NHS
University Hospitals of North Midlands
NHS Trust

Annual Report & Accounts

2024 / 2025

Kind
Excellent
Together

Contents

1 Overview of the Trust

Chair and Chief Executive's Introduction

Welcome to the Annual Report for 2024 / 25. This report provides a comprehensive overview of our performance over the past year, highlighting our achievements, challenges and the strategic direction we are taking to ensure the best possible outcomes for our patients.

As an organisation, we have continued to grow and evolve, serving a diverse population with a wide range of healthcare needs. We have made significant strides in improving patient outcomes, enhancing our facilities, and fostering a culture of excellence and innovation. Our partnerships with local and national organisations have been instrumental in driving forward our mission to provide high quality, integrated care.

Reflecting on the past year, we are proud of the progress we have made but are also acutely aware of where we fall short. The healthcare landscape is constantly changing, and we must remain agile and responsive to the needs of our patients and our population. Our commitment to sustainability, equality, and continuous improvement will guide us as we navigate these challenges.

One of the many key highlights of this year has been the improvements in our Care Quality Commission (CQC) inspection ratings for County Hospital and Maternity Services, as well as improvements made in our Emergency Department. Our thanks go to all involved in these achievements, as our staff remain at the heart of everything we do. Their dedication, expertise and compassion are the driving forces behind our success. We have continued to invest in their development and wellbeing, ensuring that they have the support and resources they need to thrive. Their resilience and dedication, especially in the face of significant challenges have been truly inspiring.

Our partnerships have been crucial in achieving our goals. We play a key role within the Staffordshire and Stoke-on-Trent Integrated Care System (ICS), working closely with health, social care and voluntary sector partners to deliver joined up care for our population. Our collaborations extend beyond the local system, including long standing relationships with Keele University and the University of Staffordshire, which help us with our research, innovation and teaching ambitions. We are proud of the successful relationships forged with our PFI partners and have succeeded in delivering many joint initiatives which continue to support our strategic and operational agenda.

We are proud to employ around 12, 500 members of staff, representing over 70 nationalities, who work tirelessly to provide exceptional care. Our staff engagement score continues to improve and whilst we recognise that we have more to do, this reflects our ongoing efforts to create a supportive and inclusive work environment and a healthy culture.

We have also made positive strides with our work on sustainability and reducing our environmental impact. Behind the scenes, we have made substantial investments in green technologies and initiatives that not only benefit our patients but also contribute to the broader goal of a healthier planet.

Our performance over the past year reflects our unwavering commitment to excellence. We have successfully implemented new technologies and processes that have enhanced patient care and operational efficiency. Our focus on quality improvement has led to better patient outcomes and higher satisfaction rates.

Looking ahead, we are excited about the future and the opportunities it holds. Our strategic priorities for the coming years are clear; to provide the best joined-up care for *all*, to innovate and to lead in healthcare and to continue to work collaboratively with our partners to improve health outcomes for our population.

Thank you for your continued support and trust in our services. Together we will continue to make a positive difference to the lives of our people, our patients and our population.

David Wakefield
Chair

Simon Constable
Chief Executive

Performance Overview of 2024 / 25

The year has been marked by significant achievements, recognitions, and challenges for us. From successful inspections and visits to innovative projects and awards, our commitment to improving patient care and service users, supporting staff and addressing operational challenges has been demonstrated.

Quality

We have made good progress against our quality priorities during the year. We welcomed our regulator, the Care Quality Commission (CQC) into our Emergency Department as part of an unannounced visit and were able to highlight the positive culture and commitment to supporting our people and our patients. The inspection team reported a positive visit and found the team to be welcoming and engaged.

The CQC also conducted thorough inspections at County Hospital and our Maternity Unit. These inspections were pivotal in assessing the quality of care provided. Following this, County Hospital's rating saw a significant improvement, with medical care at County Hospital improving from Inadequate to Good, and the County site improving overall from Requires Improvement to Good - a testament to the hard work and dedication of our people. The Maternity Unit also met the conditions of the previously issued Section 29 Notice, and improved its rating from Requires Improvement to Good, indicating substantial progress in addressing previous concerns with significant improvements with metrics around induction of labour and triage.

Professor Nina Morgan, Regional Chief Nurse praised our Maternity Unit for their outstanding services and positivity. This recognition was a significant boost for the team who have worked tirelessly on various improvement initiatives. We were delighted to have achieved all ten safety actions for the fifth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, leading to the return of our contribution into the incentive fund. This accomplishment was a testament to the hard work of our maternity and neonatal services and was supported by the Local Maternity and Neonatal System. The West Midlands Clinical Senate also conducted a visit to our maternity services during the year, and praised the valuable information shared by the team and the passion they showed in caring for women and babies.

We were pleased to have achieved above the national average across all domains of the 2024 Patient Led Assessment of the Environment (PLACE), with County Hospital scoring 100% for ward food and for cleaning for the second year running. These scores recognise that good environments and services that respond to the needs of our patients really do matter.

We have continued to monitor patient safety incidents on a weekly basis, particularly within our Emergency Department, where an increase in hospital-acquired pressure damage was noted due to delays. This proactive approach to incident reporting and management ensures that we become aware of any concerns as quickly as possible in order that prompt action can be taken. Infection, Prevention and Control has remained a key focus, with improvements being seen in rates of C Difficile and MRSA. We were also pleased to have met the required UK Health Security Agency (UKHSA) for C Difficile and e-coli.

Falls with harm were reduced, with focussed work on those falling multiple times, although we were disappointed to have seen an increase in in-hospital acquired pressure damage over winter having seen reductions throughout the year; this was again attributed to the long waits within our Emergency Department. We have, and will, continue to monitor this closely and target improvement intervention and mitigation to minimise the risk to our patients.

We successfully digitised nursing and clinical documentation in the Emergency Department, in line with our digital priorities, improving patient care efficiency, reducing printing costs and ensuring legible and auditable documentation of care. We have also maintained minimal nursing and midwifery vacancies, continued our focus on retention and were delighted to be recognised for this in winning Nursing Time Employer of the Year for Nurses.

Our refreshed priorities for quality over the next 10 years along with a refinement of our quality assurance processes and patient involvement will refocus our combined efforts to ensure that we provide timely, innovative and effective services to our patients.

People

Our people priorities have also seen significant progress and we have enjoyed a year of celebrating the achievements of our incredible workforce. We aim to create a positive work environment, ensuring that our staff feel supported and valued. We have recognised the many contributions made and were particularly pleased to see professorships being awarded by Keele University, which aligns with our priorities for research and innovation.

Engagement remained a priority, with the 2024 Staff Survey response rate at 45%, consistent with the previous year. Although we have seen some slight reduction in the engagement score from our local surveys, we have adjusted the frequency to allow time for actions to be completed sufficiently. We have reviewed our wellbeing offer, ensuring that our staff have access to psychological and financial support through numerous initiatives.

We have introduced a range of strategies to stabilise our workforce, including professional support and development. Safe staffing levels are key to ensuring patient safety and a positive experience. We saw remarkable improvements in recruitment and retention, most notably within our nursing workforce where we reached a stable position with no vacancies and a significant reduction in midwifery turnover – some of the best performance seen regionally and nationally.

Training compliance improved significantly, although some of our leadership development programmes had to be stood down during periods of critical incident, allowing us to focus on keeping our patients safe. We are very proud of the development opportunities we have on offer and have delivered a broad range of programmes which go beyond our statutory and mandatory training.

We have seen an increase in the number of concerns raised through our Freedom to Speak Up Guardian, although we attribute this to an improved speaking up culture. Investment was made into the Freedom to Speak Up team, ensuring that staff feel safe and supported in raising concerns. We have also held a range of promotional campaigns including during National Speak Up Month in October 2024, to highlight the importance of speaking up.

Our annual Night Full of Stars was a particular highlight, where 200 staff and volunteers came together to celebrate excellence. It was an uplifting evening of inspiration, admiration and positivity, with 11 awards being handed out during the ceremony. During the year we were also able to distribute George Cross badges to colleagues in recognition of their hard work during the pandemic.

We were selected as an exemplar organisation for Nursing and Midwifery Excellence, showcasing our accreditation arrangements, meaningful recognition, quality improvement, distributed leadership and research.

During Ramadan, we shared helpful information to colleagues to aid better knowledge and understanding and organised a very successful Iftar event, highlighting our commitment to supporting our Muslim colleagues, in line with our priorities for equality, diversity and inclusion.

Junior Doctors Industrial Action meant that we had to undertake additional planning, and we are incredibly grateful to our colleagues for working flexibly to cover rota gaps and maintain services for our patients.

As Stoke-on-Trent has the highest number of children in local authority care than any other city in the UK, it was great that our ICB colleagues were able to secure national funding to support a pilot project to help support young people into entry-level roles in healthcare. The project, led by our Estates, Facilities and PFI team saw 26 young people being offered substantive positions within our Soft Facilities Management services across both sites. In addition, our Project Search programme has continued to be a success, supporting young people with disabilities into employment and we are committed to working with our partners at Newfriars College and Sodexo on this programme.

Access and Responsiveness

Our Urgent and Emergency Care pathway has experienced significant pressures, with high numbers of flu, Covid, respiratory virus and norovirus cases all impacting on our ability to see and treat our patients in a timely manner. We have undertaken a range of measures to strengthen our internal processes and reduce ambulance handover delays, as we recognise the risk to patients within our community when ambulances cannot get to them quickly enough.

In line with our winter plan, we opened cohort wards and bays for flu patients, so that we could maintain patient flow and reduce delays as far as possible. We have also had to use on occasions corridor care and additional spaces on our wards to mitigate the risk as best we could – whilst we acknowledge that this does not provide the best experience for our patients.

We have worked very closely with our system partners to alleviate the pressures and have invited external experts to provide advice and guidance on further actions we should take as we move into the coming year, with a key focus being around simplification and improving discharge practices.

Despite urgent care pressures, we have continued to protect elective and cancer trajectories, with oversight from NHS England through their tiering regime. We have received additional capacity and support from partner organisations, including the Robert Jones and Agnus Hunt for orthopaedics, to ensure that our patients receive timely care.

