committees and endorsed by the Council of Governors and Remuneration Committee as appropriate.

The overarching governance framework for the trust is set out in detail in the Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. The Corporate Governance Structure, Board Committee Terms of Reference, Standing Orders and Standing

Financial Instructions were reviewed during the year to ensure the governance framework reflects the organisation of the trust and maintains internal control.

The board has overall responsibility for determining the future direction of the trust and ensuring delivery of safe and effective services in accordance with legislation and principles of the NHS. The trust Board also ensures that the organisation complies with relevant regulatory standards.

The Audit and Risk Committee is tasked with reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The Audit and Risk Committee reviews the work of the other committees within the trust once a year and will seek assurance from internal audit, external audit and counter fraud through the three lines of assurance model and using a range of external bodies and regulators.

In review the system of internal control the Audit and Risk Committee have recommended to the board that there is a significant internal control issue in relation to the performance of the trust against national priorities set out in the NHS System Oversight Framework for NHS Providers, which sets out how NHS England works alongside trusts to support the delivery of high quality and sustainable services for patients. The trust continues to be rated as '3' on the NHS Improvement Finance Score Metric where 1 is the highest score with 4 the lowest. An overall score of 3 indicates that support may be required.

Performance on this is reported and discussed monthly in the trust board meeting and its sub committees

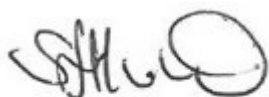
## Conclusion

In conclusion, the trust had the following significant internal control issues in 2025/26:

### System Oversight Framework

Across the themes of the SOF (quality of care, finance and use of resources, operational performance, strategic change, leadership and improvement capability) the trust is placed in segment 3. For trusts in segment 3, NHS England has undertaken a diagnostic stocktake with the trust to identify the key drivers of the concerns that need to be resolved. Through this process it was identified that no additional support needs or improvement actions were required

Signed:



**Stacey Hunter**

Chief Executive and Accounting Officer

Date: 30 June 2026

# **Independent auditor's report to the Council of Governors of South Tees Hospitals NHS Foundation Trust**

## **Draft Report on the audit of the financial statements**

### **Opinion on the financial statements**

We have audited the financial statements of South Tees Hospitals NHS Foundation Trust ('the Trust') and its subsidiaries ('the Group') for the year ended 31 March 2026 which comprise the Group and Trust Statements of Comprehensive Income for the year ended 31 March 2026, the Group and Trust Statements of Financial Position as at 31 March 2026, the Group and Trust Statements of Changes in Taxpayers' Equity for the year ended 31 March 2026, the Group and Trust Statements of Cash Flows for the year ended 31 March 2026, and notes to the financial statements, including material accounting policy information.

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 2025/26 as contained in the Department of Health and Social Care Group Accounting Manual 2025/26, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust and Group as at 31 March 2026 and of the Trust's and the Group's 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 2025/26; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

### **Basis for opinion**

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 for the audit of the financial statements" section of our report. We are independent of the Trust and Group 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 Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's or the Group'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 Accounting Officer with respect to going concern are described in the relevant sections of this report.

### **Other information**

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Directors are responsible for the other information. 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.

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 these regards.

### **Responsibilities of the Accounting Officer for the financial statements**

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2025/26 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 public sector entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust and Group to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

### **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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

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 and Group, we considered that non-compliance with the following laws and regulations might have a material effect on the financial statements: employment regulation, health and safety regulation, anti-money laundering regulation, data protection, environmental protection, corruption and anti-bribery.

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- gaining an understanding of the legal and regulatory framework applicable to the Trust and Group, the environment in which it operates, and the structure of the Trust and Group, and considering the risk of acts by the Trust and Group which were contrary to the applicable laws and regulations, including fraud;
- inquiring with management and the Audit and Risk Committee, as to whether the Trust and Group is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- inspecting correspondence, if any, with relevant licensing or regulatory authorities;
- reviewing minutes of relevant meetings in the year;
- 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 and Group which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

In addition, we evaluated management'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, in particular in relation to accruals, revenue and expenditure recognition (which we pinpointed to the cut-off assertion), and significant one-off or unusual transactions.

Our audit procedures in relation to fraud included, but were not limited to:

- making enquiries of management, and the Audit and Risk 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 both management and the Audit and Risk 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 Accounting Officer's 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, (Revised 2024) and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in November 2024.

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](http://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 2026.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in March 2026, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2026.

In June 2025 we identified a significant weakness in relation to financial sustainability for the 2024/25 year. In our view this significant weakness remains for the year ended 31 March 2026:

| Significant weakness in arrangements – issued in a previous year                                                                                                                                         | Recommendation                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Deficit budget</b></p> <p>The Trust reported a deficit outturn in 2025/26. Whilst this was in line with the Trust's financial plan, the Trust continues to operate with an underlying deficit.</p> | <p>The Trust should continue to work collaboratively with North East ICS partners and NHS England to explore and agree sustainable, long-term plans to bridge funding gaps.</p> |

## **Responsibilities of the Accounting Officer**

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

## **Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources**

We are required by Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 March 2026.

## **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 requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26; 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 NHS Foundation Trust Annual Reporting Manual 2025/26; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

We have nothing to report in respect of these matters.

## **Use of the audit report**

This report is made solely to the Council of Governors of South Tees Hospitals NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors 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 Council of Governors 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 received confirmation from the NAO that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.



James Collins (Jun 25, 2026 17:35:51 GMT+1)

James Collins, Key Audit Partner

For and on behalf of Forvis Mazars LLP (Local Auditor)

The Corner  
Bank Chambers  
26 Mosley Street  
Newcastle upon Tyne  
NE1 1DF

25 June 2026

# Accounts

For the year 1 April 2025 to 31 March 2026

**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2026**

|                                                            | NOTE | GROUP              |                 | TRUST              |                 |
|------------------------------------------------------------|------|--------------------|-----------------|--------------------|-----------------|
|                                                            |      | 2025/26<br>£000    | 2024/25<br>£000 | 2025/26<br>£000    | 2024/25<br>£000 |
| Operating income                                           | 3    | <b>1,098,824</b>   | 1,041,856       | <b>1,097,896</b>   | 1,041,106       |
| Operating expenses                                         | 4    | <b>(1,118,557)</b> | (1,042,141)     | <b>(1,117,167)</b> | (1,040,730)     |
| <b>OPERATING (DEFICIT)/SURPLUS</b>                         |      | <b>(19,733)</b>    | (285)           | <b>(19,271)</b>    | 376             |
| <b>FINANCE COSTS:</b>                                      |      |                    |                 |                    |                 |
| Finance income                                             |      | <b>3,626</b>       | 3,257           | <b>3,429</b>       | 3,065           |
| Finance costs - financial liabilities                      | 7.1  | <b>(23,166)</b>    | (20,588)        | <b>(23,166)</b>    | (20,588)        |
| Finance costs - unwinding of discount on provisions        | 22   | <b>0</b>           | (32)            | <b>0</b>           | (32)            |
| <b>NET FINANCE COSTS</b>                                   |      | <b>(19,540)</b>    | (17,363)        | <b>(19,737)</b>    | (17,555)        |
| (Loss) / Gain on disposal of assets                        |      | <b>6</b>           | 64              | <b>6</b>           | 64              |
| Corporation tax                                            |      | <b>(19)</b>        | (13)            | <b>(19)</b>        | (13)            |
| Movement in fair value of other investments                | 13   | <b>(564)</b>       | (274)           | <b>0</b>           | 0               |
| <b>DEFICIT FOR THE YEAR</b>                                |      | <b>(39,850)</b>    | (17,871)        | <b>(39,021)</b>    | (17,128)        |
| <b>Other comprehensive Expenditure</b>                     |      |                    |                 |                    |                 |
| <b>Will not be reclassified to income and expenditure:</b> |      |                    |                 |                    |                 |
| Impairments                                                | 7.2  | <b>(589)</b>       | (93)            | <b>(589)</b>       | (93)            |
| Revaluation gains on property, plant and equipment         | 7.2  | <b>2,276</b>       | 1,577           | <b>2,276</b>       | 1,577           |
| <b>TOTAL OTHER COMPREHENSIVE EXPENDITURE</b>               |      | <b>1,687</b>       | 1,484           | <b>1,687</b>       | 1,484           |
| <b>TOTAL COMPREHENSIVE EXPENDITURE</b>                     |      | <b>(38,163)</b>    | (16,387)        | <b>(37,334)</b>    | (15,644)        |

The notes on pages 5 to 45 form part of these accounts.

**STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2026**

|                                              |             | <b>GROUP</b>             |                          | <b>TRUST</b>             |                          |
|----------------------------------------------|-------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                                              |             | <b>31 March<br/>2026</b> | <b>31 March<br/>2025</b> | <b>31 March<br/>2026</b> | <b>31 March<br/>2025</b> |
|                                              | <b>NOTE</b> | <b>£000</b>              | <b>£000</b>              | <b>£000</b>              | <b>£000</b>              |
| <b>Non-current assets</b>                    |             |                          |                          |                          |                          |
| Property, plant and equipment                | 8           | <b>299,705</b>           | 310,185                  | <b>299,705</b>           | 310,185                  |
| Intangible assets                            | 9           | <b>10,055</b>            | 9,407                    | <b>10,055</b>            | 9,407                    |
| Right of use assets                          | 10          | <b>33,860</b>            | 35,792                   | <b>33,860</b>            | 35,792                   |
| Trade and other receivables                  | 16          | <b>3,221</b>             | 1,307                    | <b>3,221</b>             | 1,307                    |
| Other investments                            | 13          | <b>5,628</b>             | 6,192                    | <b>0</b>                 | 0                        |
| <b>Total non-current assets</b>              |             | <b>352,469</b>           | 362,883                  | <b>346,841</b>           | 356,691                  |
| <b>Current assets</b>                        |             |                          |                          |                          |                          |
| Inventories                                  | 14          | <b>15,416</b>            | 15,772                   | <b>14,412</b>            | 14,971                   |
| Trade and other receivables                  | 16          | <b>62,107</b>            | 75,381                   | <b>62,117</b>            | 75,313                   |
| Cash and cash equivalents                    | 15          | <b>87,496</b>            | 53,790                   | <b>85,858</b>            | 51,994                   |
| <b>Total current assets</b>                  |             | <b>165,019</b>           | 144,943                  | <b>162,387</b>           | 142,278                  |
| <b>Total assets</b>                          |             | <b>517,488</b>           | 507,826                  | <b>509,228</b>           | 498,969                  |
| <b>Current liabilities</b>                   |             |                          |                          |                          |                          |
| Trade and other payables                     | 17          | <b>(194,270)</b>         | (171,403)                | <b>(191,243)</b>         | (168,609)                |
| Borrowings                                   | 18          | <b>(23,624)</b>          | (20,836)                 | <b>(23,624)</b>          | (20,836)                 |
| Provisions                                   | 22          | <b>(1,357)</b>           | (1,220)                  | <b>(1,357)</b>           | (1,220)                  |
| <b>Total current liabilities</b>             |             | <b>(219,251)</b>         | (193,459)                | <b>(216,224)</b>         | (190,665)                |
| <b>Total assets less current liabilities</b> |             | <b>298,237</b>           | 314,367                  | <b>293,004</b>           | 308,304                  |
| <b>Non-current liabilities</b>               |             |                          |                          |                          |                          |
| Borrowings                                   | 18          | <b>(249,605)</b>         | (264,414)                | <b>(249,605)</b>         | (264,414)                |
| Provisions                                   | 22          | <b>(1,304)</b>           | (1,378)                  | <b>(1,304)</b>           | (1,378)                  |
| <b>Total non-current liabilities</b>         |             | <b>(250,909)</b>         | (265,792)                | <b>(250,909)</b>         | (265,792)                |
| <b>Total assets employed</b>                 |             | <b>47,328</b>            | 48,575                   | <b>42,095</b>            | 42,512                   |
| <b>Financed by taxpayers' equity:</b>        |             |                          |                          |                          |                          |
| Public dividend capital                      |             | <b>507,294</b>           | 470,377                  | <b>507,294</b>           | 470,377                  |
| Income and expenditure reserve               |             | <b>(517,681)</b>         | (478,888)                | <b>(517,303)</b>         | (478,582)                |
| Revaluation reserve                          |             | <b>25,628</b>            | 24,241                   | <b>25,628</b>            | 24,241                   |
| Other reserves                               |             | <b>26,476</b>            | 26,476                   | <b>26,476</b>            | 26,476                   |
| Charitable fund reserve                      | 12          | <b>5,611</b>             | 6,369                    | <b>0</b>                 | 0                        |
| <b>Total taxpayers' equity</b>               |             | <b>47,328</b>            | 48,575                   | <b>42,095</b>            | 42,512                   |

The notes on pages 5 to 45 form part of these accounts.