We were recognised by NHS England for our efforts in reducing the number of patients waiting over 78 weeks. We also made significant progress in reducing the 62-day urgent suspected cancer backlog, improving Faster Diagnosis Standard (FDS) performance by 12%. This progress was recognised nationally as some of the most positive seen.

Timely delivery of non-obstetric ultrasound has also been difficult for us, and we have taken numerous steps to address the backlog and improve access, as well as opening a dedicated unit to address the significant backlog for endoscopy following some significant investment.

We have embraced digital technology and the capabilities of Artificial Intelligence, including a hybrid model for validation of our waiting list.

Our Laboratory Information Management System (LIMS) underwent a major changeover to a new IT system, and we implemented a new digital ReSPECT process, creating recommendations for a person's clinical care and treatment in future emergencies.

Our outdated IT systems have created a number of challenges for us during the year and whilst we successfully migrated our network and telephony support over to our internal team to create more control over changes and developments, it remains a key risk for us. However, we have been working on the development of a comprehensive business case to implement a new Electronic Patient Record. We have identified this as a key priority and are hopeful to secure national support so that we can implement this as soon as possible.

As we move forward, our Urgent and Emergency Care Recovery Programme will be a key focus for us, aligned with our refreshed strategy in key programme 'Brilliant Basics'.

Developing our Hospitals

We have delivered several large-scale projects during the year to develop our hospitals and create better facilities for our people and our patients. Our new Multistorey Car Park on the Royal Stoke Site, was a particular highlight. This development was funded as part of our Strategic Transformation and Regeneration (STAR) project, which uses the reinvestment of capital from the disposal of surplus land including the old Royal Infirmary and Central Outpatients sites.

Other highlights included:

- **Acute Medical Rapid Assessment Unit:** a £14.2m modular building next to our Royal Stoke Emergency Department to accommodate the Surgical Assessment Unit and Surgical Ambulatory Care Unit, releasing space within the main building and providing increased flow due to the adjacency to our Emergency Department.
- **County Day Case Unit:** £8.15m refurbishment and remodelling of several wards at County Hospital to provide a dedicated Day Case Unit. This scheme is a key enabler to our elective hub programme and provides dedicated space for our day case patients.
- **County Breast Care Unit:** this £13.6m new build has created a dedicated unit ensuring patient dignity, privacy and capacity for future growth in a fit-for-purpose space and again enabling the elective hub programme.
- **Car Parking Barriers:** £831k supply and installation of additional cameras, barrier systems, traffic control measures and touch screen terminals across the Royal Stoke Site, releasing existing site staff to focus on visitor support and overall enhancing patient experience.
- **Stoke-on-Trent Diagnostics Centre:** £28m major conversion and refurbishment of an unused building in Hanley City Centre to create a diagnostic centre, offering diagnostic imaging, physiological measurement, pathology and endoscopy facilities.

We also continued to support a total of 21 home conversions to allow patients with kidney disease to perform dialysis treatment in the comfort of their own home rather than attending frequent hospital visits – providing greater flexibility and improving their overall experience.

Thanks to our UHNM Charity and the Denise Coates Foundation, we were also pleased to see £2.87m invested in schemes to create better environments for our patients including artwork on our ‘County Hospital Street’, a new digital ceiling in the County Day Case Unit to mimic the view of the sky, an extension to the Cancer Centre entrance to offer holistic and therapeutic services and a wall mural within the entrance to enhance wayfinding and first impressions of our Children’s Emergency Department at Royal Stoke.

About us

We are one of the largest teaching trusts in the country, primarily serving patients in Staffordshire and Stoke-on-Trent and acting as a tertiary centre to many more. We are proud to have a growing international reputation for the innovative treatments we provide and pioneer through our research, education and partnerships.

Providing care in modern facilities, we offer a full range of general hospital and specialised services for approximately 3 million people. We employ around 12,500 members of staff and we have around 1,450 inpatient beds across our two sites.

We are one of the largest hospitals in the West Midlands and have one of the busiest emergency departments in the country, with an average of around 14,000 patients attending each month across both of our sites. Many emergency patients are brought to us from a wide area both by helicopter and ambulance because of our Major Trauma Centre status as we are the specialist centre for the North Midlands and Noth Wales.

Our specialised services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care, paediatric intensive care, trauma, respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery and laparoscopic surgery.

Our Partnerships

We play a key role within the Staffordshire and Stoke-on-Trent Integrated Care System (ICS), which has partnership working at its very core. We work closely with health, social care and voluntary sector partners across Staffordshire and Stoke-on-Trent to deliver joined-up and integrated care for our population. We also collaborate with many partners beyond the Staffordshire and Stoke-on-Trent system through a range of well-established relationships that span over a decade or more.

We partner with Keele University and the University of Staffordshire to deliver world leading scientific research and pioneering teaching and technologies, providing our clinicians and our leaders with the skills and experiences they need to work in our increasingly complex health and social care environment.

We work with many partners beyond Staffordshire and Stoke-on-Trent through a range of well-established partnerships that span several decades, this includes our Private Finance Initiative (PFI) partners, where exemplar relationships are in place, recognised by our participation in the Government's Cabinet Office Supplier Relationship Management Programme (SSRM).

We play a leadership role, hosting and contributing to multiple regional and national clinical networks to deliver and improve specialist clinical services.

Key headlines in 2024 / 25

Served a population of 3 million across North Staffordshire

Delivered 5,946 babies in hospital and in the community

Employed around 12,500 staff, comprising 70 nationalities

Delivered **916,757 individual new and follow up** outpatient appointments

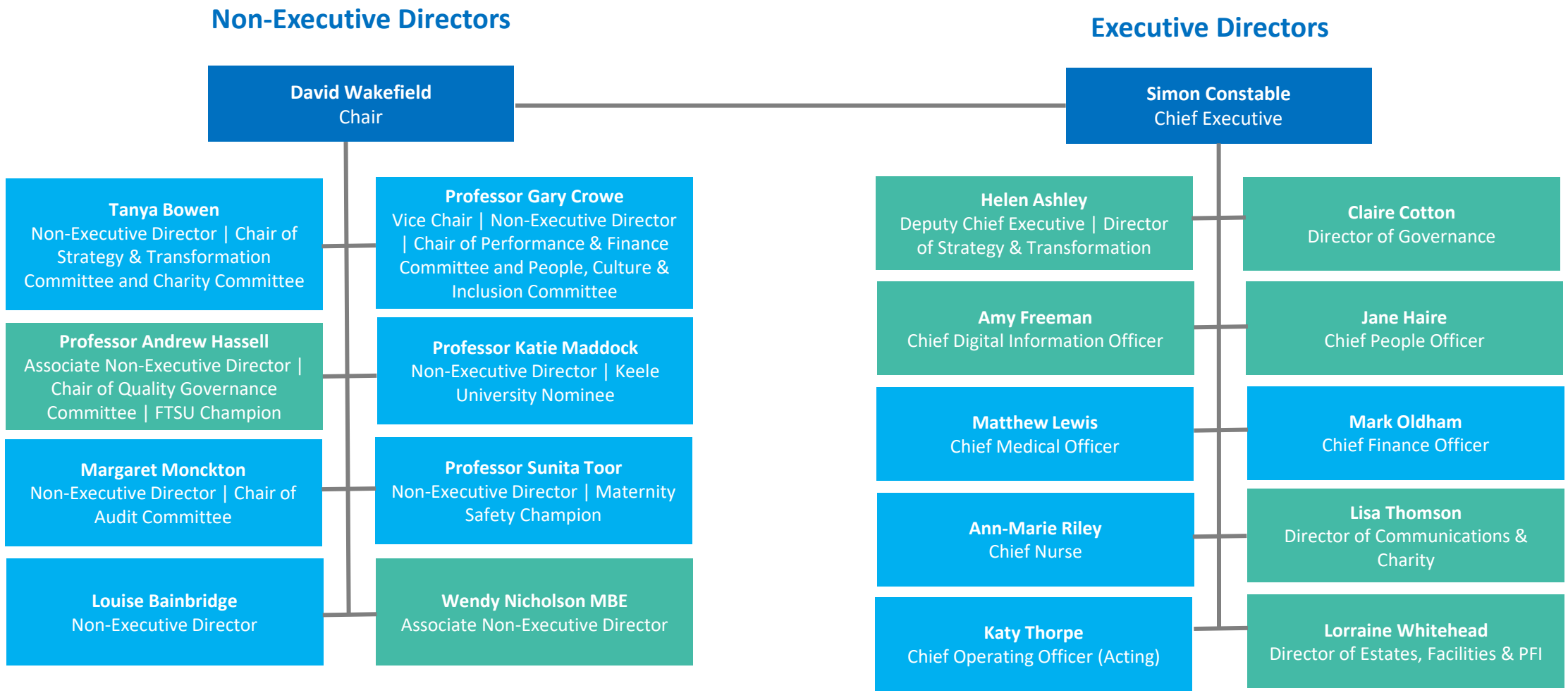
Had **annual running costs** of **£1.272 billion**

Operated **1,400 beds** across both sites

Delivered **137,146 elective, day case and non-elective** procedures

168,936 patients attended through our **Emergency Departments**

How we are organised – the Trust Board



Denotes non-voting members

How we provide care

Our organisational structure is made up of two non-clinical divisions and four clinical divisions. Each clinical division is led by a Divisional Medical Director, along with a Divisional Operations Director and a Divisional Nurse Director. The non-clinical divisions are led by an Executive Director. We also host the North Midlands and Cheshire Pathology Service, which is a networked service.