The financial statements on pages 1 to 45 were approved by the Audit Committee 19 June 2026 and signed on its behalf by:

Signed:  (Chief Finance Officer)

Date: 25 June 2026

Signed:  (Chief Executive)

Date: 25 June 2026

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2026**

|                                                                                                                                  | Public<br>Dividend<br>Capital<br>(PDC) | Income and<br>Expenditure<br>Reserve | Revaluation<br>Reserve | Other<br>reserves | Trust total   | South Tees<br>Healthcare<br>Management<br>Ltd | Charitable<br>funds<br>reserve | Group total   |
|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------|------------------------|-------------------|---------------|-----------------------------------------------|--------------------------------|---------------|
|                                                                                                                                  | £000                                   | £000                                 | £000                   | £000              | £000          | £000                                          | £000                           | £000          |
| <b>Taxpayers' equity at 1 April 2024</b>                                                                                         | 420,773                                | (471,644)                            | 32,946                 | 26,476            | 8,551         | (72)                                          | 6,878                          | 15,357        |
| <b>Changes in taxpayers' equity for 2024/25</b>                                                                                  |                                        |                                      |                        |                   |               |                                               |                                |               |
| (Deficit)/Surplus for the year                                                                                                   | 0                                      | (17,128)                             | 0                      | 0                 | (17,128)      | (234)                                         | (509)                          | (17,871)      |
| Transfer from Revaluation reserve to Income and Expenditure Reserve for impairments arising from consumption of economic benefit | 0                                      | 1,622                                | (1,622)                | 0                 | 0             | 0                                             | 0                              | 0             |
| Revaluation gains and impairment losses on property, plant and equipment.                                                        | 0                                      | 0                                    | 1,484                  | 0                 | 1,484         | 0                                             | 0                              | 1,484         |
| <b>Total comprehensive expense for the year</b>                                                                                  | 0                                      | (15,506)                             | (138)                  | 0                 | (15,644)      | (234)                                         | (509)                          | (16,387)      |
| Public dividend capital received                                                                                                 | 49,604                                 | 0                                    | 0                      | 0                 | 49,604        | 0                                             | 0                              | 49,604        |
| Other transfers between reserves                                                                                                 | 0                                      | 8,567                                | (8,567)                | 0                 | 0             | 0                                             | 0                              | 0             |
| <b>Taxpayers' equity at 31 March 2025</b>                                                                                        | <b>470,377</b>                         | <b>(478,582)</b>                     | <b>24,241</b>          | <b>26,476</b>     | <b>42,512</b> | <b>(306)</b>                                  | <b>6,369</b>                   | <b>48,575</b> |
| <b>Taxpayers' equity at 1 April 2025</b>                                                                                         | 470,377                                | (478,582)                            | 24,241                 | 26,476            | 42,512        | (306)                                         | 6,369                          | 48,575        |
| <b>Changes in taxpayers' equity for 2025/26</b>                                                                                  |                                        |                                      |                        |                   |               |                                               |                                |               |
| (Deficit)/Surplus for the year                                                                                                   | 0                                      | (39,021)                             | 0                      | 0                 | (39,021)      | (71)                                          | (758)                          | (39,850)      |
| Transfer from Revaluation reserve to Income and Expenditure Reserve for impairments arising from consumption of economic benefit | 0                                      | 228                                  | (228)                  | 0                 | 0             | 0                                             | 0                              | 0             |
| Revaluation gains and impairment losses on property, plant and equipment.                                                        | 0                                      | 0                                    | 1,687                  | 0                 | 1,687         | 0                                             | 0                              | 1,687         |
| <b>Total comprehensive expense for the year</b>                                                                                  | 0                                      | (38,793)                             | 1,459                  | 0                 | (37,334)      | (71)                                          | (758)                          | (38,163)      |
| Public dividend capital received                                                                                                 | 36,917                                 | 0                                    | 0                      | 0                 | 36,917        | 0                                             | 0                              | 36,917        |
| Other transfers between reserves                                                                                                 | 0                                      | 72                                   | (72)                   | 0                 | 0             | 0                                             | 0                              | 0             |
| <b>Taxpayers' equity at 31 March 2026</b>                                                                                        | <b>507,294</b>                         | <b>(517,303)</b>                     | <b>25,628</b>          | <b>26,476</b>     | <b>42,095</b> | <b>(377)</b>                                  | <b>5,611</b>                   | <b>47,328</b> |

Note: the amount shown as 'Other Reserves' represents the value of assets transferred to South Tees Hospitals NHS Foundation Trust following the acquisition of the former Northallerton Health Services NHS Trust, over and above the value of Public Dividend Capital repayable on dissolution of that Trust.

**STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2026**

|                                                            |      | GROUP           |                 | TRUST           |                 |
|------------------------------------------------------------|------|-----------------|-----------------|-----------------|-----------------|
|                                                            | NOTE | 2025/26<br>£000 | 2024/25<br>£000 | 2025/26<br>£000 | 2024/25<br>£000 |
| <b>Cash flows from operating activities</b>                |      |                 |                 |                 |                 |
| Operating (deficit)/ surplus from continuing operations    |      | (19,733)        | (285)           | (19,271)        | 376             |
| <b>Non-cash income and expense</b>                         |      |                 |                 |                 |                 |
| Depreciation and amortisation                              | 4    | 26,025          | 24,549          | 26,025          | 24,549          |
| Net impairments                                            | 4    | 54,647          | 33,203          | 54,647          | 33,203          |
| Decrease /(Increase) in trade and other receivables        |      | 8,675           | (16,949)        | 7,641           | (16,878)        |
| (Increase) / Decrease in inventories                       | 14   | 356             | 336             | 485             | (273)           |
| (Decrease) / Increase in trade and other payables          |      | 13,064          | (2,297)         | 13,840          | (1,955)         |
| Increase / (Decrease) in provisions                        | 22   | 63              | (159)           | 63              | (159)           |
| Other movements in operating cash flows                    |      | (138)           | (663)           | (116)           | (613)           |
| <b>Net cash generated from operations</b>                  |      | <b>82,959</b>   | <b>37,735</b>   | <b>83,314</b>   | <b>38,250</b>   |
| <b>Cash flows from investing activities</b>                |      |                 |                 |                 |                 |
| Interest received                                          |      | 3,626           | 3,257           | 3,429           | 3,065           |
| Purchase of intangible assets                              |      | (5,583)         | (3,828)         | (5,583)         | (3,828)         |
| Purchase of property, plant and equipment                  |      | (47,354)        | (57,596)        | (47,354)        | (57,596)        |
| Sales of property, plant and equipment                     |      | 14              | 87              | 14              | 87              |
| <b>Net cash used in investing activities</b>               |      | <b>(49,297)</b> | <b>(58,080)</b> | <b>(49,494)</b> | <b>(58,272)</b> |
| <b>Cash flows from financing activities</b>                |      |                 |                 |                 |                 |
| Public dividend capital received                           |      | 36,917          | 49,604          | 36,917          | 49,604          |
| Capital element of lease rental payments                   |      | (7,011)         | (6,771)         | (7,011)         | (6,771)         |
| Capital element of private finance initiative obligations  |      | (14,335)        | (8,838)         | (14,335)        | (8,838)         |
| Interest element of lease liability payments               | 7    | (1,437)         | (1,459)         | (1,437)         | (1,459)         |
| Interest element of private finance initiative obligations | 7    | (14,090)        | (14,389)        | (14,090)        | (14,389)        |
| <b>Net cash used in financing activities</b>               |      | <b>44</b>       | <b>18,147</b>   | <b>44</b>       | <b>18,147</b>   |
| <b>Increase/(decrease) in cash and cash equivalents</b>    |      | <b>33,706</b>   | <b>(2,198)</b>  | <b>33,864</b>   | <b>(1,875)</b>  |
| <b>Cash and cash equivalents at 1 April</b>                |      | <b>53,790</b>   | <b>55,988</b>   | <b>51,994</b>   | <b>53,869</b>   |
| <b>Cash and cash equivalents at 31 March</b>               | 15   | <b>87,496</b>   | <b>53,790</b>   | <b>85,858</b>   | <b>51,994</b>   |

## NOTES TO THE ACCOUNTS

### 1. Accounting policies

NHS England has directed that the accounts of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM), which shall be agreed with HM Treasury and the Secretary of State. Consequently, the following accounts have been prepared in accordance with the DHSC GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently during the financial year when dealing with items considered material in relation to the accounts.

#### 1.1 Accounting convention

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

#### 1.2 Basis of consolidation

##### NHS Charitable Fund

The Trust is the corporate trustee to South Tees Hospitals Charity and Associated Funds which is registered with the Charity Commission, registration number 1056061. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary as the Trust has the power to govern the financial and operating policies of the charitable fund to obtain benefits from its activities for the Trust, its patients and its staff.

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

- recognise and measure them in accordance with the Trust's accounting policies; and
- eliminate in full all intra-group transactions and balances.

##### 1.2.1 Alignment to accounting policies

The accounting policies and accounts of the charitable fund have been reviewed and are consistent with those of the Trust apart from the charitable fund's accounting policies on funds and investments. Details of the accounting policies that are different and have been aligned to those of the Trust are outlined below:

##### Fund balances

Funds held by the charitable fund can be both restricted and un-restricted. Donations come in for specific funds and each fund has its own objectives/purpose. If a general donation is made and no specific fund is identified then the monies will be paid into the General Purpose Fund, which is used to benefit patients and staff of the Group and Trust. Funds specific to wards or departments are held as un-restricted designated funds. Legacies and donations received for a specific purpose or 'trust' are recorded and accounted for as restricted funds.

##### Investments

Investments are stated at fair value as at the balance sheet date. The Consolidated Statement of Financial Position includes the net gains and losses arising on revaluation and disposals throughout the year.

Further information covering the nature and value of the consolidation of the charitable fund is included in Note 12 to the Accounts.

## **Notes to the Accounts - 1. Accounting Policies (Continued)**

### **1.2.1 Alignment to accounting policies (continued)**

#### **Other subsidiaries**

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The Trust formed 2 subsidiaries, the South Tees Institute of Learning, Research and Innovation LLP and South Tees Healthcare Management Limited. The financial year end of both companies is 31 March. Operations within South Tees Institute of Learning, Research and Innovation LLP are currently dormant, there have been no transactions within this company in 2025/26 and the company has not been consolidated on the basis of materiality.

#### **South Tees Healthcare Management Limited**

This company started operations on 6 October 2019 providing an outpatient pharmacy service and the financial statements for the year to 31 March 2026 are consolidated in these accounts. The subsidiary's accounting policies are aligned with the Trust and the amounts included have been adjusted during consolidation with intra-Group balances and transactions eliminated in full on consolidation.

### **1.3 Critical accounting judgements and key sources of estimation in applying the Trust's accounting policies**

In the application of the Group and 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. The estimates and assumptions that have a significant risk of causing a material adjustment to the accounts are highlighted below:

a) Asset valuation and indices - the valuation of land and buildings is based on building cost indices and location factors provided by and used by Cushman and Wakefield in their valuation work. The valuation at 31 March 2026 amounted to £214.1 million based on Modern Equivalent Alternative Site Valuation methodology by Cushman and Wakefield (the valuer employed by Cushman and Wakefield is an appropriately qualified member of the Royal Institute of Chartered Surveyors). From 1 April 2014 these valuations did not include VAT (Note 1.3). The process utilised Gross Internal Areas (GIA), asset life and obsolescence data to determine the valuation. The indices are based on an indication of trend of accepted tender prices within the construction industry as applied to the Public Sector.

The judgements that have a significant risk of causing a material adjustment to the accounts are highlighted below:

a) Basis of PP&E valuation - Specialised property is valued at depreciated replacement cost. The cost of VAT has been excluded from the full trust estate specialised property valuations from 1 April 2014. The Trust estate is predominantly PFI assets. This significant management judgement was made on the basis that:

(i) the majority of the James Cook Hospital is currently under a PFI arrangement and the Trust recovers the VAT on the Unitary Payment. When the Trust recognised the property as an asset in 2009/10 in its first IFRS-based accounts it appropriately excluded VAT from the initial measurement of Fair Value.

(ii) The majority of non-PFI assets relate to the Friarage Hospital, which transferred to the Trust in 2006. The Friarage Hospital would have formed part of the PFI development if it had been part of the Trusts assets at the date of the development.

(iii) The Trust considers that when, in the future, it procures a significant replacement of its estate, it would do so through either a PFI arrangement or through a subsidiary undertaking. The Trust would set up the subsidiary or would utilise the subsidiary of North Tees and Hartlepool NHS Foundation Trust to undertake the investment. The Trust has received confirmation that this service can be provided and taken appropriate guidance that the Trust would be able to recover VAT on capital projects.

**Notes to the Accounts - 1. Accounting Policies (Continued)**

**1.3 Critical accounting judgements and key sources of estimation in applying the Trust's accounting policies (continued)**

b) Asset lives - asset lives on property are reviewed by Cushman and Wakefield every 5 years in conjunction with a full site valuation. The last review took place as at 31 March 2026. In between the 5 year period an annual desktop revaluation exercise is undertaken with asset lives revisited for material in-year changes. In the event that property lives change, the impact on depreciation from an increase of one year would be a movement in depreciation of circa £0.1 million.

c) IFRS16 arrangements - the Trust has identified a number of arrangements which involve the use of property and assets. These have been capitalised in line with the Trust's Accounting Policies with the asset life based on the term of the agreements. This particularly applies to arrangements involving vehicles and equipment. Agreements or contracts are not generally in place for property arrangements and the Trust has applied a 20 year term on assets used for the provision of healthcare. This term is a reasonable assessment of the period that the Trust expects to deliver services from these assets based on the Trust's Strategic Plan, existing healthcare needs in the region and the facilities currently available.

d) Private Finance Initiative (PFI) schemes - as part of the South Tees Hospitals PFI scheme, the Group and Trust is required to pay the operator for lifecycle replacement assets (2025/26, £7.9 million). A judgement has been made that payment for the assets is accounted for in line with the operator's model over the life of the scheme. Where there is a variation between the model and the timing of actual asset replacement, the variation is dealt with as a prepayment. The prepayment is reversed at the point when asset replacement occurs. This position will be assessed on an ongoing basis to determine whether the PFI Provider is expected to expend the prepayment and if this is not the case, whether a charge should be made to revenue.

**1.3.1 Going concern**

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case and the financial statements have been prepared on a going concern basis.

## Notes to the Accounts - 1. Accounting Policies (Continued)

### 1.4 Income

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).

Income in respect of goods or services provided is recognised when and to the extent that, performance obligations are satisfied and is measured at the fair value of the consideration receivable. 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 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.

The main source of income for the Trust is contracts with commissioners for health care services with funding envelopes set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare. Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element and under the variable element, providers earn income for targeted activity to improve performance (both ordinary elective and day case), out-patient procedures, out-patient first attendances and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration

High costs drugs and devices are excluded from the calculation of national prices and are reimbursed by NHS England based on actual usage or by ICB commissioners at an agreed fixed amount.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Research and development income is recognised when the conditions attached to the grant are met. Education and training income is recognised either in equal instalments over the financial year or if the income can be identified with specific expenditure, in line with the expenditure.

## **Notes to the Accounts - 1. Accounting Policies (Continued)**

### **1.4 Income (continued)**

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums under the sale contract.