Clinical Divisions

Medicine & Urgent Care

Acute Medicine
Diabetes & Endocrinology
Elderly Care
Emergency Medicine
Endoscopy
Gastroenterology
General Medicine
Infectious Diseases
Respiratory
Renal
Therapies

Network Services

Haematology
Heart Centre
Neurosciences
Neurosurgery
Oncology
Therapies
Trauma & Orthopaedics

Surgery, Theatres & Critical Care

Anaesthetics
Critical Care
Emergency Surgery
General Surgery
Pain Management
Specialised Surgery
Sterile Services
Theatres
Urology

Women, Children & Clinical Support Services

Child Health
Imaging
Neonatal
Obstetrics & Gynaecology
Outpatients
Pharmacy

Non-clinical Divisions

Central Functions

Communications
Corporate Governance
Digital Services
Finance
Medical Education
Medical Examiners & Bereavement
Nursing & Improvement
Operations
People
Performance & Information
Quality, Safety & Compliance
Research & Innovation
Strategy & Planning
Supplies & Procurement
Transformation

Estates, Facilities & PFI

Capital Developments
Clinical Technology
Estates Governance, Compliance & Administration
Estate Operations
Facilities Management
Land & Property
PFI Contract Management
Sustainability & Transformation

Our Strategy 2025 - 2035: The best joined-up care for *all*

University Hospitals of North Midlands NHS Trust

Our Priorities

Our People

We will create an **inclusive** workforce where **everyone** learns, thrives, and makes a positive difference

Key Metric:
Staff Engagement Score

Our Patients

We will provide **timely, innovative** and effective services to our **patients**

Key Metric:
Combined Hospital Score

Our Population

We will provide **tackle inequality,** and improve the health of our population

Key Metric:
Number of Years in Good Health

Our Programmes

Brilliant Basics: Standards & Performance

Addressing the immediate concerns facing our patients

Digitally Enabled Care Transformation

Standardising and redesigning pathways – enabled by a new EPR

Our Future Hospital Services

Designing services so they reflect the latest developments in medical knowledge and provide care closer to home

Collaborations & Networks

Working with others to ensure sustainable and joined-up care

Our Strategic Plans

Quality, Access & Performance | People | Population Health | Digital | Research | Innovation | Estates & Facilities

Our Values

Our future

During 2024 / 25 we refreshed our organisational strategy for the years 2025 – 2035, with the vision of providing 'the best joined-up care for *all*'. Our Strategy is built on 3 core values; Kind, Together and Excellent. We aim to be a leader in health by harnessing innovation, investing in people and improving community health and wellbeing.

Our Strategic Framework includes three key priorities for our people, our patients and our population:

- **Creating a great place to work for everyone**, fostering an inclusive workplace where everyone feels valued and supported. This includes improving work environments, offering exceptional learning and development opportunities and ensuring flexibility and adaptability.
- **Providing timely, innovative and effective services to our patients,** as we aim to excel in delivering excellent patient outcomes by transforming services to deliver seamless, person-centred pathways, embedding a culture of continuous improvement and innovation and utilising digital technologies to enhance safety and productivity.
- **Tackling inequality and improving the health of our population,** by focussing on tackling inequalities in access, experience and outcomes, empowering staff and patients to improve their health and wellbeing and using our influence as a major employer to enhance to overall health of our population.

Our Strategy also emphasises the importance of partnerships and collaboration. We work closely with health, social care, and voluntary sector partners to deliver joined up and integrated care. Additionally, we are committed to addressing significant challenges such as climate change, cost of living, and inequality by adopting a proactive approach and making long term commitments.

To achieve these goals, we have identified several major programmes of work, including:

- **Brilliant Basics: Standards & Performance**: Improving quality, productivity, and meeting NHS performance expectations.
- **Digitally Enabled Care Transformation**: Redesigning and standardising care pathways using an Electronic Patient Record System and clinical decision support tools.
- **Care Closer to Home**: Delivering care in community and home settings to manage rising demand and improve health outcomes.
- **Our Future Hospital Services**: Driving research, innovation, and technology to meet future healthcare needs.
- **Collaborations and Networks**: Ensuring sustainable service delivery and effective interfaces between care providers.
- **Rightsizing Our Hospitals: Rebalancing demand with capacity**: Addressing capacity shortfalls through a series of short, medium, and long-term priorities.

Our Strategy was developed through extensive consultation with staff, patients and service users, our community and our partners, ensuring that our ambitions are aligned with the needs and expectations of those we serve. We are dedicated to making a positive difference in the lives of our patients and our community, guided by our core values.

Principal risks

Our Risk Management Policy sets out the framework we use to identify, assess, manage and oversee risk. This includes operational and strategic risks. Operational risks are reported through our Risk Register and strategic risks are reported through the Board Assurance Framework (BAF).

The BAF is updated on a quarterly basis and these strategic risks are scrutinised by our Board Committees, who each have allocated risks. The Audit Committee is responsible for oversight of the BAF process and therefore receives the full BAF, a summary is presented to the Board.

A review of strategic risks is undertaken on an annual basis by the Board, considering existing and emerging internal and external factors which might threaten the achievement of our strategic priorities. Each strategic risk is assigned to a designated Executive Director, who is responsible for its quarterly review.

Throughout 2024/25, we managed a total of nine strategic risks, which we have assessed as being a threat to our strategic priorities and which formed the basis of our BAF. The full BAF can be found within our Trust Board papers at https://www.uhnm.nhs.uk/about-us/our-board/trust-board-papers/ .

Our Risk Management Policy also sets out our Risk Appetite Statement which has been subject to review during the year. Risk appetite is the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategy after balancing the potential opportunities and threats a situation presents.

When setting target risk scores for the strategic risks contained within our BAF, we have taken into consideration the level of appetite determined in our statement, as well as what level of risk we are prepared to tolerate.

A summary of the strategic risks contained within our BAF during 2024 / 25 is shown here, including the risk level each quarter and the target being worked towards.

Strategic Risk Type	Q1	Q2	Q3	Q4	Target
Positive Patient Outcomes	High 12	High 12	Ext 20	Ext 16	Mod 6
Workforce Sustainability & Culture	Ext 16	Ext 15	Ext 15	Ext 15	High 10
Improving Population Health	Ext 15	Ext 15	Ext 15	High 10	High 10
Responsive Patient Care	Ext 20	Ext 15	Ext 20	Ext 20	High 10
Digital Transformation	High 12	Ext 16	Ext 20	Ext 20	High 8
Fit for Purpose Estate	High 12	High 12	High 12	High 12	High 12
Financial In Year Delivery	Ext 16	Ext 16	High 12	Mod 5	High 12
Financial Sustainability	Ext 16	Ext 16	Ext 16	Ext 20	Ext 16
Research & Innovation	High 12	High 12	High 12	Ext 16	High 8

Going concern disclosure

After making enquiries, the directors have a reasonable expectation that the services we provide 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.

What does Going Concern mean?

Accounting standards state that financial statement shall be prepared on a going concern basis unless management either intends to liquidate the entity or to cease trading or has no realistic alternative to do so. When management is aware, in making its assessment, of material uncertainties related to events or conditions that may cast significant doubt upon our ability to continue as a going concern, we must disclose those uncertainties. When an entity does not prepare financial statements on a going concern basis, it must disclose that fact, together with the basis upon which it prepared the financial statements and the reason why it is not regarded as a going concern.

Assessment Rules

The approach for going concern is based on the requirements of ISA (UK) 570, interpreted as Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (revised 2020) and the National Audit Office's Supplementary Guidance Note 01: Going Concern – Auditors responsibilities for local public bodies.

2 Performance Analysis

Performance measures, key performance indicators, links to risks and uncertainties

Our Accountability and Performance Framework outlines our arrangements for monitoring, managing and improving performance across the organisation. This is reviewed and refreshed annually.

Performance is monitored through from ward to board using a variety of key performance metrics including constitutional targets and spanning numerous domains.

The Board receives the Integrated Performance Report (IPR) which is presented with an explanation from the Executive Directors which includes a description of performance against expectations, any drivers of under performance, actions being taken and the expected impact of those actions. The Board may request further improvement actions where there is concern with any area of performance.

Data Quality and Statistical Process Control

- Data Quality Assurance Indicators are used to assess the reliability and quality of data using the STAR (sign off, timely and complete, audit and accuracy, robust systems and data capture) Framework. Each domain is rated to indicate the level of assurance.
- Statistical Process Control methods are used to analyse performance data, focussing on variation (improvement, decline or no change) and assurance (confidence in meeting targets).

Assurance Grid

An Assurance Grid categorises metrics based on their performance and assurance levels, using icons to indicate whether metrics are consistently meeting targets, showing improvement or requiring attention.

Performance Domains

Performance Domains are aligned with our Strategic Priorities, each with its own set of metrics and dashboards. In summary, these cover:

- **High Quality**: focusses on providing safe, effective and caring services. Metrics include patient safety incidents, falls with harm, medication incidents and sepsis management.
- **Responsive:** ensures efficient and responsive services. Metrics include emergency and elective pathway performance, cancer treatment times and diagnostic wait times.
- **People:** as we aim to create a great place to work. Metrics include employee engagement, sickness absence, vacancy and turnover rates.
- **Improving and Innovating:** focusses on excellence in development and research. Metrics include clinical trial participation, clinical academic posts and research active employees.
- **System and Partners:** Emphasises working together to improve population health. Metrics include tobacco and alcohol dependency treatment and anchor institution maturity.
- **Resources:** ensures optimal use of resources including staff, assets and finances. Metrics include elective and emergency activity, outpatient appointments and financial performance.

Each domain is also mapped to the BAF, to support triangulation of performance with strategic risk.

This structured approach enables us to track progress, identify areas for improvement and implement necessary changes to enhance overall performance and patient care.

In addition to the IPR to the Board, our committees scrutinise performance to a greater depth, with more detailed reports being provided which are relevant to the respective committee role and responsibilities. These include a range of performance metrics and are presented by Executive Directors.

Performance Management Reviews

The performance of our divisions is scrutinised through our Performance Management Review process. These are monthly reviews, led by the Executive Team and are a key mechanism through which divisional leadership teams are held to account.

To support the Performance Management Review, a comprehensive data pack is prepared by our Performance and Information Team which, like the IPR, includes a range of performance metrics with supporting narrative provided by the division.

In addition to key performance metrics, these packs include an overview of key risks which are being managed by the Division. This aligns with our Risk Management Policy and provides a means through which areas of underperformance can be triangulated with risks. Using a simple methodology, the report flags any risks which require review, do not have actions identified and where there is concern that the level of risk has not reduced over time. Divisions are asked to pay attention to those risks which have been flagged through this approach and appropriate actions are agreed.