### **1.5 Employee benefits**

#### **1.5.1 Short-term employee benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the accounts to the extent that employees are permitted to carry forward leave into the following period.

#### **1.5.2 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 for Health and Social Care 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. Employer's pension cost contributions are charged to operating expenses as and when they become due.

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 operating expenses at the time the Group and Trust commits itself to the retirement, regardless of the method of payment.

### **1.6 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 and inventories unused at the end of the financial year.

### **1.7 Property, plant and equipment**

#### **1.7.1 Recognition**

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Group and 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 a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

## **Notes to the Accounts - 1. Accounting Policies (Continued)**

### **1.7 Property, plant and equipment (continued)**

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

#### **1.7.2 Valuation**

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at current value in existing use. Land and buildings used for the Group and Trust's services or for administrative purposes are stated in the Statement of Financial Position at their re-valued amounts, being the current value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case the valuer adopts a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model, estimates current value in existing use 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. The valuation included in the Statement of Financial Position at 31 March 2026 is based on an alternative site MEA valuation, undertaken specifically in accordance with the HM Treasury guidance which states that such valuations are an option if the Group and Trust's service requirements can be met from the alternative site. The valuation has been adjusted from 1 April 2014 to exclude VAT in line with existing VAT regulations on recovery from the cost of construction (in line with the existing PFI arrangement on the James Cook Site).

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 re-valued and depreciation commences when they are brought into use.

Professional valuations are carried out by Cushman and Wakefield. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS). Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

#### **1.7.3 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 will flow to the Trust or Group 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 written off. 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.

#### **1.7.4 Depreciation**

Freehold land is considered to have an infinite life and is not depreciated. Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment on a straight line basis over their remaining useful economic lives, in a manner consistent with the consumption of economic or service delivery benefits.

The estimated useful life of an asset is the period over which the Group and Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Group and Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under leases are depreciated over the shorter of their estimated useful lives or the lease term. See Note 8.4 for further information on asset lives.

## **Notes to the Accounts - 1. Accounting Policies (Continued)**

### **1.7 Property, plant and equipment (continued)**

#### **1.7.5 Revaluation gains and losses**

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease previously recognised in operating expenses, in which case they are recognised in operating expenses.

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".

#### **1.7.6 Impairments**

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

An impairment arising from a loss of economic benefit or 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 expenses 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.

### **1.8 Intangible assets**

#### **1.8.1 Recognition**

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Group and Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Group and Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000 and where the asset is expected to be used for more than one financial year.

#### **1.8.2 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 where it meets recognition criteria.

#### **1.8.3 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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve. Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

**Notes to the Accounts - 1. Accounting Policies (Continued)**

**1.8 Intangible assets (continued)**

**1.8.4 Impairments**

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

**1.8.5 Amortisation**

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

**1.9 Donated, government grant and other funded assets**

Donated and grant funded non-current assets are capitalised at their fair value on receipt. These are valued, depreciated and impaired as described above for purchased assets. The donation/grant is credited to income at the same time that the asset is capitalised, unless the donor has imposed a condition that the future economic benefits embodied in the grant/donation 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.

**1.10 Revenue government and other grants**

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Grants from the Department of Health and Social Care, including those from the Big Lottery Fund, are accounted for as Government Grants. Where the Government Grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match the expenditure.

**1.11 Leases**

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets. The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

**1.11.1 The Trust as lessee**

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a Right of Use (ROU) asset and a lease liability.

The right of use asset is initially recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

## **Notes to the Accounts - 1. Accounting Policies (Continued)**

### **1.11 Leases (continued)**

#### **1.11.2 Subsequent Remeasurement**

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use property assets. For non property assets the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset. Revaluations are undertaken on specialist ROU on an annual basis with revaluations on other property assets undertaken at regular intervals in line with contractual lease remeasurements. Professional revaluations are undertaken by Cushman and Wakefield in accordance with 'IFRS 16: Principles for UK Real Estate Professionals – Accounting for leases on the balance sheet', as prepared by RICS. The Trust has elected to apply the revaluation model to all of ROU assets on the basis that the ROU value is the value of a lessee's right to use an underlying asset for the lease term.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

### **1.12 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. Cash and cash equivalents are recorded at current values.

## Notes to the Accounts - 1. Accounting Policies (Continued)

### 1.13 Private Finance Initiative (PFI) transactions

HM Treasury has determined that a PFI transaction where the Group or Trust controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement and which meets 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 Group or Trust.

Annual contract payments to the operator (the unitary charge) are separated into the following component parts, using appropriate estimation techniques where necessary:

- a) Payment for the fair value of services received;
- b) Repayment of the PFI liability including finance costs; and
- c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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

#### 1.13.1 Services received

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

#### 1.13.2 PFI Asset

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16. Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

#### 1.13.3 PFI liability

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

#### 1.13.4 Application of IFRS 16 liability measurement principles to PFI liabilities

IFRS 16 liability measurement principles were applied to PFI and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

#### 1.13.5 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Group and Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

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 liability or prepayment will be recognised.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

## Notes to the Accounts - 1. Accounting Policies (Continued)

### 1.13 Private Finance Initiative (PFI) transactions (continued)

#### 1.13.5 Assets contributed by the Trust to the operator for use in the scheme

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

#### 1.13.6 Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Group and Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, were recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset was made available to the Trust, the prepayment was treated as an initial payment towards the finance lease liability and was set against the carrying value of the liability.

### 1.14 Inventories

Inventories are valued at the lower of cost or net realisable value. Provision is made for obsolete, slow moving and defective stock whenever evidence exists that a provision is required. The cost of inventories is measured using the first in, first out (FIFO) method.

### 1.15 Provisions

Provisions are recognised when the Group and Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Group and Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation, taking into account the risks and uncertainties.

Where the effect of the time value of money is significant, the estimated risk adjusted cash flows required to settle the obligation are discounted using 3 real time HM Treasury discount rates that range from 3.64% (2024/25, 4.03%) in the short term to 5.07% (2024/25, 4.55%) for very long term cash flow expectations. This excludes early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.95% in real terms (2024/25, 2.40%).

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

#### 1.15.1 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Group and Trust pays an annual contribution and NHS Resolution, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution are administratively responsible for all clinical negligence cases, the legal liability remains with the Group and Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Group and Trust is disclosed at Note 22 but is not recognised in the Group and Trust's accounts. Since financial responsibility for clinical negligence cases transferred to NHS Resolution, the only charge to operating expenditure in relation to clinical negligence in 2025/26 relates to the contribution to the Clinical Negligence Scheme for Trusts.

## **Notes to the Accounts - 1. Accounting Policies (Continued)**

### **1.15 Provisions (continued)**

#### **1.15.2 Non-clinical risk pooling**

The Group and Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Group and 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.

#### **1.16 Climate Change Levy**

Expenditure on the Climate Change Levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

### **1.17 Financial assets and financial liabilities**

#### **1.17.1 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

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items, which are entered into in accordance with the Group's normal purchase, sale or usage requirements, are recognised when the Group becomes party to the financial instrument contract or when performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leases are recognised and measured in accordance with the accounting policy for leases are described in policy 1.11.

#### **1.17.2 De-recognition**

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Group has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

#### **1.17.3 Classification and measurement**

The Group currently holds financial assets at fair value through profit and loss in the form of Investments. Other financial assets are held at amortised cost. The Group does not hold any financial liabilities 'at fair value through profit and loss' that would require a fair value calculation and adjustment to the income statement. Investments held by the Group relate to investments held within charitable funds which are managed by CCLA. The value disclosed within the financial statements are based on formal valuations undertaken and provided by CCLA.

#### **1.17.4 Financial Assets**

Receivables are non-derivative financial assets which are included in current and non-current assets. After initial recognition, they are measured at amortised cost, less any impairment. The Group's NHS and non-NHS receivables balances, accrued income and cash and cash equivalents have been classified as financial instruments and further information is available in Note 23.

#### **1.17.5 Financial liabilities**

All financial liabilities, after initial recognition, are measured at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. The Group does hold instruments that would fall into this category in the form of leases and the PFI Scheme (see Accounting Policy 1.11 and 1.13 for further information). The Group's outstanding NHS and non-NHS payables balances are classified as financial instruments and further information is available in Note 23.

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

## Notes to the Accounts - 1. Accounting Policies (Continued)

### 1.17.6 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust has adopted the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition, and otherwise at an amount equal to 12-month expected credit losses. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the creation of a provision for impairment of receivables.

For financial assets that have become credit impaired since initial recognition, 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.

### 1.18 Value Added Tax

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

### 1.19 Foreign currencies

The Group's functional currency and presentational currency is sterling. A transaction which is denominated in a foreign currency is translated into sterling at the spot exchange rate ruling on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Group's income or expense in the period in which they arise.

### 1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Group and Trust has no beneficial interest in them.

### 1.21 Public Dividend Capital (PDC) and PDC dividend

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

At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust.

An annual charge, reflecting the cost of capital utilised by the Group and Trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real 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, except for donated assets, average daily cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, assets under construction for nationally directed schemes and any PDC dividend balance receivable or payable. These additions and deductions as defined in the PDC dividend policy issued 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, the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

## Notes to the Accounts - 1. Accounting Policies (Continued)

### 1.22 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

### 1.23 Accounting standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and interpretations to be adopted in 2025/26. These Standards are still subject to HM Treasury FReM adoption.

- IFRS 14 Regulatory Deferral Accounts (not UK-endorsed and applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies);
- IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted.
- IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM and early adoption is not permitted.

In relation to the above standards the Trust has not been in the position to assess the expected impact of applying these standard in future periods as limited detailed information is available at this time.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

- Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.
- From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £247.9 million as at 31 March 2026.
- The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £214.1 million at 31 March 2026.

### 1.24 Accounting standards issued that have been adopted early

There have not been any accounting standards issued with an effective date of 1 April 2026, that have been adopted early.

### 1.25 Segmental reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The chief operating decision maker, who makes the strategic decisions, is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Board.

## **2. Operating segments**

The Group received £1,016.262 million under contracts with commissioners during the year (£944.742 million in 2024/25) from Integrated Care Boards and NHS England, which equated to 92% (91% in 2024/25) of total Trust income. There were no other significant external customers amounting to more than 8% of total income.

Commissioner funding was provided under a block contract arrangement during 2025/26. The previous Acute split by service has been updated in the following disclosures.

The Group has reviewed the process of reporting the financial performance at a trust wide level to the Board. Only limited divisional information is reported and this is similar in the nature of the products and services provided, the nature of the production process, the type of class of customer for the product or service, the method used to provide our services and the nature of the regulatory environment.

The Board is the chief decision making body within the Group and receives monthly updates on the financial position. These reports provide a global update on the Group's actual position compared to plan on expenditure, income, current surplus/deficit and progress on capital investment. The current position on cash balances is reported in conjunction with an updated risk rating. The figures reported to the Board are consistent with those included within these accounts

On the basis of the information provided to the Board it has been determined that there is only one operating segment, that of healthcare.

### 3. Operating income

#### 3.1 Income from activities by classification

|                                                   | GROUP            |                  | TRUST            |                  |
|---------------------------------------------------|------------------|------------------|------------------|------------------|
|                                                   | 2025/26<br>£000  | 2024/25<br>£000  | 2025/26<br>£000  | 2024/25<br>£000  |
| Block contract/system envelope income (*)         | 814,191          | 753,789          | 814,191          | 753,789          |
| High cost drugs income from Commissioners         | 116,332          | 107,458          | 116,332          | 107,458          |
| Accident and emergency income                     | 1,371            | 1,712            | 1,371            | 1,712            |
| Urgent Treatment and Community Diagnostic income  | 0                | 7,632            | 0                | 7,632            |
| Community services                                | 50,905           | 48,241           | 50,905           | 48,241           |
| Private patient income                            | 1,546            | 930              | 1,546            | 930              |
| Pay award central funding                         | 0                | 1,898            | 0                | 1,898            |
| Additional pension contribution central funding   | 34,834           | 33,356           | 34,834           | 33,356           |
| Other non-protected clinical income               | 397              | 291              | 397              | 291              |
| <b>Total income from activities</b>               | <b>1,019,576</b> | <b>955,307</b>   | <b>1,019,576</b> | <b>955,307</b>   |
| Research and development                          | 7,467            | 7,046            | 7,467            | 7,046            |
| Education and training                            | 29,719           | 28,086           | 29,719           | 28,086           |
| Charitable and other contributions to expenditure | 14,092           | 16,639           | 14,092           | 16,639           |
| Deficit support funding                           | 0                | 17,314           | 0                | 17,314           |
| Non-patient care services to other bodies         | 2,189            | 3,131            | 2,189            | 3,131            |
| Charitable fund - incoming resources              | 860              | 647              | 0                | 0                |
| Other income (**)                                 | 24,921           | 13,686           | 24,853           | 13,583           |
|                                                   | <b>79,248</b>    | <b>86,549</b>    | <b>78,320</b>    | <b>85,799</b>    |
| <b>Total income from continuing operations</b>    | <b>1,098,824</b> | <b>1,041,856</b> | <b>1,097,896</b> | <b>1,041,106</b> |

\* Further information on income is available within the Accounting Policies, Note 1.4.

\*\* Other income includes consideration arising from car parking charges £2.815 million (2024/25 £2.288 million), clinical excellence awards £0.852 million (2024/25 £0.819 million), staff accommodation £1.341 million (2024/25 £1.468 million), clinical tests £3.055 million (2024/25 £3.401 million) and creche services £1.070 million (2024/25 £0.715 million). The Trust has not received an individual transaction within fees and charges greater than £1.0 million in the financial year.

Under the Terms of Authorisation the Group's total activity income from Commissioner Requested Services amounts to £981.428 million (2024/25 £909.488 million). All other activity income relates to Non-Commissioner Requested Services

#### 3.2 Income from activities by source

|                                                  | 2025/26<br>£000  | 2024/25<br>£000 |
|--------------------------------------------------|------------------|-----------------|
| <b>Group and Trust</b>                           |                  |                 |
| Integrated Care Boards                           | 876,065          | 613,334         |
| NHS Foundation Trusts                            | 0                | 7,632           |
| NHS England                                      | 140,197          | 331,408         |
| Non-NHS - overseas patients (non-reciprocal) (*) | 397              | 265             |
| Non-NHS - private patients                       | 1,546            | 930             |
| Non-NHS - other                                  | 0                | 26              |
| NHS Injury Scheme                                | 1,371            | 1,712           |
| <b>Total income from activities</b>              | <b>1,019,576</b> | <b>955,307</b>  |

(\*) Cash payments received in year from overseas visitors, where patients are charged directly by the Trust, and relating to invoices raised in the current and prior years amounted to £0.099 million (£0.032 million in 2024/25). Additions to the provision for the impairment of receivables amounted to £0.230 million (£0.159 million increase in 2024/25) and the Trust did not write off any charges in year (no write offs in 2024/25).

Injury cost recovery is subject to a charge for credit loss allowances on receivables of 24.62% (2024/25, 24.45%) to reflect expected rates of collection.

#### 4. Operating expenses

##### 4.1 Operating expenses comprise:

|                                                                | GROUP            |                  | TRUST            |                  |
|----------------------------------------------------------------|------------------|------------------|------------------|------------------|
|                                                                | 2025/26          | 2024/25          | 2025/26          | 2024/25          |
|                                                                | £000             | £000             | £000             | £000             |
| Services from NHS Foundation Trusts                            | 8,374            | 8,273            | 8,374            | 8,273            |
| Purchase of healthcare from non NHS bodies                     | 10,781           | 8,818            | 11,558           | 9,509            |
| Employee expenses - non-executive directors                    | 150              | 161              | 150              | 161              |
| Employee expenses - staff                                      | 656,635          | 621,785          | 655,772          | 620,980          |
| Employee expenses - charitable fund                            | 418              | 499              | 0                | 0                |
| Drug costs                                                     | 109,978          | 105,550          | 109,887          | 105,477          |
| Supplies and services - clinical                               | 125,727          | 116,979          | 125,798          | 116,897          |
| Supplies and services - general                                | 6,680            | 4,259            | 6,679            | 4,259            |
| Research and development                                       | 1,543            | 1,498            | 1,543            | 1,498            |
| Establishment                                                  | 14,223           | 12,376           | 14,207           | 12,337           |
| Transport                                                      | 4,908            | 5,128            | 4,908            | 5,128            |
| Premises                                                       | 64,240           | 71,104           | 64,240           | 71,101           |
| Increase/(decrease) in provision for impairment of receivables | 1,025            | 372              | 1,025            | 372              |
| Increase/(decrease) in other provisions                        | 326              | (229)            | 326              | (229)            |
| Change in provisions discount rate                             | (3)              | (2)              | (3)              | (2)              |
| Inventories written down                                       | 258              | 332              | 258              | 332              |
| Depreciation of property, plant and equipment                  | 20,539           | 19,812           | 20,539           | 19,812           |
| Amortisation of intangible assets                              | 5,486            | 4,737            | 5,486            | 4,737            |
| Net impairments of property, plant and equipment               | 54,647           | 33,203           | 54,647           | 33,203           |
| Audit fees - audit services - statutory audit (*)              | 174              | 178              | 161              | 155              |
| - audit services - charitable fund (*)                         | 12               | 12               | 0                | 0                |
| Clinical negligence                                            | 22,455           | 19,589           | 22,455           | 19,589           |
| Legal fees                                                     | 222              | 114              | 222              | 114              |
| Consultancy costs                                              | 1,578            | 282              | 1,578            | 282              |
| Internal audit costs                                           | 146              | 248              | 146              | 248              |
| Training, courses and conferences                              | 2,329            | 1,951            | 2,326            | 1,950            |
| Redundancy                                                     | 537              | 0                | 537              | 0                |
| Other services                                                 | 1,257            | 1,157            | 1,257            | 1,157            |
| Hospitality                                                    | 1                | 3                | 1                | 3                |
| Insurance                                                      | 443              | 342              | 443              | 340              |
| Losses, ex gratia and special payments                         | 176              | 176              | 176              | 176              |
| Other resources expended - charitable fund                     | 821              | 563              | 0                | 0                |
| Other                                                          | 2,471            | 2,871            | 2,471            | 2,871            |
|                                                                | <b>1,118,557</b> | <b>1,042,141</b> | <b>1,117,167</b> | <b>1,040,730</b> |

\* the value of statutory audit fees disclosed above excludes VAT.

## 5. Employee expenses and numbers

### 5.1 Employee expenses (including Executive Directors' costs)

| Group and Trust                                                        | GROUP           |                 | TRUST           |                 |
|------------------------------------------------------------------------|-----------------|-----------------|-----------------|-----------------|
|                                                                        | 2025/26<br>£000 | 2024/25<br>£000 | 2025/26<br>£000 | 2024/25<br>£000 |
| Salaries and wages                                                     | 490,138         | 468,137         | 489,476         | 467,555         |
| Social security costs                                                  | 58,166          | 45,832          | 58,092          | 45,777          |
| Pension costs - defined benefit employer contributions to NHS Pensions | 88,033          | 84,377          | 88,033          | 84,377          |
| Agency/contract staff                                                  | 21,738          | 24,265          | 21,611          | 24,097          |
| Charitable fund staff                                                  | 418             | 499             | 0               | 0               |
| <b>Total staff costs</b>                                               | <b>658,493</b>  | 623,110         | <b>657,212</b>  | 621,806         |
| Costs capitalised as part of assets                                    | (903)           | (826)           | (903)           | (826)           |
| <b>Total staff costs excluding capitalised costs</b>                   | <b>657,590</b>  | 622,284         | <b>656,309</b>  | 620,980         |

### 5.2 Monthly average number of people employed

| Group and Trust                                                        | 2025/26<br>Total | 2024/25<br>Total |
|------------------------------------------------------------------------|------------------|------------------|
|                                                                        | Number           | Number           |
| Medical and dental                                                     | 1,408            | 1,377            |
| Administration and estates                                             | 2,039            | 2,146            |
| Healthcare assistants and other support staff                          | 288              | 617              |
| Nursing, midwifery and health visiting staff                           | 3,163            | 3,093            |
| Nursing, midwifery and health visiting learners                        | 1,343            | 1,114            |
| Scientific, therapeutic, technical staff and other                     | 1,615            | 1,494            |
| <b>Total</b>                                                           | <b>9,856</b>     | 9,841            |
| Number of staff (WTE) capitalised in capital projects (included above) | 14               | 14               |

Note: the figures represent the Whole Time Equivalent as opposed to the number of employees.

## 5. Employee expenses and numbers

### 5.3 Staff exit packages

#### Exit package cost band

| Group and Trust                                       | 2025/26                           |                                 |                                            |                                          | 2024/25                           |                                 |                                            |                                          |
|-------------------------------------------------------|-----------------------------------|---------------------------------|--------------------------------------------|------------------------------------------|-----------------------------------|---------------------------------|--------------------------------------------|------------------------------------------|
|                                                       | Number of other departures agreed | Cost of other departures agreed | Total number of exit packages by cost band | Total cost of exit packages by cost band | Number of other departures agreed | Cost of other departures agreed | Total number of exit packages by cost band | Total cost of exit packages by cost band |
|                                                       | Number                            | £000's                          | Number                                     | £000's                                   | Number                            | £000's                          | Number                                     | £000's                                   |
| < £10,000                                             | 19                                | 115                             | 19                                         | 115                                      | 1                                 | 4                               | 1                                          | 4                                        |
| £10,000 to £25,000                                    | 15                                | 243                             | 15                                         | 243                                      | 0                                 | 0                               | 0                                          | 0                                        |
| £25,001 to £50,000                                    | 3                                 | 82                              | 3                                          | 82                                       | 0                                 | 0                               | 0                                          | 0                                        |
| £50,001 to £100,000                                   | 1                                 | 97                              | 1                                          | 97                                       | 0                                 | 0                               | 0                                          | 0                                        |
| £100,001 to £150,000                                  | 0                                 | 0                               | 0                                          | 0                                        | 2                                 | 247                             | 2                                          | 247                                      |
| £150,001 to £200,000                                  | 0                                 | 0                               | 0                                          | 0                                        | 0                                 | 0                               | 0                                          | 0                                        |
| > £200,001                                            | 0                                 | 0                               | 0                                          | 0                                        | 0                                 | 0                               | 0                                          | 0                                        |
| <b>Total number and cost of exit packages by type</b> | <b>38</b>                         | <b>537</b>                      | <b>38</b>                                  | <b>537</b>                               | <b>3</b>                          | <b>251</b>                      | <b>3</b>                                   | <b>251</b>                               |

Redundancy and other departure costs have been paid in accordance with NHS Agenda for Change terms and conditions. Exit costs are accounted for in full in the year of departure. Where the Group has agreed to early retirements, the additional costs are met by the Group and not by the NHS Pension Scheme. Ill health retirement costs are met by the NHS Pension scheme and are not included in the table. There were no departures in 2025/26 or in 2024/25 where special payments were made.

### 5.4 Exit packages: non-compulsory departure payments

|                                                                     | 2025/26           |                  | 2024/25           |                  |
|---------------------------------------------------------------------|-------------------|------------------|-------------------|------------------|
|                                                                     | Agreements number | Total value £000 | Agreements number | Total value £000 |
| Voluntary redundancies including early retirement contractual costs | 0                 | 0                | 0                 | 0                |
| Mutually agreed resignations (MARS) contractual costs               | 0                 | 0                | 0                 | 0                |
| Contractual payments in lieu of notice                              | 38                | 537              | 3                 | 251              |
| <b>Total</b>                                                        | <b>38</b>         | <b>537</b>       | <b>3</b>          | <b>251</b>       |

Further information on exit packages is included in the Remuneration statements in the Annual Report. There were no non-contractual payments requiring HMT approval in 2025/26 or 2024/25.

## **5. Employee expenses and numbers (continued)**

### **5.5 Retirements due to ill-health**

During 2025/26 there were 19 (2024/25, 17) early retirements from South Tees Hospitals NHS Foundation Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £1.815 million (2024/25, £0.853 million). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

## **6. Pension costs**

Past and present employees are covered by the provisions of the 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](http://www.nhsbsa.nhs.uk/pensions). Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care 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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027. The employer contribution rate for 2026/27 is 14.38% (amounting to £52.8 million) and a further 9.4% will be funded centrally by NHS England.

## **6. Pension costs (continued)**

### **c) Scheme provisions**

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

#### **Annual pensions**

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and the best of the last 3 years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

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

#### **Pensions indexation**

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in the Consumer Price Index (CPI) in the twelve months ending 30 September in the previous calendar year.

#### **Ill-health retirement**

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

#### **Early retirements other than ill-health**

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

#### **Additional Voluntary Contributions (AVCs)**

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

## 7. Finance costs

| <b>7.1 Finance costs - interest expenses</b>                           | <b>2025/26</b> | <b>2024/25</b> |
|------------------------------------------------------------------------|----------------|----------------|
|                                                                        | <b>£000</b>    | <b>£000</b>    |
| <b>Group and Trust</b>                                                 |                |                |
| Leases                                                                 | <b>1,437</b>   | 1,459          |
| <b>Finance costs in PFI obligations</b>                                |                |                |
| - Main finance cost                                                    | <b>14,090</b>  | 14,389         |
| - IFRS16 remeasurement of PFI liability resulting from change in index | <b>7,639</b>   | 4,740          |
| <b>Total</b>                                                           | <b>23,166</b>  | 20,588         |

## 7.2 Impairment of assets (property, plant and equipment)

| <b>Group and Trust</b>             | <b>2025/26</b> | <b>2024/25</b> |
|------------------------------------|----------------|----------------|
|                                    | <b>£000</b>    | <b>£000</b>    |
| <u>Income and Expenditure:</u>     |                |                |
| Impairment of PPE                  | <b>54,647</b>  | 33,203         |
| <u>Other Comprehensive Income:</u> |                |                |
| Impairment                         | <b>589</b>     | 93             |
| Revaluation gain                   | <b>(2,276)</b> | (1,577)        |
| <b>Total</b>                       | <b>52,960</b>  | 31,719         |

Further information on impairments is available within Note 8.3 and 10.1 to the Accounts.

The impairment relates to decreases in property valuations and capital works that do not increase the value of the property. This includes impairments on new build including the Surgical Hub development on the Friarage site (£22.657 million), lifecycle investment in year undertaken by the PFI Provider (£6.769 million) and significant enhancement schemes including the Decarbonisation scheme on both the James Cook and Friarage sites. The impairment also includes movements in the valuation of Right of Use assets.

The impairment reported of £54.647 million also includes the reversal of prior year impairments arising from the revaluation exercise undertaken at 31 March 2026 by Cushman and Wakefield. This reversal amounted to £8.988 million.