The Performance Management Review process is replicated at a Directorate level, with Divisional Leadership teams following the same approach to hold their directorate leadership teams to account, for performance and risk management across their specialties, wards and departments.

Key Performance Indicators (KPI)

High Quality

1. Induction of labour
2. Maternity triage
3. Patient Safety Incident (PSI) rate per 1000 bed days
4. Patient Safety Incidents (PSI) with moderate harm and above per 1000 bed days
5. Patient falls with harm for 1000 bed days
6. Medication incidents % with moderate harm or above
7. Patient Safety Incident Investigation (PSII) instigated
8. Never Events per month
9. Pressure ulcers developed under UHNM per 1000 bed days
10. Family & Friends Test: inpatient
11. Family & Friends Test: Emergency Department
12. Family & Friends Test: Maternity
13. Sepsis: Adult Inpatient Screening
14. Sepsis: Adult Inpatient IVAB
15. Sepsis: Emergency portals screening
16. Sepsis: Emergency portals IVAB
17. Sepsis: Children's screening
18. Sepsis: Children's IVAB
19. Sepsis: Maternity screening
20. Sepsis: Maternity IVAB

Responsive

1. Urgent and Emergency Care (UEC) 4-hour target
2. Over 12 hours in Emergency Department
3. UEC category 2 handover average time
4. Cancer 28-day Faster Diagnosis Standard (FDS)
5. Cancer 31-day combined
6. Cancer 62-day combined
7. Diagnostics DMO1 performance
8. Referral to Treatment (RTT) no. patients waiting over 52 weeks
9. RTT no. patients waiting over 65 weeks
10. RTT no. patients waiting over 78 weeks
11. RTT no. patients waiting over 104 weeks

Resources

1. Day case / elective activity
2. Non-elective activity
3. Outpatient 1st appointment
4. Outpatient follow up
5. Freedom of Information performance
6. Subject Access Request performance
7. Data Security breaches
8. Total income
9. Expenditure (pay and non-pay)

People

1. Employee engagement
2. Sickness Absence
3. Vacancy rate
4. Turnover rate
5. Appraisal rate
6. Agency utilisation

System and Partners

1. Alcohol dependency treatment
2. Tobacco dependency treatment (inpatients)
3. Tobacco dependency treatment (Maternity)
4. Anchor Maturity Assessment

Improving and Innovating

1. Increase clinical trial participation
2. Increase clinical academic posts / honorary contracts
3. Increase research active employees

Detailed analysis and explanation of performance

Our operational performance for 2024 / 25 explained.

The year has been a period of significant challenges and achievements, and we have remained committed to providing efficient and response services to our patients. Despite facing operational pressures and critical incidents, we have made notable progress in various areas, in line with our commitment to ensuring the best joined-up care for all our patients.

Non-Elective Care

Our non-elective care performance has shown resilience amidst high demand and seasonal variations. The validated performance for the 4-hour target remained static at 64.6% in March, slightly below the improvement trajectory of 78%. However, we have seen a reduction in the number of patients waiting over 12 hours in our Emergency Department, with a 4.74% improvement from February to March as we reached the end of the year.

The average handover time for Category 2 patients improved significantly from December to January, although an increase was then seen. There remains significant transformation and improvement work to undertake our non-elective care patients. During the winter, we invited an external review, and an improvement programme was developed which is a key priority for us as we move into 2025 / 2026.

KPI	Target	2023 / 2024 Performance	2024 / 2025 Performance
Urgent and Emergency Care (UEC) 4-hour	95%	67.43%	67.92%
Over 12 hours in Emergency Department	-	22, 280	26,057
UEC category 2 handover average	-	68	82
Cancer 28-day Faster Diagnosis Standard	75%	67.56%	73.99%
Cancer 31-day combined	96%	87.91%	92.10%
Cancer 62-day combined	85%	60.42%	65.86%
Diagnostics DMO1 performance	99%	70.82%	60.79%
RTT number patients waiting over 52 weeks	-	5, 016	1, 423
RTT number patients waiting over 65 weeks	-	806	186
RTT number patients waiting over 78 weeks	-	67	7
RTT number patients waiting over 104 weeks	-	1	0

Elective Care and Diagnostics

Elective care faced interruptions due to operational pressures, particularly during the winter months, but we have managed to prioritise patients with the greatest clinical need during this time; with overall significant improvements in our long waiting patient lists. Our faster diagnosis standard performance improved to 77.7% in March, surpassing the national standard of 75%. The 31-day combined cancer performance showed a decline in March, highlighting areas for further improvement. We have been able to sustain improvements in elective care across the year and this is reflected in having moved from Tier 1 oversight by NHS England national team to Tier 2 oversight from their regional team, however, we are acutely aware of where we fall short and where further improvements are required.

Diagnostic performance, particularly for non-obstetric ultrasound, remains a challenge with a performance of 37.6%. Despite this, we have seen significant improvements in echocardiogram and endoscopy performance, with echocardiogram reaching 97.1% and endoscopy performance at approximately 96%. Efforts to reduce the backlog of patients waiting for scans have shown progress, and we will continue with this progress as we move into the coming year.

Referral to Treatment (RTT)

Our RTT performance has seen a substantial reduction in the number of patients waiting over 52 weeks, with a 68% decrease over the 12-month period. The number of patients waiting over 65 weeks also decreased to 193 in February, although the rate of reduction had slowed due to pressures within urgent and emergency care pathways. We successfully eliminated the number of patients waiting over 104 weeks, achieving zero breaches in March.

Activity and Utilisation

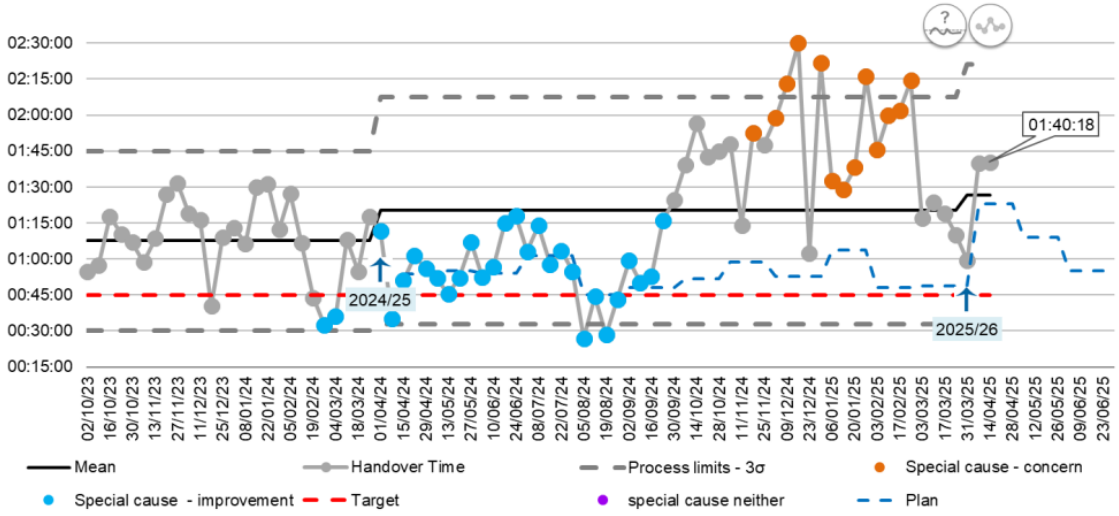
Non-elective activity has continued to grow, although below plan, with a notable increase in zero-length of stay and one-day admissions. Elective activity saw improvements in day case and outpatient procedures, with day case activity running above plan at 107.4%. The County Elective Hub has significantly increased procedure numbers, contributing to overall performance.

Future Outlook

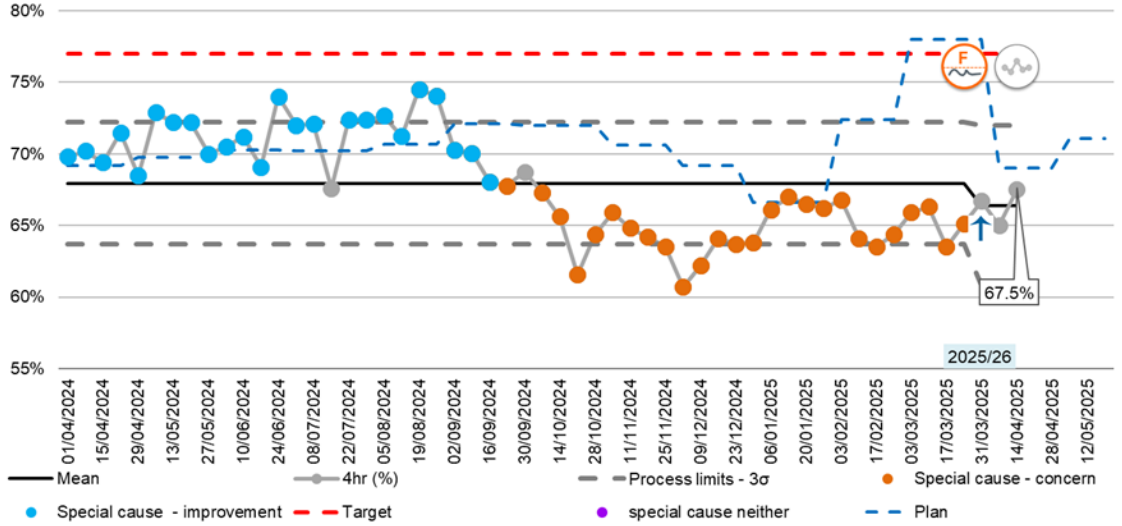
Looking ahead, we expect continued challenges in our urgent and emergency care trajectories. However, with the revised Urgent and Emergency Care improvement programme and the appointment of a Recovery Director, we anticipate systematic and prioritised improvements in performance. Elective care planning for RTT and cancer shows a required increase in performance by March 2026, with focused efforts on improving cancer pathways and validation processes.