## 8. Property, plant and equipment

### 8.1 Property, plant and equipment comprise the following:

|                                                        | Land         | Buildings<br>excluding<br>dwellings | Dwellings  | Assets under<br>construction | Plant and<br>machinery | Transport<br>equipment | Information<br>technology | Furniture and<br>fittings | Total          |
|--------------------------------------------------------|--------------|-------------------------------------|------------|------------------------------|------------------------|------------------------|---------------------------|---------------------------|----------------|
| Group and Trust                                        | £000         | £000                                | £000       | £000                         | £000                   | £000                   | £000                      | £000                      | £000           |
| <b>Cost or valuation</b>                               |              |                                     |            |                              |                        |                        |                           |                           |                |
| <b>Cost or valuation at 1 April 2025</b>               | 2,688        | 184,515                             | 607        | 76,962                       | 144,888                | 84                     | 41,987                    | 2,927                     | 454,658        |
| Additions purchased                                    | 0            | 1,816                               | 0          | 38,868                       | 3,553                  | 0                      | 1,155                     | 0                         | 45,392         |
| Additions donated and government granted               | 0            | 0                                   | 0          | 13,739                       | 278                    | 0                      | 0                         | 0                         | 14,017         |
| Reclassifications from assets under construction       | 0            | 81,651                              | 0          | (82,971)                     | 835                    | 0                      | 485                       | 0                         | 0              |
| Disposals                                              | 0            | 0                                   | 0          | 0                            | (41,243)               | (34)                   | (11,260)                  | (2,395)                   | (54,932)       |
| Impairments charged to the revaluation reserve         | 0            | (589)                               | 0          | 0                            | 0                      | 0                      | 0                         | 0                         | (589)          |
| Revaluation surpluses credited to revaluation reserve  | 0            | 2,276                               | 0          | 0                            | 0                      | 0                      | 0                         | 0                         | 2,276          |
| Adjustment for in year revaluation                     | 0            | (58,780)                            | (24)       | 0                            | 0                      | 0                      | 0                         | 0                         | (58,804)       |
| <b>Cost or valuation at 31 March 2026</b>              | <b>2,688</b> | <b>210,889</b>                      | <b>583</b> | <b>46,598</b>                | <b>108,311</b>         | <b>50</b>              | <b>32,367</b>             | <b>532</b>                | <b>402,018</b> |
| <b>Depreciation</b>                                    |              |                                     |            |                              |                        |                        |                           |                           |                |
| <b>Accumulated depreciation at 1 April 2025</b>        | 0            | 0                                   | 0          | 118                          | 108,893                | 71                     | 32,673                    | 2,718                     | 144,473        |
| Disposals                                              | 0            | 0                                   | 0          | 0                            | (41,235)               | (34)                   | (11,260)                  | (2,395)                   | (54,924)       |
| Impairments                                            | 0            | 62,633                              | 0          | 0                            | 1                      | 0                      | 63                        | 0                         | 62,697         |
| Reversal of impairments credited to operating expenses | 0            | (8,799)                             | 0          | 0                            | 0                      | 0                      | 0                         | 0                         | (8,799)        |
| Provided during the year                               | 0            | 4,946                               | 24         | 0                            | 9,318                  | 4                      | 3,305                     | 73                        | 17,670         |
| Adjustment for accumulated depreciation on valuation   | 0            | (58,780)                            | (24)       | 0                            | 0                      | 0                      | 0                         | 0                         | (58,804)       |
| <b>Accumulated depreciation at 31 March 2026</b>       | <b>0</b>     | <b>0</b>                            | <b>0</b>   | <b>118</b>                   | <b>76,977</b>          | <b>41</b>              | <b>24,781</b>             | <b>396</b>                | <b>102,313</b> |
| <b>Net book value at 1 April 2025</b>                  |              |                                     |            |                              |                        |                        |                           |                           |                |
| Owned                                                  | 2,688        | 33,800                              | 607        | 56,045                       | 31,126                 | 13                     | 8,895                     | 47                        | 133,221        |
| Private Finance Initiative                             | 0            | 141,447                             | 0          | 0                            | 1,720                  | 0                      | 0                         | 0                         | 143,167        |
| Donated and government granted                         | 0            | 9,268                               | 0          | 20,799                       | 2,095                  | 0                      | 419                       | 162                       | 32,743         |
| Donated from DHSC for COVID response                   | 0            | 0                                   | 0          | 0                            | 1,054                  | 0                      | 0                         | 0                         | 1,054          |
| <b>Net book value total at 1 April 2025</b>            | <b>2,688</b> | <b>184,515</b>                      | <b>607</b> | <b>76,844</b>                | <b>35,995</b>          | <b>13</b>              | <b>9,314</b>              | <b>209</b>                | <b>310,185</b> |
| <b>Net book value at 31 March 2026</b>                 |              |                                     |            |                              |                        |                        |                           |                           |                |
| Owned                                                  | 2,688        | 55,465                              | 583        | 35,358                       | 27,532                 | 9                      | 7,200                     | 15                        | 128,850        |
| Private Finance Initiative                             | 0            | 146,401                             | 0          | 0                            | 1,426                  | 0                      | 0                         | 0                         | 147,827        |
| Donated and government granted                         | 0            | 9,023                               | 0          | 11,122                       | 1,551                  | 0                      | 386                       | 121                       | 22,203         |
| Donated from DHSC for COVID response                   | 0            | 0                                   | 0          | 0                            | 825                    | 0                      | 0                         | 0                         | 825            |
| <b>Net book value total at 31 March 2026</b>           | <b>2,688</b> | <b>210,889</b>                      | <b>583</b> | <b>46,480</b>                | <b>31,334</b>          | <b>9</b>               | <b>7,586</b>              | <b>136</b>                | <b>299,705</b> |

Note: The gross book value of assets fully written down amounts to £67.741 million for the Group and Trust as at 31 March 2026 (31 March 2025 £129.413 million). The majority of these assets relate to the categories of IT, Plant & Machinery and Furniture & Fittings. In 2025/26 the Trust disposed of £54.932 million following significant investment in the estate funded by the Department of Health and Social Care and NHS England. This was predominantly in the areas of Plant and Machinery and Information Technology.

## 8. Property, plant and equipment (continued)

### 8.2 Prior year - Property, plant and equipment comprise the following:

|                                                        | Land         | Buildings<br>excluding<br>dwellings | Dwellings  | Assets under<br>construction | Plant and<br>machinery | Transport<br>equipment | Information<br>technology | Furniture<br>and fittings | Total          |
|--------------------------------------------------------|--------------|-------------------------------------|------------|------------------------------|------------------------|------------------------|---------------------------|---------------------------|----------------|
| <b>Group and Trust</b>                                 |              |                                     |            |                              |                        |                        |                           |                           |                |
| <b>Cost or valuation at 1 April 2024</b>               | 2,688        | 179,641                             | 621        | 60,820                       | 132,591                | 84                     | 40,267                    | 2,857                     | 419,569        |
| Additions purchased                                    | 0            | 21,590                              | 0          | 10,760                       | 8,379                  | 0                      | 922                       | 1                         | 41,652         |
| Additions donated and government granted               | 0            | 650                                 | 0          | 15,240                       | 614                    | 0                      | 66                        | 69                        | 16,639         |
| Reclassifications from assets under construction       | 0            | 4,637                               | 0          | (9,858)                      | 4,489                  | 0                      | 732                       | 0                         | 0              |
| Disposals                                              | 0            | 0                                   | 0          | 0                            | (1,185)                | 0                      | 0                         | 0                         | (1,185)        |
| Impairments charged to the revaluation reserve         | 0            | (93)                                | 0          | 0                            | 0                      | 0                      | 0                         | 0                         | (93)           |
| Revaluation surpluses credited to revaluation reserve  | 0            | 1,577                               | 0          | 0                            | 0                      | 0                      | 0                         | 0                         | 1,577          |
| Adjustment for in year revaluation                     | 0            | (23,487)                            | (14)       | 0                            | 0                      | 0                      | 0                         | 0                         | (23,501)       |
| <b>Cost or valuation at 31 March 2025</b>              | <b>2,688</b> | <b>184,515</b>                      | <b>607</b> | <b>76,962</b>                | <b>144,888</b>         | <b>84</b>              | <b>41,987</b>             | <b>2,927</b>              | <b>454,658</b> |
| <b>Depreciation</b>                                    |              |                                     |            |                              |                        |                        |                           |                           |                |
| <b>Accumulated depreciation at 1 April 2024</b>        | 0            | 0                                   | 0          | 118                          | 97,085                 | 67                     | 29,935                    | 2,635                     | 129,840        |
| Disposals                                              | 0            | 0                                   | 0          | 0                            | (1,161)                | 0                      | 0                         | 0                         | (1,161)        |
| Impairments                                            | 0            | 21,858                              | 0          | 0                            | 4,326                  | 0                      | 0                         | 0                         | 26,184         |
| Reversal of impairments credited to operating expenses | 0            | (3,153)                             | (10)       | 0                            | 0                      | 0                      | 0                         | 0                         | (3,163)        |
| Provided during the year                               | 0            | 4,782                               | 24         | 0                            | 8,643                  | 4                      | 2,738                     | 83                        | 16,274         |
| Adjustment for accumulated depreciation on valuation   | 0            | (23,487)                            | (14)       | 0                            | 0                      | 0                      | 0                         | 0                         | (23,501)       |
| <b>Accumulated depreciation at 31 March 2025</b>       | <b>0</b>     | <b>0</b>                            | <b>0</b>   | <b>118</b>                   | <b>108,893</b>         | <b>71</b>              | <b>32,673</b>             | <b>2,718</b>              | <b>144,473</b> |
| <b>Net book value at 1 April 2024</b>                  |              |                                     |            |                              |                        |                        |                           |                           |                |
| Owned                                                  | 2,688        | 26,527                              | 621        | 55,143                       | 32,971                 | 17                     | 9,979                     | 129                       | 128,075        |
| Private Finance Initiative                             | 0            | 144,251                             | 0          | 0                            | 0                      | 0                      | 0                         | 0                         | 144,251        |
| Donated and government granted                         | 0            | 8,863                               | 0          | 5,559                        | 1,251                  | 0                      | 353                       | 93                        | 16,119         |
| Donated from DHSC for COVID response                   | 0            | 0                                   | 0          | 0                            | 1,284                  | 0                      | 0                         | 0                         | 1,284          |
| <b>Net book value total at 1 April 2024</b>            | <b>2,688</b> | <b>179,641</b>                      | <b>621</b> | <b>60,702</b>                | <b>35,506</b>          | <b>17</b>              | <b>10,332</b>             | <b>222</b>                | <b>289,729</b> |
| <b>Net book value at 31 March 2025</b>                 |              |                                     |            |                              |                        |                        |                           |                           |                |
| Owned                                                  | 2,688        | 33,800                              | 607        | 56,045                       | 31,126                 | 13                     | 8,895                     | 47                        | 133,221        |
| Private Finance Initiative                             | 0            | 141,447                             | 0          | 0                            | 1,720                  | 0                      | 0                         | 0                         | 143,167        |
| Donated and government granted                         | 0            | 9,268                               | 0          | 20,799                       | 2,095                  | 0                      | 419                       | 162                       | 32,743         |
| Donated from DHSC for COVID response                   | 0            | 0                                   | 0          | 0                            | 1,054                  | 0                      | 0                         | 0                         | 1,054          |
| <b>Net book value total at 31 March 2025</b>           | <b>2,688</b> | <b>184,515</b>                      | <b>607</b> | <b>76,844</b>                | <b>35,995</b>          | <b>13</b>              | <b>9,314</b>              | <b>209</b>                | <b>310,185</b> |



## 8. Property, plant and equipment (continued)

### 8.3 Property, plant and equipment - revaluation

A full revaluation exercise was undertaken during March as at 31 March 2026 on the Group and Trust's owned land and buildings by Cushman and Wakefield. The exercise was undertaken in accordance with the HM Treasury's Modern Equivalent Asset (MEA) recommendation adjusting the valuation undertaken at 31 March 2025, for movements in building cost indices and location factors since that date.

The exercise undertaken as at 31 March, 2026, identified a net revaluation increase of £9.1 million on Trust properties over the James Cook and Friarage sites. The resulting changes in valuation on both sites are summarised in Note 7.2.

### 8.4 Economic lives of property, plant and equipment

The economic asset lives are as follows:

|                               | <b>Min life<br/>Years</b> | <b>Max life<br/>Years</b> |
|-------------------------------|---------------------------|---------------------------|
| Buildings excluding dwellings | 17                        | 55                        |
| Dwellings                     | 47                        | 47                        |
| Plant and machinery           | 5                         | 15                        |
| Transport equipment           | 7                         | 7                         |
| Information technology        | 5                         | 7                         |
| Furniture and fittings        | 5                         | 7                         |

This represents the current range of asset lives relating to these assets.

### 8.5 Capital management

The Trust's capital programme is approved on an annual basis via the Capital Planning Oversight Group, Senior Leadership Team and Clinical Policy Group with final approval through the Board of Directors. The full plan is included in the Annual Plan submitted to NHS England. The revised capital programme for the year amounted to £67.2 million (2024/25, £78.7 million) and included essential investment in infrastructure, the estate, medical equipment, Information Technology replacement programmes and lifecycle works under the PFI contract.

### 8.6 Donated assets

There are no restrictions or conditions imposed by the donor on the use of donated assets reported within the Trust's Statement of Financial Position. The Trust's consolidated charity and other capital contributions towards investment in the estate to the value of £14.1 million (2024/25, £16.6 million) has been received during the year to help deliver patient care. This investment in the estate is held on the Trust's Statement of Financial Position at 31 March 2026.

## 9. Intangible assets

### 9.1 Intangible assets

| 2025/26:<br>Group and Trust                      | Computer software<br>purchased<br>£000 | Assets under<br>construction<br>£000 | Total<br>£000 |
|--------------------------------------------------|----------------------------------------|--------------------------------------|---------------|
| <b>Gross cost at 1 April 2025</b>                | 34,404                                 | 312                                  | 34,716        |
| Additions purchased                              | 1,776                                  | 4,358                                | 6,134         |
| Disposals                                        | (7,269)                                | 0                                    | (7,269)       |
| Reclassifications from assets under construction | 1,953                                  | (1,953)                              | 0             |
| <b>Gross cost at 31 March 2026</b>               | <b>30,864</b>                          | <b>2,717</b>                         | <b>33,581</b> |
| <b>Accumulated amortisation at 1 April 2025</b>  | 25,309                                 | 0                                    | 25,309        |
| Provided during the year                         | 5,486                                  | 0                                    | 5,486         |
| Disposals                                        | (7,269)                                | 0                                    | (7,269)       |
| <b>Accumulated amortisation at 31 March 2026</b> | <b>23,526</b>                          | <b>0</b>                             | <b>23,526</b> |
| <b>Net book value at 1 April 2025</b>            |                                        |                                      |               |
| Purchased                                        | 8,904                                  | 312                                  | 9,216         |
| Donated                                          | 191                                    | 0                                    | 191           |
| <b>Net book value total at 1 April 2025</b>      | <b>9,095</b>                           | <b>312</b>                           | <b>9,407</b>  |
| <b>Net book value at 31 March 2026</b>           |                                        |                                      |               |
| Purchased                                        | 7,099                                  | 2,717                                | 9,816         |
| Donated                                          | 239                                    | 0                                    | 239           |
| <b>Net book value total at 31 March 2026</b>     | <b>7,338</b>                           | <b>2,717</b>                         | <b>10,055</b> |

### 9.2 Prior year Intangible assets

| 2024/25:<br>Group and Trust                      | Computer software<br>purchased<br>£000 | Assets under<br>construction<br>£000 | Total<br>£000 |
|--------------------------------------------------|----------------------------------------|--------------------------------------|---------------|
| <b>Gross cost at 1 April 2024</b>                | 31,429                                 | 225                                  | 31,654        |
| Additions purchased                              | 1,830                                  | 1,232                                | 3,062         |
| Reclassifications from assets under construction | 1,145                                  | (1,145)                              | 0             |
| <b>Gross cost at 31 March 2025</b>               | <b>34,404</b>                          | <b>312</b>                           | <b>34,716</b> |
| <b>Accumulated amortisation at 1 April 2024</b>  | 20,572                                 | 0                                    | 20,572        |
| Provided during the year                         | 4,737                                  | 0                                    | 4,737         |
| <b>Accumulated amortisation at 31 March 2025</b> | <b>25,309</b>                          | <b>0</b>                             | <b>25,309</b> |
| <b>Net book value at 1 April 2024</b>            |                                        |                                      |               |
| Purchased                                        | 10,642                                 | 225                                  | 10,867        |
| Donated                                          | 215                                    | 0                                    | 215           |
| <b>Net book value total at 1 April 2024</b>      | <b>10,857</b>                          | <b>225</b>                           | <b>11,082</b> |
| <b>Net book value at 31 March 2025</b>           |                                        |                                      |               |
| Purchased                                        | 8,904                                  | 312                                  | 9,216         |
| Donated                                          | 191                                    | 0                                    | 191           |
| <b>Net book value total at 31 March 2025</b>     | <b>9,095</b>                           | <b>312</b>                           | <b>9,407</b>  |

### 9.3. Intangible assets - asset lives

Each class of intangible asset has a finite remaining life as detailed below:

#### Economic lives of assets

|                   | Min life<br>Years | Max life<br>Years |
|-------------------|-------------------|-------------------|
| Computer software | 5                 | 5                 |

This represents the current range of asset lives relating to these assets.

## 10. Right of Use Assets

### 10.1 Right of Use Assets comprise of the following:

|                                                        | Property<br>land and<br>buildings | Plant and<br>machinery | Transport<br>equipment | Information<br>technology | Total         |
|--------------------------------------------------------|-----------------------------------|------------------------|------------------------|---------------------------|---------------|
| <b>Group and Trust</b>                                 |                                   |                        |                        |                           |               |
| <b>Cost or valuation</b>                               | <b>£000</b>                       | <b>£000</b>            | <b>£000</b>            | <b>£000</b>               | <b>£000</b>   |
| <b>Gross cost or valuation at 1 April 2025</b>         | 27,459                            | 14,353                 | 251                    | 5,189                     | 47,252        |
| Additions - lease liability                            | 0                                 | 732                    | 0                      | 0                         | 732           |
| Remeasurement of the lease liability                   | 954                               | 0                      | 0                      | 0                         | 954           |
| Disposals                                              | 0                                 | (8,715)                | (226)                  | 0                         | (8,941)       |
| Adjustment for in year revaluation                     | (1,378)                           | 0                      | 0                      | 0                         | (1,378)       |
| <b>Gross cost or valuation at 31 March 2026</b>        | <b>27,035</b>                     | <b>6,370</b>           | <b>25</b>              | <b>5,189</b>              | <b>38,619</b> |
| <b>Depreciation</b>                                    |                                   |                        |                        |                           |               |
| <b>Accumulated depreciation at 1 April 2025</b>        | 0                                 | 10,193                 | 233                    | 1,034                     | 11,460        |
| Provided during the year - right of use asset          | 1,706                             | 672                    | 16                     | 475                       | 2,869         |
| Impairments                                            | 938                               | 0                      | 0                      | 0                         | 938           |
| Disposals                                              | 0                                 | (8,715)                | (226)                  | 0                         | (8,941)       |
| Reversal of impairments credited to operating expenses | (189)                             | 0                      | 0                      | 0                         | (189)         |
| Adjustment for accumulated depreciation on valuation   | (1,378)                           | 0                      | 0                      | 0                         | (1,378)       |
| <b>Accumulated depreciation at 31 March 2026</b>       | <b>1,077</b>                      | <b>2,150</b>           | <b>23</b>              | <b>1,509</b>              | <b>4,759</b>  |
| <b>Net book value total at 31 March 2026</b>           | <b>25,958</b>                     | <b>4,220</b>           | <b>2</b>               | <b>3,680</b>              | <b>33,860</b> |

The revaluation exercise was undertaken as at 31 March, 2026, on Specialised leased buildings by Cushman and Wakefield. The exercise identified a net impairment of £0.7 million over the Community estate. The resulting changes in valuation are summarised in Note 7.2.

## 10. Right of Use Assets

### 10.2 Prior year Right of Use Assets comprise of the following:

|                                                      | Property<br>land and<br>buildings | Plant and<br>machinery | Transport<br>equipment | Information<br>technology | Total         |
|------------------------------------------------------|-----------------------------------|------------------------|------------------------|---------------------------|---------------|
| <b>Group and Trust</b>                               |                                   |                        |                        |                           |               |
| <b>Cost or valuation</b>                             | <b>£000</b>                       | <b>£000</b>            | <b>£000</b>            | <b>£000</b>               | <b>£000</b>   |
| <b>Gross cost or valuation at 1 April 2024</b>       | 27,140                            | 14,353                 | 251                    | 559                       | 42,303        |
| Additions - lease liability                          | 0                                 | 0                      | 0                      | 4,630                     | 4,630         |
| Remeasurement of the lease liability                 | 12,761                            | 0                      | 0                      | 0                         | 12,761        |
| Adjustment for in year revaluation                   | (12,442)                          | 0                      | 0                      | 0                         | (12,442)      |
| <b>Gross cost or valuation at 31 March 2025</b>      | <b>27,459</b>                     | <b>14,353</b>          | <b>251</b>             | <b>5,189</b>              | <b>47,252</b> |
| <b>Depreciation</b>                                  |                                   |                        |                        |                           |               |
| <b>Accumulated depreciation at 1 April 2024</b>      | 0                                 | 9,439                  | 184                    | 559                       | 10,182        |
| Provided during the year - right of use asset        | 2,260                             | 754                    | 49                     | 475                       | 3,538         |
| Impairments                                          | 10,182                            | 0                      | 0                      | 0                         | 10,182        |
| Adjustment for accumulated depreciation on valuation | (12,442)                          | 0                      | 0                      | 0                         | (12,442)      |
| <b>Accumulated depreciation at 31 March 2025</b>     | <b>0</b>                          | <b>10,193</b>          | <b>233</b>             | <b>1,034</b>              | <b>11,460</b> |
| <b>Net book value total at 31 March 2025</b>         | <b>27,459</b>                     | <b>4,160</b>           | <b>18</b>              | <b>4,155</b>              | <b>35,792</b> |

## 11. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these accounts:

| Group and Trust               | 31 March 2026<br>£000 | 31 March 2025<br>£000 |
|-------------------------------|-----------------------|-----------------------|
| Property, plant and equipment | 1,464                 | 9,012                 |
| Intangible assets             | 2,393                 | 2,910                 |
| <b>Total</b>                  | <b>3,857</b>          | <b>11,922</b>         |

The decrease this year is mainly due to the completion of the Friarage Hospital Theatre scheme.

## 12. Subsidiaries and consolidation of charitable funds

The Trust's 1 principal subsidiary, South Tees Healthcare Management Limited which provides an outpatient pharmacy service, and South Tees Hospitals Charity and Associated Funds are included in the consolidation at 31 March 2026. The accounting date of the financial statements for these subsidiaries is in line with the Trust date of 31 March 2026. The South Tees Institute of Learning, Research and Innovation LLP also has a financial year end of 31 March 2026 but has not been consolidated as it is dormant and has not had any transactions in 2025/26.

South Tees Hospitals NHS Foundation Trust also holds a 5% holding in North Tees and Hartlepool Solutions LLP which is a fully owned and consolidated company of North Tees and Hartlepool NHS Foundation Trust. There are no financial implications or disclosures included within these accounts for this company. Key financial information for the charitable fund and South Tees Healthcare Management Limited are provided as follows:

### South Tees Hospitals Charity and Associated Funds

#### 12.1 Reserves

|                    | 31 March 2026<br>£000 | 31 March 2025<br>£000 |
|--------------------|-----------------------|-----------------------|
| Restricted funds   | 1,569                 | 1,137                 |
| Unrestricted funds | 4,042                 | 5,232                 |
| <b>Total</b>       | <b>5,611</b>          | <b>6,369</b>          |

Funds specific to wards, departments or schemes are held as un-restricted designated funds. Legacies and donations received for a specific purpose or 'trust' are recorded and accounted for as restricted funds. Further information covering the nature of the restricted and unrestricted funds is available within Accounting Policy 1.2.

#### 12.2 Aggregated amounts relating to the charitable fund

|                                                                             | 31 March 2026<br>£000 | 31 March 2025<br>£000 |
|-----------------------------------------------------------------------------|-----------------------|-----------------------|
| <b>Summary Statement of Financial Position:</b>                             |                       |                       |
| Non-current assets                                                          | 5,628                 | 6,192                 |
| Current assets                                                              | 1,371                 | 1,192                 |
| Current liabilities                                                         | (1,388)               | (1,015)               |
| <b>Net assets</b>                                                           | <b>5,611</b>          | <b>6,369</b>          |
| <b>Reserves</b>                                                             | <b>5,611</b>          | <b>6,369</b>          |
| <b>Summary Statement of Financial Activities:</b>                           |                       |                       |
| Income                                                                      | 1,260                 | 1,357                 |
| Expenditure                                                                 | (1,454)               | (1,592)               |
| <b>Total</b>                                                                | <b>(194)</b>          | <b>(235)</b>          |
| Net realised (loss)/ gain on investment assets and other reserve movements. | (564)                 | (274)                 |
| <b>Net movement in funds</b>                                                | <b>(758)</b>          | <b>(509)</b>          |

## 12. Subsidiaries and consolidation of charitable funds (continued)

### South Tees Healthcare Management Limited

#### 12.3 Subsidiary undertakings

The company is a 100% subsidiary to the Trust that began operations on 6 October 2019 providing an outpatient pharmacy service. Further information covering the nature of the company is available within Accounting Policy 1.2.

#### 12.4 Aggregated amounts relating to the company

|                                                   | 31 March 2026 | 31 March 2025 |
|---------------------------------------------------|---------------|---------------|
|                                                   | £000          | £000          |
| <b>Summary Statement of Financial Position:</b>   |               |               |
| Current assets                                    | 3,202         | 2,883         |
| Current liabilities                               | (3,578)       | (3,189)       |
| <b>Net assets</b>                                 | <b>(376)</b>  | <b>(306)</b>  |
| <b>Reserves</b>                                   | <b>(376)</b>  | <b>(306)</b>  |
| <b>Summary Statement of Financial Activities:</b> |               |               |
| Income                                            | 23,389        | 22,499        |
| Expenditure                                       | (23,561)      | (22,733)      |
| <b>Net movement in funds</b>                      | <b>(172)</b>  | <b>(234)</b>  |

#### 12.5 Group eliminations of the subsidiary and charitable funds

In 2025/26 on the charity, eliminations consisted of a £0.203 million adjustment to income and expenditure for capital transactions (£0.518 million in 2024/25) and adjustments to working capital, consisting of a receivable in the Trust and a payable in the Charity, amounted to £1.189 million (£0.942 million in 2024/25).

On the subsidiary, intra group eliminations on income and expenditure consisted of a £23.320 million adjustment for drug and rendering recharges and corporate service charges (£22.551 million in 2024/25) and adjustments for working capital, consisting of a payable in the Trust and a receivable in the subsidiary, amounting to £0.440million (£0.552 million in 2024/25).

The above summary statements have initially been presented before group eliminations with an explanation to reconcile to the amounts included within the consolidated statements. As per accounting policy 1.2 the accounts of the charitable fund and the subsidiary have been consolidated in full after the elimination of intra group transactions and balances.

### 13. Other investments

The management of the investment portfolio of South Tees Hospitals Charity and Associated Funds is undertaken by CCLA. Cash funds are held outside the portfolio by the fund to deal with short term cash flow issues. The movements in the fund during 2025/26 are detailed in the table below.

|                                 | 31 March 2026<br>£000 | 31 March 2025<br>£000 |
|---------------------------------|-----------------------|-----------------------|
| Fair value brought forward      | 6,192                 | 6,466                 |
| Fair value (losses) / gains     | (564)                 | (274)                 |
| <b>Market value at 31 March</b> | <b>5,628</b>          | <b>6,192</b>          |

#### Investments held:

|                                        |              |              |
|----------------------------------------|--------------|--------------|
| COIF Charities Ethical Investment Fund | 5,628        | 6,192        |
|                                        | <b>5,628</b> | <b>6,192</b> |

No investments were disposed of during the financial year 2025/26.