In conclusion, the year has been a testament to our resilience and dedication to providing high quality care to our patients. While there are areas requiring further improvement, our achievements in cancer treatment, diagnostic performance, and RTT reductions demonstrate a commitment to excellence. We will continue to build on these successes, ensuring the best joined-up care for all our patients in the coming year.

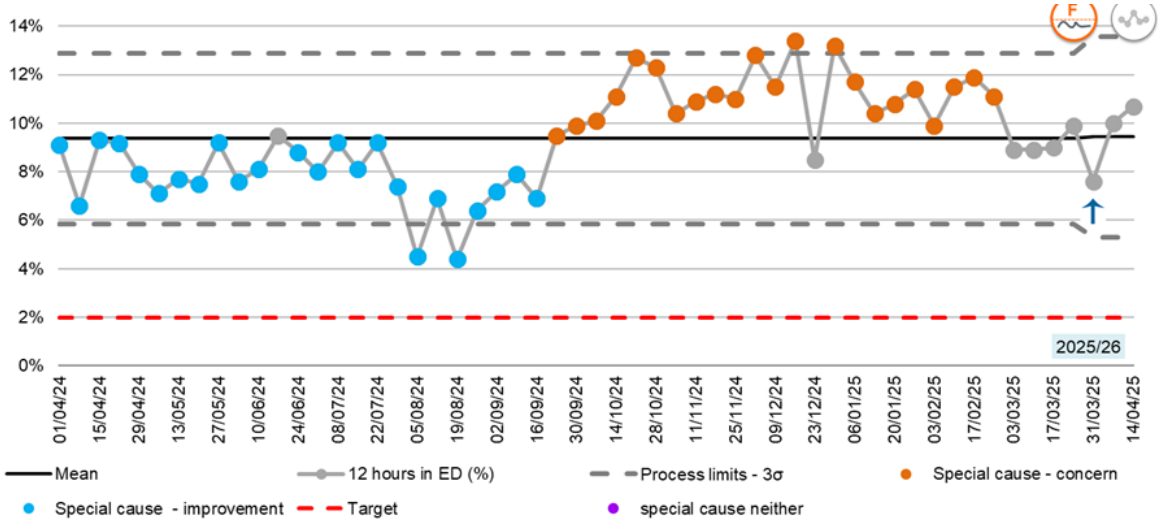
Ambulance Handover Time



Emergency Department 4-hour performance



Emergency Department 12-hour performance



Detailed analysis and explanation of performance

Our quality performance for 2024 / 25 explained.

Throughout the year, we have maintained our priority to provide high quality, safe care for all patients, and to learn from our errors and we are committed to driving improvement and a culture of excellence.

We made good progress across many of our quality indicators, including:

- Reduction in total patient falls per 1000 bed days and in falls resulting in any harm to patients per 1000 bed days when compared to 2023/2024
- Continued improvement in Sepsis Screening and IV antibiotics for inpatients, in our Emergency Portals and for children

KPI	Target	2023 / 2024 Performance	2024 / 2025 Performance
Induction of labour	95%	87.6%	98.0%
Maternity triage	85%	85.6%	92.9%
Patient safety incident rate per 1000 bed days	50.7	53.8	52.8
Patient safety incident investigations with moderate harm or above per 1000 bed days	0.6	0.7	0.6
Patient falls with harm per 1000 bed days	1.5	1.75	1.75
Medication incidents % with moderate harm or above	5%	1.75%	1.6%
Patient safety incident investigations instigated	n/a	82*	31
Never Events per month	0	7	9
Pressure ulcers developed under UHNM per 1000 bed days	1.6	1.66	1.75
Family & Friends Test: inpatients	95%	95.5%	95.7%
Family & Friends Test: Emergency Department	85%	70.2%	66.9%
Family & Friends Test: Maternity	95%	91.1%	86.4%
Sepsis: Adult inpatient screening	90%	95.1%	95.4%
Sepsis: Adult inpatient IVAB	90%	99.5%	99.1%
Sepsis: Emergency portals screening	90%	82.5%	85.5%
Sepsis: Emergency portals IVAB	90%	75.5%	81.9%
Sepsis: Children's screening	90%	89.0%	87.1%
Sepsis: Children's IVAB	90%	100%	75.0%
Sepsis: Maternity screening	90%	71.9%	78.9%
Sepsis: Maternity IVAB	90%	86.3%	78.7%

*82 Serious Incidents logged and NOT PSIIs. PSIRF was not fully adopted until December 2023.

- Continuing to embed our Patient Safety Incident Response Framework and our approach to responding to incidents and system-based learning
- Exceeding the national Friends and Family Test recommendation benchmark, of 95% for inpatients and maternity services
- Introducing four Patient Safety Partners in line with the national Patient Safety Incident Review Framework (PSIRF) to support patient safety initiatives
- Two Patient Safety Specialists have completed Level 3 and 4 national training via Loughborough University
- A reduction in like for like numbers compared to the previous year for Clostridium Difficile and Trust apportioned MRSA
- Call for Concern (Martha's Rule) has now been implemented across Royal Stoke and co-design of our solution to daily feedback from patients, families and carers – designed with patient involvement

We are proud of these achievements; however, we recognise we need to ensure further improvements are made, particularly in relation to:

- Improving our Emergency Department waiting times and Ambulance Handover delays
- Improving our Cancer performance for 28, 31 and 62-day treatment standards
- Continuing to improve Sepsis screening compliance and pathway
- Further reduce harm from falls
- Improve recording of timely observation using our electronic system
- Implementation of electronic prescribing and medicines administration
- Continue to reduce hospital acquired pressure ulcers and deep tissue injuries with lapses in care
- Continue to reduce numbers of Clostridium Difficile cases

Future Outlook

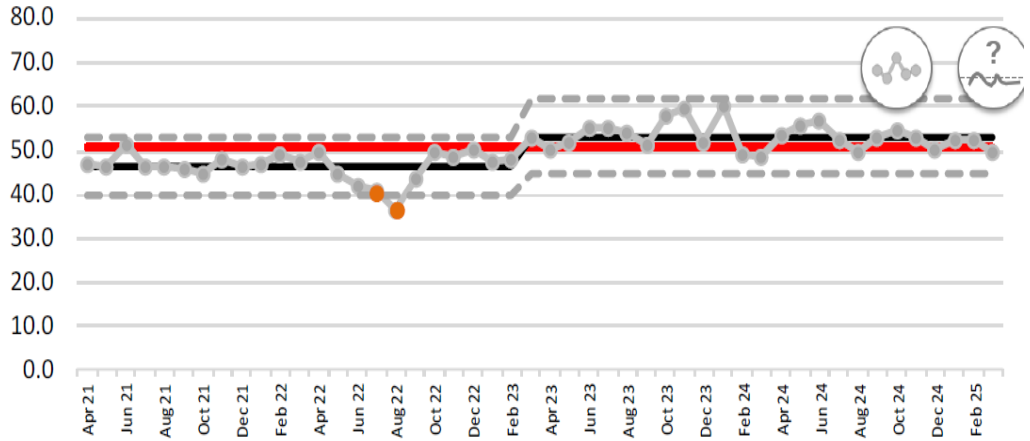
Looking ahead, we remain committed to delivering high-quality, safe, and compassionate care while navigating ongoing operational pressures and rising demand. We will continue to embed a culture of continuous improvement, enhance patient safety via the Patient Safety Incident Response Framework (PSIRF), and strengthen staff wellbeing and engagement.

With a focus on innovation, digital transformation, and collaborative partnerships, we aims to improve patient outcomes, reduce harm, and become one of the UK's top university teaching hospitals by 2025.

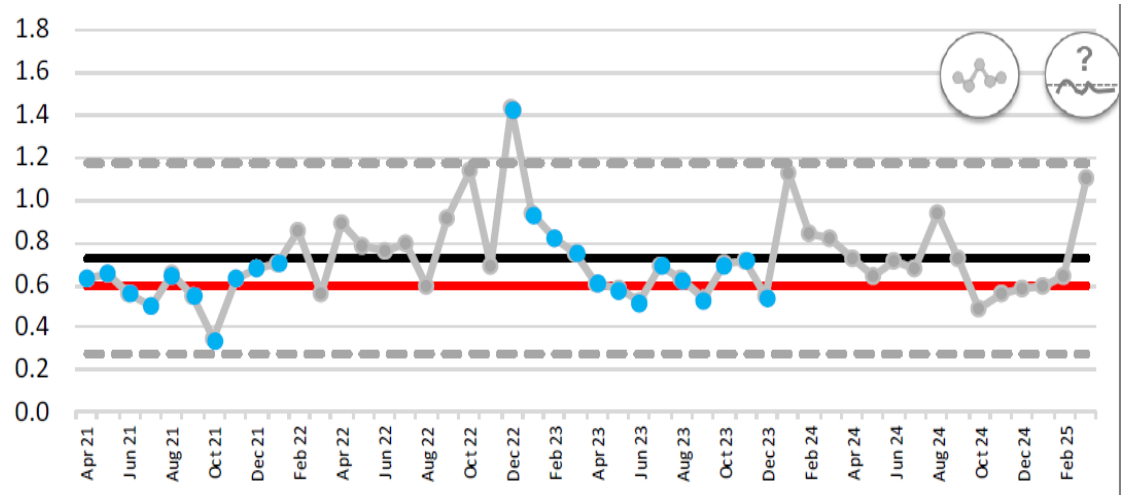
12 Month Trend Analysis – Quality KPIs

Metric	R12M Trend
Induction of Labour	
Maternity Triage	
Patient Safety Incidents rate per 1000 bed days	
Patient Safety Incidents with moderate harm and above per 1000 bed days	
Patient falls with harm per 1000 bed days	
Medication Incidents per 1000 bed days	
Medication Incidents % with moderate harm or above	
Patient Safety Incident Investigation (PSII's) instigated	
Never Events per month	
Pressure ulcers developed under UHNM per 1000 bed days	
Family & Friends Test - Inpatient	
Family & Friends Test - ED	
Family & Friends Test - Maternity	
Sepsis - Adult Inpatient Screening	
Sepsis - Adult Inpatient IVAB	
Sepsis - ED Portals Screening	
Sepsis - ED Portals IVAB	
Sepsis - Childrens Screening	
Sepsis - Childrens IVAB	
Sepsis - Maternity Screening	
Sepsis - Maternity IVAB	

Patient Safety Incidents per 1000 bed days



Patient Safety Incidents with moderate harm or above per 1000 bed days



Detailed analysis and explanation of performance

Our workforce performance for 2024 / 25 explained.

Staff Engagement

Our Staff Engagement score for 2024 / 25 was 6.84, a slight increase on the score of 6.83 for the previous year. In addition to the National Staff Survey, our local Staff Voice Survey is undertaken on a quarterly basis. We continue to focus on improving engagement through various initiatives and feedback mechanisms.

Sickness Absence

The Sickness absence remains above our expected standard of 3.39%. The 12-month rolling average slightly reduced to 5.29%. The main drivers of sickness absence continue to be stress and anxiety, followed by gastrointestinal and musculoskeletal problems. Seasonal changes also influence these rates, with a noticeable reduction in cold, cough and flu-related absences in March 2025.

Turnover Rate and Vacancy Rates

The turnover rate remained low at 7.5%, consistently below our 11% target for more than two years. This low turnover rate signifies ongoing successes in our recruitment and retention processes and reflects our efforts to make UHNM a great place to work for everyone.

Vacancies decreased to 8.3% compared to 9.2% in the previous year. The main drivers of this improvement were increases across various staff groups, including Registered Nursing, Support to Clinical Staff, and infrastructure, while Medical and Dental saw a reduction. These overall increases were counter-balanced by a slight uplift in the total budgeted establishment.

KPI (Based on 12 month Average)	Target	2023 / 2024 Performance	2024 / 2025 Performance
Employee engagement	7.2	6.83	6.84
Sickness absence (rolling 12 month)	3.4%	5.3%	5.3%
Vacancy rate	8.0%	9.2%	8.3%
Turnover rate	10%	8.8%	7.5%
Appraisal rate	95.0%	83.0%	86.3%
Agency utilisation	3.2%	4.6%	2.8%

Agency Utilisation

Agency costs decreased to 2.8%, remaining below the threshold set by NHS England. Despite an increase in overall agency usage to 219.49 whole time equivalent (WTE) in March, executive and divisional level scrutiny, along with system-level controls, have helped keep agency utilisation below the 3.2% threshold.

Additional scrutiny of agency utilisation is provided through our electronic rostering solution. These controls require matron level authorisation for nursing and midwifery rosters, helping to manage and reduce usage.

Appraisal Rate

Performance Development Reviews (PDR) continue to perform below our 95% target, at 86.3%, an improvement on the previous year. Divisions actively monitor and review PDR performance to improve compliance.

Employee Engagement Initiatives

We have implemented several initiatives to enhance employee engagement, including:

- Medical Staff Finishing School
- Employment of a People Promise (Retention) Manager
- Implementation of a Wagestream solution for bank staff to provide financial flexibility
- Monthly targeted campaigns aligned to our People Promise areas of focus, such as Neurodiversity Week

Future Outlook

As we look to the future, our People Plan is closely aligned with our overarching goal of providing the best joined-up care for all. We will continue to prioritise staff engagement by addressing feedback from our Staff Voice Survey and the National NHS Staff Survey, to implement targeted initiatives to improve the work environment.

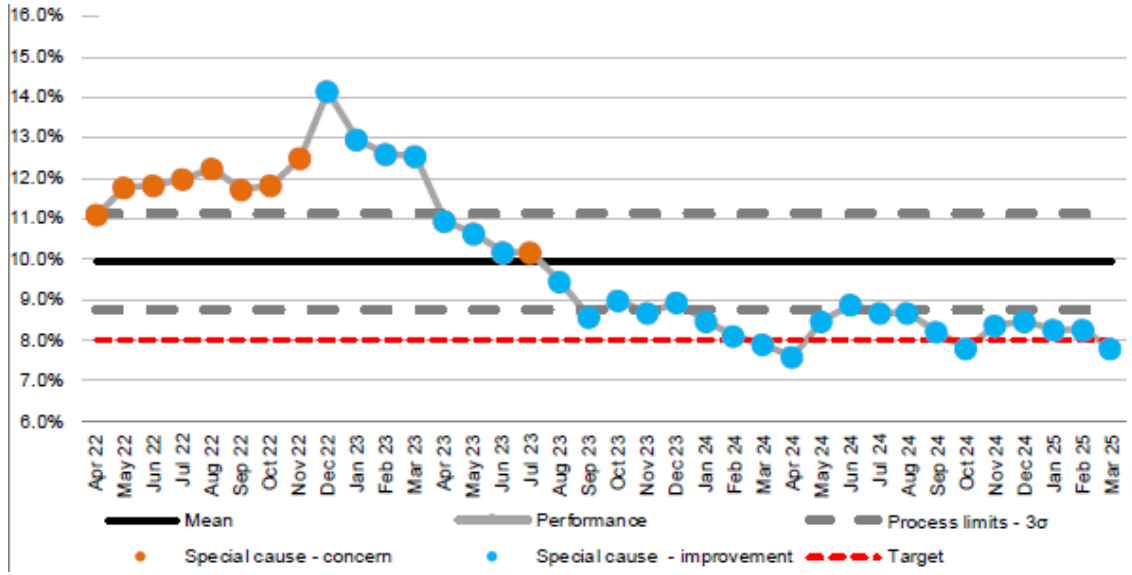
We anticipate improvements in our sickness absence rates throughout the summer months and we will maintain our focus on staff wellbeing and supporting staff with stress and anxiety through resilience training and mental health resources.

Our successful recruitment and retention strategies will continue, with targeted recruitment events and social media campaigns highlighting us as a great place to work. We aim to maintain our low turnover rate and further reduce vacancy rates to ensure we have a stable and skilled workforce. We expect our agency usage to remain below the NHS England threshold, thanks to our ongoing scrutiny and control measures. Our focus will be on converting agency roles to bank or substantive positions where possible, ensuring cost-effective staffing solutions.

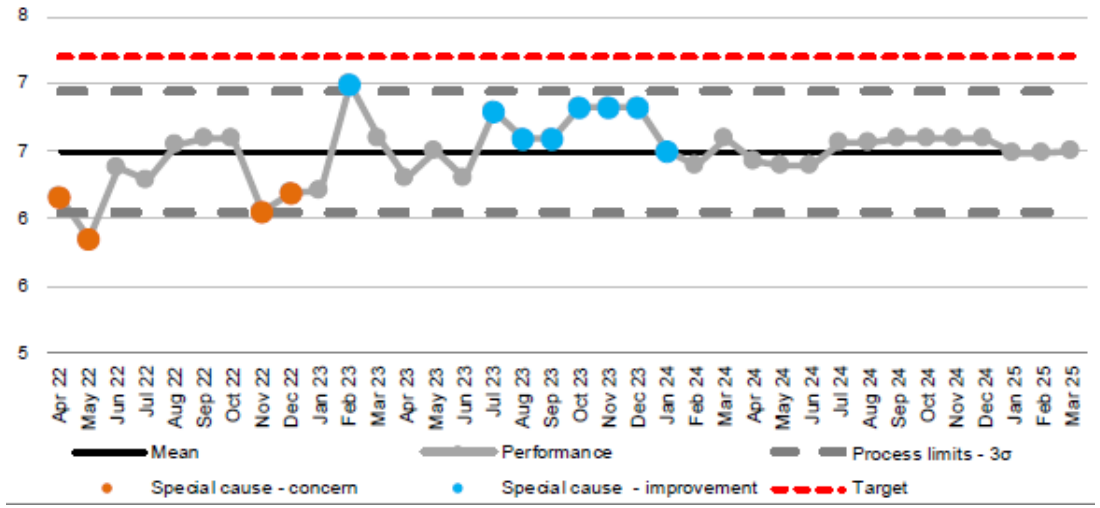
We will work towards achieving our target of 95% for PDR by providing additional support and monitoring to our teams. Regular updates and focussed assistance will help improve compliance and ensure that all our staff receive timely appraisals. Our partnerships with local and national organisations, including the Integrated Care System, Keele University and the University of Staffordshire will continue to play a crucial role in our strategy. These collaborations help us deliver integrated care, advance research and provide training opportunities for our staff.

By focussing on these priorities, we are confident that we can create a supportive and engaging work environment, ensuring the wellbeing and development of our staff, and maintaining efficient workforce management practices.

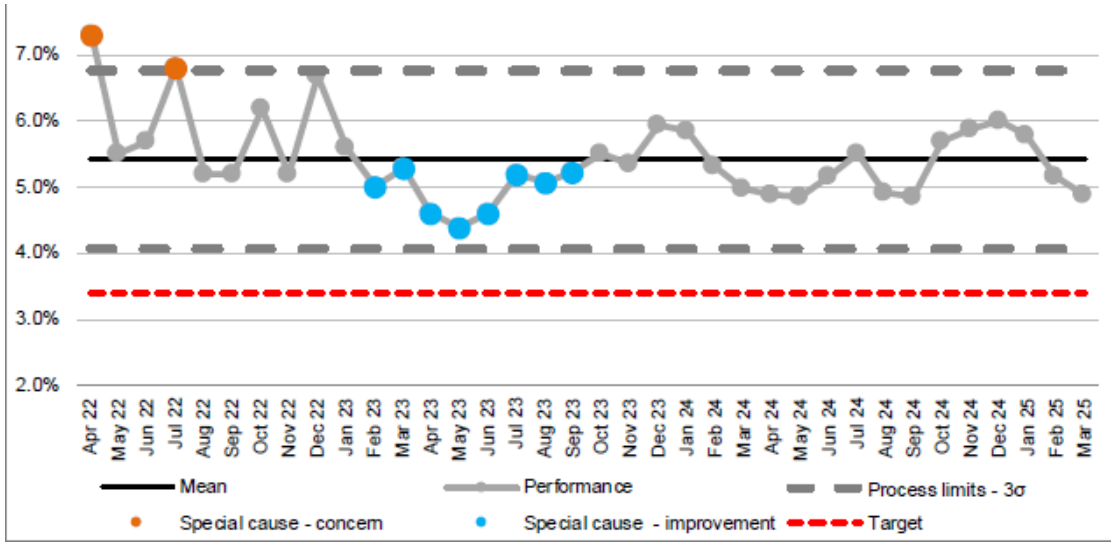
Vacancy Rate



Employee Engagement



Sickness Absence



Financial performance

Our financial performance for 2024 / 25 explained.