### 14. Inventories

#### Group

#### Trust

| 14.1 Inventories                                   | 31 March 2026<br>£000         | 31 March 2025<br>£000         | 31 March 2026<br>£000         | 31 March 2025<br>£000         |
|----------------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| <b>Group and Trust</b>                             |                               |                               |                               |                               |
| Drugs                                              | 6,447                         | 6,489                         | 5,443                         | 5,688                         |
| Consumables                                        | 8,969                         | 9,283                         | 8,969                         | 9,283                         |
| <b>Total</b>                                       | <b>15,416</b>                 | <b>15,772</b>                 | <b>14,412</b>                 | <b>14,971</b>                 |
| <b>14.2 Inventories recognised in expenses</b>     | <b>31 March 2026<br/>£000</b> | <b>31 March 2025<br/>£000</b> | <b>31 March 2026<br/>£000</b> | <b>31 March 2025<br/>£000</b> |
| <b>Group and Trust</b>                             |                               |                               |                               |                               |
| Inventories recognised as an expense               | 249,031                       | 235,265                       | 226,460                       | 213,487                       |
| Write-down of inventories recognised as an expense | 258                           | 332                           | 176                           | 268                           |
| <b>Total</b>                                       | <b>249,289</b>                | <b>235,597</b>                | <b>226,636</b>                | <b>213,755</b>                |

## 15. Cash and cash equivalents

| Group and Trust                                                | Group                 |                       | Trust                 |                       |
|----------------------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|                                                                | 31 March 2026<br>£000 | 31 March 2025<br>£000 | 31 March 2026<br>£000 | 31 March 2025<br>£000 |
| At 1 April                                                     | 53,790                | 55,988                | 51,994                | 53,869                |
| Net change in year                                             | 33,706                | (2,198)               | 33,864                | (1,875)               |
| <b>Balance at 31 March</b>                                     | <b>87,496</b>         | <b>53,790</b>         | <b>85,858</b>         | <b>51,994</b>         |
| <b>Broken down to:</b>                                         |                       |                       |                       |                       |
| Cash with the Government Banking Service                       | 83,458                | 50,455                | 83,458                | 50,455                |
| Commercial banks and in hand                                   | 4,038                 | 3,335                 | 2,400                 | 1,539                 |
| <b>Cash and cash equivalents as in statement of cash flows</b> | <b>87,496</b>         | <b>53,790</b>         | <b>85,858</b>         | <b>51,994</b>         |

## 16. Trade and other receivables

### 16.1 Trade and other receivables

| Group and Trust                                | Group                 |                       | Trust                 |                       |
|------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|                                                | 31 March 2026<br>£000 | 31 March 2025<br>£000 | 31 March 2026<br>£000 | 31 March 2025<br>£000 |
| <b>Current</b>                                 |                       |                       |                       |                       |
| Contract receivables invoiced                  | 14,612                | 15,007                | 14,612                | 15,007                |
| Contract receivables not yet invoiced          | 27,456                | 23,180                | 27,466                | 23,120                |
| Capital receivables                            | 1,858                 | 12,271                | 1,858                 | 12,271                |
| Other trade receivables                        | 72                    | 657                   | 72                    | 657                   |
| VAT                                            | 0                     | 0                     | 0                     | 0                     |
| Allowance for impaired contract receivables    | (4,057)               | (957)                 | (4,057)               | (957)                 |
| Clinicians Pension tax provision reimbursement | 31                    | 42                    | 31                    | 42                    |
| Prepayments                                    | 22,135                | 25,181                | 22,135                | 25,173                |
| <b>Total</b>                                   | <b>62,107</b>         | <b>75,381</b>         | <b>62,117</b>         | <b>75,313</b>         |
| <b>Non-current</b>                             |                       |                       |                       |                       |
| Contract receivables not yet invoiced          | 2,783                 | 2,836                 | 2,783                 | 2,836                 |
| Allowance for impaired contract receivables    | (685)                 | (2,760)               | (685)                 | (2,760)               |
| Clinicians Pension tax provision reimbursement | 1,123                 | 1,231                 | 1,123                 | 1,231                 |
| <b>Total</b>                                   | <b>3,221</b>          | <b>1,307</b>          | <b>3,221</b>          | <b>1,307</b>          |

A significant proportion of trade is with Integrated Care Boards and NHS England, as commissioners for NHS patient care services and the commissioners are funded by the government. The GAM prohibits the Trust from making an allowance for impairment on any outstanding receivables that relate to NHS bodies.

## 16. Trade and other receivables (continued)

| <b>16.2 Allowance for credit losses</b> | <b>31 March 2026</b> | 31 March 2025 |
|-----------------------------------------|----------------------|---------------|
|                                         | <b>£000</b>          | £000          |
| <b>Balance at 1 April</b>               | <b>3,717</b>         | 3,345         |
| Utilisation/reversal of allowances      | <b>(454)</b>         | (884)         |
| Increase in allowance                   | <b>1,479</b>         | 1,256         |
| <b>Balance at 31 March</b>              | <b>4,742</b>         | <b>3,717</b>  |

The allowance relates to outstanding Compensation Recovery Unit debts concerning Road Traffic Accidents (24.62% allowance created on all outstanding debt), and allowances on non-NHS debtors (providing between 10 and 100% dependant on the type of debt) that includes allowances for individual invoices in dispute and in formal recovery . The Group does not hold any collateral in support of these debts.

## 17. Trade and other payables

|                                                     | <b>GROUP</b>         |               | <b>TRUST</b>         |               |
|-----------------------------------------------------|----------------------|---------------|----------------------|---------------|
|                                                     | <b>31 March 2026</b> | 31 March 2025 | <b>31 March 2026</b> | 31 March 2025 |
|                                                     | <b>£000</b>          | £000          | <b>£000</b>          | £000          |
| <b>Current</b>                                      |                      |               |                      |               |
| NHS payables and accruals                           | <b>29,213</b>        | 23,256        | <b>29,213</b>        | 23,256        |
| Amounts due to other related parties                | <b>1,209</b>         | 4,125         | <b>1,209</b>         | 4,125         |
| Other trade payables and accruals - revenue         | <b>83,862</b>        | 73,862        | <b>80,543</b>        | 70,900        |
| Other trade payables - capital                      | <b>33,983</b>        | 24,180        | <b>33,983</b>        | 24,180        |
| Taxes payable (VAT, Income Tax and Social Security) | <b>13,664</b>        | 11,278        | <b>13,957</b>        | 11,449        |
| Annual Leave accrual                                | <b>9,879</b>         | 7,152         | <b>9,878</b>         | 7,151         |
| Receipts in advance                                 | <b>12,082</b>        | 14,862        | <b>12,082</b>        | 14,862        |
| Other payables                                      | <b>10,378</b>        | 8,737         | <b>10,378</b>        | 8,735         |
| <b>Total current trade and other payables</b>       | <b>194,270</b>       | 167,452       | <b>191,243</b>       | 164,658       |

Other payables includes £7.393 million for outstanding pensions contributions (31 March 2025, £7.181 million).

# 18. Borrowings

| Group and Trust                      | 31 March 2026<br>£000 | 31 March 2025<br>£000 |
|--------------------------------------|-----------------------|-----------------------|
| <b>Current</b>                       |                       |                       |
| Obligations under:                   |                       |                       |
| Lease liabilities                    | 7,180                 | 6,938                 |
| Private finance initiative contracts | 16,444                | 13,898                |
| <b>Total current borrowings</b>      | <b>23,624</b>         | <b>20,836</b>         |
| <b>Non-current</b>                   |                       |                       |
| Obligations under:                   |                       |                       |
| Lease liabilities                    | 98,910                | 104,477               |
| Private finance initiative contracts | 150,695               | 159,937               |
| <b>Total non-current borrowings</b>  | <b>249,605</b>        | <b>264,414</b>        |

# 19. Lease Liabilities

Significant contractual arrangements involving assets have been reviewed to assess compliance with IFRS16. There are a number of arrangements that comply with the standard and the term of these arrangements range from 3 to 20 years in line with the economic use and lives of the assets. The arrangements including the value held in Right of Use assets at 31 March 2026 mainly are used to support the provision of patient care and consist of:

- NHS Property buildings consisting of acute and community hospitals, health centres, clinics and surgeries with a value of £14.321 million;
- Sale and leaseback of the residences and Strive on the James Cook site and other administrative buildings, with a value held of £10.742 million; and
- Medical equipment and vehicles, specifically for Pathology, microbiology etc and including robotic navigation systems and Mako SmartRobotics. Value held at 31 March 2026, £8.796 million.

The minimum lease payments outstanding on the lease agreements amount to £115.571 million (2024/25 £122.081 million) and the Present Value of minimum lease payments included on the Group and Trust's Statement of Financial Position amounts to £106.090 million (2024/25 £111.415 million) at 31 March 2026. The variance of £9.481 million (2024/25 £10.666 million) at 31 March 2026 relates to future finance charges on the agreements. The values disclosed do not include any liabilities relating to the private finance initiative.

## Minimum lease liability payments

| Group and Trust                                    | 31 March 2026<br>£000 | 31 March 2025<br>£000 |
|----------------------------------------------------|-----------------------|-----------------------|
| Not later than one year                            | 8,534                 | 8,355                 |
| Later than one year, not later than five years     | 33,236                | 32,666                |
| Later than five years                              | 73,801                | 81,060                |
| Sub total                                          | 115,571               | 122,081               |
| Less: interest element                             | (9,481)               | (10,666)              |
| <b>Total</b>                                       | <b>106,090</b>        | <b>111,415</b>        |
| <b>Net lease liabilities</b>                       |                       |                       |
| Not later than one year;                           | 7,180                 | 6,938                 |
| Later than one year and not later than five years; | 28,992                | 28,097                |
| Later than five years                              | 69,918                | 76,380                |
| <b>Total</b>                                       | <b>106,090</b>        | <b>111,415</b>        |
| <b>Analysis of Net Lease Liabilities:</b>          | <b>£000</b>           | <b>£000</b>           |
| Leased from DHSC bodies                            | 78,118                | 81,661                |
| Leased from non DHSC bodies                        | 27,972                | 29,754                |
| <b>Total</b>                                       | <b>106,090</b>        | <b>111,415</b>        |

Note: the Group and Trust does not offer any leases as a Lessor and does not recover any rental income through such arrangements.

## 20. Private finance Initiative contracts

### 20.1 PFI schemes on Statement of Financial Position

The scheme was for the development of the James Cook University Hospital (JCUH) site resulting in the rationalisation of four existing sites into one. Services at Middlesbrough General Hospital, North Riding Infirmary and West Lane Hospital transferred to JCUH upon completion of the scheme in August 2003.

The scheme comprised 60,000m<sup>2</sup> of new build with 11,000m<sup>2</sup> of refurbishment, with an approximate capital cost of £157 million. Upon completion of the scheme the Trust granted a head lease with associated rights to Endeavour SCH Plc for a period of 30 years. Endeavour maintain the site, providing facilities management services via Serco Group plc, and grant an underlease with associated rights to the Trust for the use of the buildings. The Trust makes a unitary payment, quarterly in advance, to Endeavour SCH Plc for use of the building and associated facilities management services that amounts to approximately £78.621 million per annum excluding VAT. An element of the payment is also set aside to fund lifecycle expenditure amounting to £7.109 million. In return the Trust receives guaranteed income of approximately £0.430 million in respect of mall retail units, laundry and catering income. Responsibility for the collection of car parking income transferred back to the Trust from 1 April 2014.

The annual service fee is indexed linked in line with the 12 month rolling average of retail price indices (CHAW) as at January of each year, for the following contract year. The availability fee is uplifted in line with RPI twice a year based upon the published CHAW indices for March (effective from 1 April) and September (effective from 1 October). The soft services element of the facilities management service is subject to market testing or benchmarking every 5 years, although the Trust has the option to extend this period by a further 12 months. The hard service element of the service is subject to benchmarking every 10 years.

Upon the Contract Period Expiry Date in 2033 the Trust has a number of options ("the Expiry Options"):

- to extend the agreement on terms to be agreed with the concessionaire;
- to re-tender for the provision of services;
- to leave the hospital and terminate the underlease; and
- to remain in the hospital and assume responsibility for the provision of services.

Under the control test of IFRIC 12, the asset has been treated as an asset of the Trust. The substance of the contract is that the Trust has a lease arrangement and payments to the contractor comprise 2 elements; a lease charge and service charges. Total lease obligations for the on-Statement of Financial Position PFI contract due are:

| <b>Group and Trust</b>                             | <b>31 March 2026</b> | <b>31 March 2025</b> |
|----------------------------------------------------|----------------------|----------------------|
|                                                    | <b>£000</b>          | <b>£000</b>          |
| Not later than one year                            | <b>29,532</b>        | 27,566               |
| Later than one year, not later than five years     | <b>121,670</b>       | 116,465              |
| Later than five years                              | <b>74,039</b>        | 99,070               |
| Sub total                                          | <b>225,241</b>       | 243,101              |
| Less: interest element                             | <b>(58,102)</b>      | (69,266)             |
| <b>Total</b>                                       | <b>167,139</b>       | 173,835              |
| <b>Net PFI liabilities</b>                         |                      |                      |
| Not later than one year;                           | <b>16,444</b>        | 13,898               |
| Later than one year and not later than five years; | <b>84,759</b>        | 75,005               |
| Later than five years                              | <b>65,936</b>        | 84,932               |
|                                                    | <b>167,139</b>       | 173,835              |

## 20. Private finance initiative contracts (continued)

### 20.2 Charges to expenditure

The total charged in the year to expenditure in respect of the service element of on-Statement of Financial Position PFI contracts was £40.691 million (2024/25 £38.598 million).