KPI	2023 / 24 Performance	2024 / 25 Performance
Day case / elective activity	111, 971	125, 108
Non-elective activity	128, 776	130, 452
Outpatient first appointment	271, 213	316, 711
Outpatient follow-up	382, 355	391, 944
Total income (£'000)	1, 151, 805	1, 272, 878
Expenditure - pay (£'000)	692, 877	787, 322
Expenditure - non-pay (£'000)	337, 315	484, 501

Our resources are managed within a financial governance framework that incorporates systems of financial control, budgetary control and the financial responsibilities for individuals outlined within our corporate governance policies and procedures. Financial and quality governance arrangements incorporate benchmarking activities and an internal audit function to ensure probity, accuracy and the economic, efficient and effective use of resources, include value for money.

Financial performance is reported into the non-executive led Performance and Finance Committee which meets monthly. Standing items on the agenda include the monthly financial position, cost improvement schemes, capital schemes and cost pressure analysis to ensure regular review of any financial challenges and implementation of recovery measures.

We have a policy and governance framework in place to guide staff on the appropriate use of resources and are designed to ensure that our financial transactions are carried out in accordance with the law and with Government policy, through our Standing Orders, Standing Financial Instructions and Scheme of Delegation. In addition, there is a robust system for developing and routinely developing policies and procedures and staff are regularly updated and guided or trained on their application.

We ended the financial year with a deficit of £11.773 million against a breakeven plan for the year. We achieved an adjusted financial deficit of £18.056 million for the year, and this was further adjusted to a £15.614 million deficit for the year (as shown in note 37 of the accounts) against the breakeven duty in-year financial performance.

It should be noted that the position relied heavily on non-recurrent cost improvement scheme delivery and other one-off benefits, and we will need to focus on recurrent cost control and efficiency programmes to ensure long term financial sustainability.

Throughout the course of the year, delivery of our financial plan has been subject to scrutiny and oversight each month via the Performance and Finance Committee and the Board.

During 2024 / 25, our internal auditors have reviewed our key financial systems and controls in relation to expenditure and concluded with 'reasonable assurance with minor improvements required'. A number of recommendations were made which will remain a focus throughout 2025 / 26.

Our external auditors give an expert and independent opinion on whether our financial statements are a true and fair view of our financial position at the end of the financial year. They also provide an expert and independent opinion on whether the financial statements comply with relevant laws. In carrying out their audit, they must have regard to aspects of corporate governance and securing economy, efficiency and effective use of resources.

Although a surplus has been achieved in the last four years, due to previous deficits, we breached the requirement under Section 30 of the Local Audit and Accountability Act 2014 to achieve a breakeven on a cumulative basis. As such our External Auditors made a referral to the Secretary of State for Health in June 2021, which remains in place during 2024 / 25 as we still have a cumulative deficit. This referral was made under Section 30 of the 2014 Act.

We recognise that this position is set within the context of a wider sustainability gap across the local health and social care economy. To address this challenge, work remains ongoing with our system partners, via the Integrated Care Board.

For detailed accounts, please see the accounts section.

Statement of Comprehensive Income Account for the year ended 31 March 2025

	2024/25	2023/24
	£'000	£'000
Revenue from patient care activities	1,186,037	1,055,578
Other operating revenue	106,840	96,227
Total revenue	**1,292,878**	**1,151,805**
Operating expenses	(1,271,823)	(1,130,192)
Operating surplus/(deficit)	**21,055**	**21,613**
Other gains and losses	70	(78)
Surplus/(deficit) before interest	**21,125**	**21,535**
Investment revenue	6,054	5,780
Finance costs	(35,422)	(75,118)
Surplus/(deficit) for the financial year	**(8,243)**	**(47,803)**
Public dividend capital dividends payable	(3,530)	(3,171)
Retained surplus/(deficit) for the year	**(11,773)**	**(50,974)**

Performance against breakeven duty

	2024/25	2023/24
	£'000	£'000
Surplus/(deficit) for the period	(11,773)	(50,974)
Impairments not scoring to Department of Health limit	360	7,026
I&E impact of capital grants and donations	(4,293)	(2,300)
Impact of IFRS 16 on IFRIC 12 schemes	(2,442)	46,189
Net impact of DHSC provided inventories for COVID response	92	288
Adjusted financial performance surplus	**(18,056)**	**229**

Revenue Income

Income in 2024 / 25 totalled £1, 292.9m. The majority of our income £1167.9m, (90%) from Integrated Care Boards and NHS England in relation to healthcare services provided to patients during the year. Other operating revenue relates to services provided to other Trusts, training and education and miscellaneous fees and charges. Also included is Top Up Funding and Elective Recovery Fund (ERF) funding.

Summary of Total Income

	2024/25	2023/24
	£m	£m
Clinical commissioning groups, Integrated Care Boards and NHS England (patient care)	1,168	1,040
Other patient care income	18	15
Education, training and R&D income	47	40
Non patient care services to other NHS bodies	41	40
Top Up Funding and Deficit support	0	0
Other	19	17
Total revenue	**1,293**	**1,152**

Summary of Income from ICB's and NHSE

	2024/25	2023/24	% change
	£m	£m	%
Revenue from patient care activities	1,186.0	1,055.6	12%
Other revenue:			
Medical school (SIFT)	8.6	8.1	6%
Junior doctor training (MADEL)	24.5	18.8	30%
WDD funding	6.8	6.4	6%
Research and development	3.2	3.2	0%
Non patient care services to other NHS bodies	36.1	34.1	6%
Other income	27.7	25.6	8%
Total other revenue	**106.8**	**96.2**	**11%**
Total revenue	**1,292.9**	**1,151.8**	**12%**

Operating Expenditure

Staff costs at £737.3m represent 61.9% of our operating expenditure with clinical supplies and services non-pay costs at £2608m representing a further 20.5%. A summary of operating expenditure is shown in the table below:

	2024/25	2023/24	% change
	£m	£m	%
Staff costs	787.3	692.9	14%
Other costs	114.5	94.8	21%
Clinical supplies and services	260.8	239.0	9%
Depreciation	39.7	37.7	5%
Premises costs	43.2	33.3	30%
Clinical negligence	26.0	25.5	2%
Total operating expenditure before impairments	**1,271.5**	**1,123.2**	**13%**
Impairments	0.4	7.0	
Total operating expenditure	**1,271.8**	**1,130.2**	**13%**

Capital

Of the capital funding in 2024 / 25, £29.1m was generated internally from the depreciation of assets and use of our cash reserves and this is predominantly allocated to the replacement of equipment, ICT systems and the refurbishment of our buildings and estate. In addition, we were awarded central capital funding totalling £41.0m for a number of investments including the funding of imaging and diagnostic equipment. ICT projects including the development of an Electronic Patient Record, developments at the County site, replacement boilers and continuing work on a Community Diagnostic Centre. The main areas of capital expenditure are set out in the table to the right.

Capital spend	2024/25 £'000	2024/25 £'000
Medical Assets:		
Community Diagnostic Centre Equipment	6,338.0	
Imaging Equipment	4,941.0	
Theatre Equipment	3,132.0	
Day Case Unit Equipment	1,039.0	
Pathology Equipment	937.0	
Other Equipment	5,155.0	
Total Medical Assets:		**21,542.0**
ICT schemes		
Computer Hardware Refresh	6,037.0	
Electronic Patient Record refresh	3,172.0	
ICT Infrastructure and Security	1,853.0	
Community Diagnostic Centre ICT	516.0	
Electronic Prescribing (EPMA)	499.0	
Other ICT Equipment	1,849.0	
Total ICT schemes		**13,926.0**
Estates and General works		
County Site Developments - Day Case and Breast Care Units	10,628.0	
Purchase and Lease of Premises (inc CDC)	6,098.0	
Estates Infrastructure and Backlog Maintenance	5,842.0	
Community Diagnostic Centre Estates Works	5,388.0	
Air Heat Boiler Replacement	3,162.0	
Additional Emergency Beds (AMRA Unit)	2,733.0	
Car Parking Barriers and Infrastructure	1,684.0	
PFI and other Enabling costs	404.0	
Total Estates & PFI schemes		**35,939.0**
	Total:	**71,407**

Risk profile

As part of the Board Assurance Framework, key strategic risks are identified and linked to our six Strategic Priorities which were in place throughout the year. These priorities have been refined as part of our refreshed strategy, 'The best joined-up care for *all*' as we move into 2025 / 26 and beyond.

During 2024 / 25, these six Strategic Priorities were:

We opened the year with nine strategic risks we felt could affect the achieving of our priorities. One of these risks was rated at a score of 20 out of a possible 25 in accordance with the risk matrix outlined within our Risk Management Policy. A further three risks were rated at 16, one at 15 and four at 12. The most significant risk as we entered the year was in relation to our ability to deliver responsive patient care, reflecting our challenges in particular within the Urgent and Emergency Care pathway.

We also closed the year with nine strategic risks we felt could affect us in achieving our priorities although not all risks were the same score when the year opened.

- The risk to financial sustainability increased to 20, which was the same score as the risk to digital transformation and delivering responsive patient care; these were our highest scoring risks
- The risk to delivering positive patient outcomes increased to 16, as did the risk to research and innovation
- The risk to improving our workforce sustainability and culture remained at 15 for the majority of the year
- The risk to our estate remained stable throughout the year at 12
- The risk to improving the health of our population reduced to 10 and the risk to financial in year deliver reduced to five

The existing risks described in our Annual Governance Statement continue to be acknowledged as our principal risks although we will be revising these as we shift the focus towards our new strategy from April 2025.