The Trust is committed to the following annual charges:

| <b>Group and Trust</b>                         | <b>31 March 2026</b> | <b>31 March 2025</b> |
|------------------------------------------------|----------------------|----------------------|
|                                                | <b>£000</b>          | <b>£000</b>          |
| Not later than one year                        | <b>40,691</b>        | 38,598               |
| Later than one year, not later than five years | <b>162,764</b>       | 154,392              |
| Later than five years                          | <b>98,337</b>        | 131,877              |
| <b>Total</b>                                   | <b>301,792</b>       | 324,867              |

### 20.3 Total concession arrangement charges

The Trust is committed to the following annual charges in respect of the PFI.

| <b>Group and Trust</b>                         | <b>31 March 2026</b> | <b>31 March 2025</b> |
|------------------------------------------------|----------------------|----------------------|
|                                                | <b>£000</b>          | <b>£000</b>          |
| Not later than one year                        | <b>78,621</b>        | 75,117               |
| Later than one year, not later than five years | <b>314,484</b>       | 300,468              |
| Later than five years                          | <b>190,001</b>       | 256,650              |
| <b>Total</b>                                   | <b>583,106</b>       | 632,235              |

### 20.4 Total unitary payment charge on PFI scheme

The unitary payment paid in year to the service concession operator is made up as follows:

| <b>Group and Trust</b>                   | <b>31 March 2026</b> | <b>31 March 2025</b> |
|------------------------------------------|----------------------|----------------------|
|                                          | <b>£000</b>          | <b>£000</b>          |
| Interest charge                          | <b>14,090</b>        | 14,389               |
| Repayment of balance sheet obligation    | <b>14,335</b>        | 8,838                |
| Service element                          | <b>40,691</b>        | 38,598               |
| Capital lifecycle maintenance            | <b>7,945</b>         | 7,318                |
| Addition to capital lifecycle prepayment | <b>0</b>             | 4,466                |
| <b>Total</b>                             | <b>77,061</b>        | 73,609               |

## 21. Reconciliation of Liabilities arising from financing activities

The total outstanding liability from financing is detailed below:

| <b>Group and Trust</b>                          | <b>Lease Liabilities</b> | <b>PFI</b>     | <b>Total 2025/26</b> | <b>Total 2024/25</b> |
|-------------------------------------------------|--------------------------|----------------|----------------------|----------------------|
|                                                 | <b>£000</b>              | <b>£000</b>    | <b>£000</b>          | <b>£000</b>          |
| <b>Carrying value at 1 April 2025</b>           | <b>111,415</b>           | <b>173,835</b> | <b>285,250</b>       | 278,728              |
| <b>Cash movements:</b>                          |                          |                |                      |                      |
| Financing cash flows - principal                | (7,011)                  | (14,335)       | (21,346)             | (15,609)             |
| Financing cash flows - interest                 | (1,437)                  | (14,090)       | (15,527)             | (15,848)             |
| <b>Non-cash movements:</b>                      |                          |                |                      |                      |
| Remeasurement of Liability from change in index | 954                      | 7,639          | 8,593                | 17,501               |
| Additions in year                               | 732                      | 0              | 732                  | 4,630                |
| Interest charge arising in year                 | 1,437                    | 14,090         | 15,527               | 15,848               |
| <b>Carrying value at 31 March 2026</b>          | <b>106,090</b>           | <b>167,139</b> | <b>273,229</b>       | 285,250              |

## 22. Provisions

| Group and Trust                  | Current       |               | Non-current   |               |
|----------------------------------|---------------|---------------|---------------|---------------|
|                                  | 31 March 2026 | 31 March 2025 | 31 March 2026 | 31 March 2025 |
|                                  | £000          | £000          | £000          | £000          |
| Pensions relating to staff       | 94            | 106           | 101           | 60            |
| Legal claims                     | 1,038         | 878           | 80            | 87            |
| Restructuring                    | 194           | 194           | 0             | 0             |
| Clinicians Pension Reimbursement | 31            | 42            | 1,123         | 1,231         |
| <b>Total</b>                     | <b>1,357</b>  | <b>1,220</b>  | <b>1,304</b>  | <b>1,378</b>  |

| Group and Trust          | Pensions relating to staff | Legal claims | Restructuring | Clinicians pension reimbursement | Total        |
|--------------------------|----------------------------|--------------|---------------|----------------------------------|--------------|
|                          | £000                       | £000         | £000          | £000                             | £000         |
| At 1 April 2025          | 166                        | 965          | 194           | 1,273                            | 2,598        |
| Arising during the year  | 139                        | 201          | 0             | 0                                | 340          |
| Changes in discount rate | (2)                        | (1)          | 0             | (88)                             | (91)         |
| Utilised during the year | (94)                       | (47)         | 0             | (31)                             | (172)        |
| Reversed unused          | (14)                       | 0            | 0             | (74)                             | (88)         |
| Unwinding of discount    | 0                          | 0            | 0             | 74                               | 74           |
| <b>At 31 March 2026</b>  | <b>195</b>                 | <b>1,118</b> | <b>194</b>    | <b>1,154</b>                     | <b>2,661</b> |

### Expected timing of cash flows:

|                               |            |              |            |              |              |
|-------------------------------|------------|--------------|------------|--------------|--------------|
| - not later than one year;    | 94         | 1,038        | 194        | 31           | 1,357        |
| - later than one year and not | 101        | 53           | 0          | 205          | 359          |
| - later than five years.      | 0          | 27           | 0          | 918          | 945          |
| <b>Total</b>                  | <b>195</b> | <b>1,118</b> | <b>194</b> | <b>1,154</b> | <b>2,661</b> |

### Pensions relating to staff

The amounts relate to sums payable to former employees who have retired prematurely. The outstanding liability is based on actuarial guidance from the NHS Pension Agency using computed life expectancies for the pension recipients. Variations in life expectancy will impact on these figures and the timings of payments. There is no contingent liability associated with this provision.

### Legal claims

The timings and amounts within the provision are based upon the NHS Litigation Authority's assessment of probabilities in line with IAS 37 guidance. The provision relates to employer and public liability claims with the Group and Trust raised by staff and patients. This provision also includes injury benefit claims made by NHS employees with the level of awards determined by the NHS Pension Agency. The discounted provision is based on notifications received from the agency.

£210.634 million is included in the provisions of NHS Resolution at 31 March 2026, in respect of clinical negligence liabilities of the Group and Trust (2024/25, £188.196 million). This is not provided for within these financial statements.

### Restructuring

The amount relates to the creation of a provision for the obligations arising from internal and group restructuring which will be undertaken in 2026/27.

### Clinicians pension tax reimbursement

The provision is held for lump sums due to clinicians on retirement where 'scheme pays' is expected to be used to settle the additional tax liability due under the 2019/20 scheme.

## 23. Financial instruments

### 23.1 Financial assets

|                                                                       | GROUP          |                | TRUST          |                |
|-----------------------------------------------------------------------|----------------|----------------|----------------|----------------|
|                                                                       | 31 March 2026  | 31 March 2025  | 31 March 2026  | 31 March 2025  |
|                                                                       | £000           | £000           | £000           | £000           |
| <b>Financial Assets held at amortised cost</b>                        |                |                |                |                |
| Receivables excluding non financial assets with DHSC and other bodies | 43,193         | 51,507         | 43,203         | 51,758         |
| Cash and cash equivalents at bank and in hand                         | 87,496         | 53,790         | 85,858         | 51,994         |
| <b>Assets at fair value through profit and loss</b>                   |                |                |                |                |
| Investments                                                           | 5,628          | 6,192          | 0              | 0              |
| <b>Total</b>                                                          | <b>136,317</b> | <b>111,489</b> | <b>129,061</b> | <b>103,752</b> |

### 23.2 Financial liabilities

|                                                                                         | GROUP            |                  | TRUST            |                  |
|-----------------------------------------------------------------------------------------|------------------|------------------|------------------|------------------|
|                                                                                         | 31 March 2026    | 31 March 2025    | 31 March 2026    | 31 March 2025    |
|                                                                                         | £000             | £000             | £000             | £000             |
| <b>Financial Liabilities held at amortised cost</b>                                     |                  |                  |                  |                  |
| Obligations under leases                                                                | (106,090)        | (111,415)        | (106,090)        | (111,415)        |
| Obligations under PFI contracts                                                         | (167,139)        | (173,835)        | (167,139)        | (173,835)        |
| Trade and other payables excluding non financial liabilities with DHSC and other bodies | (151,053)        | (130,857)        | (148,134)        | (127,968)        |
| <b>Total</b>                                                                            | <b>(424,282)</b> | <b>(416,107)</b> | <b>(421,363)</b> | <b>(413,218)</b> |

### 23.3 Maturity of financial liabilities

|                                                    | GROUP            |                  | TRUST            |                  |
|----------------------------------------------------|------------------|------------------|------------------|------------------|
|                                                    | 31 March 2026    | 31 March 2025    | 31 March 2026    | 31 March 2025    |
|                                                    | £000             | £000             | £000             | £000             |
| In one year or less                                | (189,119)        | (166,778)        | (186,200)        | (163,889)        |
| In more than one year but not more than five years | (154,906)        | (149,131)        | (154,906)        | (149,131)        |
| In more than five years                            | (147,840)        | (180,130)        | (147,840)        | (180,130)        |
| <b>Total</b>                                       | <b>(491,865)</b> | <b>(496,039)</b> | <b>(488,946)</b> | <b>(493,150)</b> |

This maturity analysis for financial liabilities is a requirement of IFRS7 and provides an analysis of undiscounted future contractual cash flows i.e. gross liabilities including finance charges.

### 23.4 Fair values of financial instruments held at amortised cost

The fair values of financial instruments are considered to be materially similar to the book values.

### 23.5 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the NHS Foundation Trust has with Integrated Care Boards and NHS England and the way that these are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. 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 Group has limited powers to invest surplus funds and requires support to deliver the capital programme in the form of Public Dividend Capital (PDC) from the Department of Health and Social Care. Financial assets and liabilities are only generated by the day-to-day operational activities of the Group in undertaking its operations.

The Group's treasury management operations are carried out by the finance department, within parameters defined formally within the Group's Treasury Management Policy and Standing Financial Instructions agreed by the Board. A key theme of the Group's strategic direction is business stability which means achieving target levels of financial performance. To support this target, the key objectives of the Treasury Management Policy includes the achievement of a competitive return on surplus cash balances and effectively identifying and managing financial risk.

## **23. Financial instruments (continued)**

### **23.5 Financial risk management (continued)**

#### **Currency risk**

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

#### **Interest rate risk**

The Group and Trust receives support from the government for capital expenditure in the form of Public Dividend Capital. The Trust does not have any borrowing on the Balance Sheet and it is the Trust's expectation that it will not need to borrow to finance forthcoming capital spend. The Group and Trust therefore has low exposure to interest rate fluctuations.

The Trust is exposed to interest rate risk on the PFI scheme due to the linkage of the availability payment to RPI which impacts on PFI lifecycle and non-operating expenditure.

#### **Credit risk**

The majority of the Group's income comes from contracts with other public sector bodies, the Group has low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from customers, as disclosed in Note 16.

The financial instruments utilised by the Group and Trust are deemed to be minimum risk. The Group's investments are held within the Charity with investment management undertaken by CCLA utilising a COIF Charities Ethical Investment Fund.

#### **Liquidity risk**

The Group's operating costs are incurred under contracts with Integrated Care Boards and NHS England, which are financed from resources voted annually by Parliament. The Group and Trust funds its capital expenditure from funds allocated by the Department of Health and Social Care and does not have any flexibility to vary principal or interest payments on any of its fixed term liabilities, including those relating to the PFI contract. Further information on risk within the Group and Trust's annual plans is included within the disclosures within the Annual Report.

## **24. Events after the reporting year**

There have been no significant events since the end of the reporting period. The audited accounts for the Trust were authorised for issue on xx June 2026.

## **25. Related party information**

### **25.1 Related party transactions**

South Tees Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. The Trust completes national returns in accordance with the requirements of IAS 24 "Related Party Disclosures". The Department of Health and Social Care is the parent organisation.

### **25.2 Whole of Government Accounts bodies**

All government bodies which fall within the Whole of Government accounts boundary are regarded as related parties because they are all under the common control of HM Government and Parliament. This includes for example, all NHS bodies, all local authorities and central government bodies. The Trust's major related parties include:

- NHS North East and North Cumbria ICB;
- NHS Humber and North Yorkshire ICB;
- NHS Property Services;
- NHS Resolution;
- Department of Health and Social Care;
- NHS England;
- County Durham and Darlington NHS Foundation Trust;
- North Tees and Hartlepool NHS Foundation Trust;
- Northumbria Healthcare NHS Foundation Trust;
- The Newcastle Upon Tyne Hospitals NHS Foundation Trust;
- Tees, Esk and Wear Valleys NHS Foundation Trust;
- Middlesbrough Borough Council;
- North Yorkshire County Council;
- HM Revenue and Customs;
- Ministry of Defence;
- NHS Pension Scheme;
- NHS Blood and Transplant; and
- NHS Professionals.

### **25.3 Charitable funds**

The Trust receives revenue and capital payments from a number of charitable funds, including South Tees Hospitals Charity and Associated Funds. The Trust Board members are also corporate trustees of the charity. The accounts of South Tees Hospitals Charity and Associated Funds are consolidated into the Trust's Annual Accounts as detailed in Accounting Policies 1.2 and Note 12 to the Accounts.

### **25.4 Board Members and Directors**

During the year no Group Board Members or members of the key management staff, or parties related to any of them, have undertaken any material transactions with South Tees Hospitals NHS Foundation Trust (2024/25, £nil)

Declarations of interests, completed on an annual basis by Executive and Non-Executive Directors, have been reviewed to identify any related party relationships requiring disclosure within this note.

IAS 24 specifically requires the separate disclosure of compensation payments made to management. In line with the standard, the HM Treasury has given dispensation that this requirement will be satisfied through disclosure in the Remuneration Report included in the Group and Trust's Annual Report.

26. Losses and special payments

The total number and value of losses and special payments in year amounted to the following:

| Group and Trust                                                          | 2025/26         |                           | 2024/25         |                           |
|--------------------------------------------------------------------------|-----------------|---------------------------|-----------------|---------------------------|
|                                                                          | Number of cases | Total value of cases £000 | Number of cases | Total value of cases £000 |
| <b>Losses:</b>                                                           |                 |                           |                 |                           |
| Losses of cash                                                           | 6               | 1                         | 9               | 2                         |
| Damage to buildings, property as a result of theft, criminal damage etc. | 43              | 16                        | 114             | 41                        |
| <b>Special payments:</b>                                                 |                 |                           |                 |                           |
| Ex gratia payments                                                       | 53              | 159                       | 84              | 133                       |
| <b>Total</b>                                                             | <b>102</b>      | <b>176</b>                | <b>207</b>      | <b>176</b>                |

The amounts included above are reported on an accruals basis and exclude provisions for future losses.

There were no special severance payments (2024/25, there were no cases over £100,000 and there were no severance payments requiring HMT approval) arising from divisional restructuring or other cases of clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment exceeded £300,000.