We continue to use our Risk Appetite Statement as part of our Risk Management Policy, to determine both risk appetite and tolerance and to guide us in our approach to risk reduction.

Information about social, community, anti-bribery and human rights

The Modern Slavery Bill was introduced into Parliament on 10 June 2014 and passed into UK law on 26 March 2025. The Modern Slavery Act is an act to make provision about slavery, servitude and forced or compulsory labour and about human trafficking, including the provision for the protection of victims.

A person commits an offence if:

- The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude
- The person requires another person to perform forced or compulsory labour, and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour

We are fully aware of the responsibilities we bear towards patients, employees, and the local community and as such, have a strict set of ethical values that we use as guidance regarding our commercial activities. We therefore expect that all our suppliers adhere to the same ethical principles.

We have a non-pay annual budget of £506m (inclusive of drugs at approximately £55m) of which more than £367m per annum is spent on goods and services.

It is important to ensure that our suppliers have in place robust systems to ensure that their own staff, and organisations within their own supply chain are fully compliant with the requirements of the Modern Slavery Act 2015.

In compliance with the consolidation of offences relating to trafficking and slavery within the Modern Slavery Act 2015, we have an ongoing process of reviewing our supply chains with a view to confirming that such behaviour is not taking place. The standard NHS Terms and Conditions of Contract which form the basis of all orders and contracts with suppliers have a specific clause contained within them relating to modern slavery that determine that suppliers (and their sub-contractors) will:

- Comply with the Modern Slavery Act 2015
- Implement due diligence policies for its sub-contractors
- Respond promptly to all slavery and trafficking due diligence questionnaires
- At our request, prepare and deliver an annual slavery and trafficking and report setting out steps to ensure slavery and trafficking is not taking place within its own supply chain
- Implement a system for all employees to ensure compliance with the Act

As part of our commitment to ensuring that we do not trade with organisations who do not meet the requirements of the act, suppliers will be required to provide a copy of their annual Modern Slavery Act Statutory Statement detailing actions undertaken to ensure they meet and enforce the requirements of the Act.

This will only apply to a supplier defined as a ‘commercial organisation’; in accordance with the Act if it:

- Supplies goods and services
- Has a turnover of not less than £36m

Our Procurement Team is committed to raising awareness with all suppliers by ensuring that all suppliers we trade with are aware of our commitment to ensure compliance with the Act. As part of our procurement processes, when trading with new suppliers, and prior to establishing the supplier on our systems, the supplier will be requested to confirm in writing that they are compliant with the Act.

Counter Fraud

We have a zero-tolerance approach to fraud and are committed to taking all necessary steps to counter fraud and bribery which includes maintaining and honest, open atmosphere, to best fulfil our objectives and those of the NHS. We adhere to the NHS Counter Fraud Authority Standards for Providers, as well as other directions and procedures they publish in addition to adhering to the anti-fraud manual.

We fully investigate any suspicion of fraud, bribery or corruption, through a rigorous review of any such allegation, to taking appropriate action including possible criminal prosecution, as well as taking steps to recover any assets lost because of fraud. We have numerous key policies in place to protect against fraud and corruption, including the following:

- Standards of Business Conduct
- Standing Financial Instructions
- Anti-bribery and Anti-fraud Policy
- Scheme of Reservation and Delegation

We also have a nominated Local Counter Fraud Specialist (LCFS) whose role is to provide support and advice on all matters relating to fraud as well as being a point of contact for fraud reporting. The LCFS undertakes proactive and reactive work and provides a report to each meeting of our Audit Committee. The LCFS service is provided by our Internal Auditors at RSM.

The Accountable Officer for anti-fraud is the Chief Finance Officer. There were 31 referrals made to the LCFS during 2024 / 25, which were reviewed and investigated where appropriate in line with our policy.

The LCFS workplan for 2024 / 25 was aligned to meet government standards and was approved by the Audit Committee. This has included a comprehensive fraud risk assessment.

Equality of service delivery

As a public sector organisation, all NHS Trusts are required to demonstrate how they meet the Public Sector Equality Duty as outlined in section 149 of the Equality Act 2010.

We aim to provide equality of access to our patients, people and our population and this is reinforced through our Equality, Diversity and Inclusion Strategy. We are committed to furthering equality, diversity, inclusion and human rights, and work in partnership with a variety of external partners and advocacy groups. This allows for a greater understanding of our local population, their health needs and any barriers to accessing healthcare, which enables us to better address potential health inequalities across the geographical area we serve. Adherence to the Public Sector Equality Duties is demonstrated through our reporting on equalities.

In addition to the Equality Act 2010 and Human Rights Act 1998, the Armed Forces Act 2021 further enshrines the Armed Forces Covenant into law to help prevent service personnel and veterans being disadvantaged when accessing services. The Act introduces a duty to have 'due regard' to the principles of the Armed Forces Covenant and we are proud to have received accreditation by the Veterans Covenant Healthcare Alliance. This highlights a series of pledges we have made around sharing and driving best practice in NHS care for people who currently serve or have served in the UK Armed Forces and their families.

We were also very proud to have secured the prestigious RACE (Reporting, Action, Composition and Education) Equality Code Quality Mark in recognition of our work to support race equality and ability and our determination to eliminate all discrimination in the workplace.

Our Equality, Diversity and Inclusion Policy sets the standards which enable us to meet our statutory duties, both as an employer and as a healthcare provider. Implementation of our policy is fundamental to delivery of good quality patient care and ensuring a positive workplace experience for our staff. As such:

- Our policy is applied fairly and equitably to all workers
- Each member of staff has access to appropriate training and development in relation to their equality, diversity and inclusion responsibilities
- We encourage a speaking up culture to empower and enable individuals to feel safe when raising concerns
- The policy underpins the development of all our policies and procedures to ensure equality, diversity and inclusion

We comply with national reporting requirements through our People, Culture and Inclusion Committee and our Equality, Diversity and Inclusion Strategy was built upon much of the work already in place and is aligned to our People Strategy, which supports regional and system equality, diversity and inclusion priorities driven by the NHS People Plan.

The strategy was developed and based on feedback from staff, service users and other stakeholders and shaped by the equality duties and data review for our service user and workforce populations.

Our well-established Diversity Networks meet on a regular basis to support us in delivering our strategy, and ultimately our statutory responsibilities and each of these has an executive sponsor. Our networks include:

- Black and Minority Ethnicities (BAME) Network
- Disability and Long-Term Conditions Network
- LGBT+ Network

In addition, we have established a Women's Network and a Men's Health Network.

Work to address health inequalities

We have been actively working to address health inequalities across our population and have agreed our Population Health and Wellbeing Strategy, which sets out our key areas of priority and future plans.

Our population is growing and demand for health and care services is increasing. Many illnesses we see are preventable. Physical inactivity and excess weight, smoking and excess alcohol consumption are significant contributors to poor health. This results in increasing numbers of people living with cardiovascular disease, respiratory disease, musculoskeletal conditions and cancer.

Groups who are marginalised, live in deprived communities and have other protected characteristics are at risk of preventable disease and premature death.

Our local population has a shorter life expectancy compared to other areas in England and spend between 16 and 22 years living in poor health. This is stark in Stoke-on-Trent where 53% of the local population lives in the 20% of the most deprived communities in England.

Our ambition is to focus on preventing sickness, so that people live as much of their life as possible in good health and that, when care is needed, the best outcomes are achieved by all. Our Population Health and Wellbeing Strategy has been developed to support this.

To deliver our Population Health and Wellbeing Strategy, during 2023 / 24 we developed three programmes which focus on Healthcare Inequalities and Equity, Prevention and Making Every Contact Count and Anchor Institution. We have developed infrastructure to support these programmes, along with the transformation needed to deliver.

We have made strong progress in delivering our strategy with the increased infrastructure and strong partnerships that we have established, and in the future, we will be focussing on scaling those programmes and engaging with ICS partners to expand delivery.

During the year, our progress has been as follows:

Healthcare Inequalities and Equity

Infant Mortality

- Made a significant contribution to a system workshop on infant mortality with our partners at the Stoke-on-Trent City Council Public Health Team
- Developed a joint system infant mortality action plan
- Made improvements in data insight and monitoring of risk factors for infant mortality

Outpatient Missed Appointments

- Developed our understanding of inequalities in missed appointments in our respiratory and cardiology specialities
- Undertook initiatives to review invitation and booking systems, location of community-based clinics and transport arrangements
- Reached agreement with Voluntary Action Stoke-on-Trent (VAST) for community engagement to address factors causing missed appointments

Ethnicity and Protected Characteristics

- Undertook the highest level of ethnicity reporting in the West Midlands
- Developed plans to improve data quality on ethnicity and other protected characteristics
- Developed new initiatives to support equitable healthcare and strengthen links with other Equality, Diversity and Inclusion initiatives

Cancer Screening

- Formed a Cancer Screening Access and Uptake collaborative with ICS and regional partners
- Improved data sharing and co-ordination of community engagement for cancer awareness and healthcare literacy

Prevention

Smoking Cessation
- Provided an integrated smoking cessation offer enabling transition from in-hospital initiation to community-based support
- Systematic identification and offering of smoking cessation across inpatient settings

Alcohol Care
- Undertook an evaluation of the Alcohol Care Team
- Contributed to the ICS Alcohol Strategy, ensuring that our priorities were reflected

Flu and Covid-19
- Reviewed our staff and patient vaccination offers to inform plans for the 2025 / 2026 season
- Undertook data analysis and audit of flu admissions to improve vaccination uptake and prevent emergency hospital admissions

Weight Management
- Commenced a Tier 3 weight management pilot in collaboration with ICS partners and the SWITCH Alliance
- Contributed to ICS implementation of Mounjaro in General Practice

Anchor Institution

Local Economy and Workforce Health
- Engaged with procurement to identify our contributions to the local economy
- Undertook data analysis to segment the workforce and understand inequalities in health and wellbeing outcomes

Partnerships and Leadership
- Worked with system partners to provide a contribution to ICS partnership programmes
- Took a leadership role in prevention, alcohol, and early cancer diagnosis

Infrastructure and Capability
- Developed critical infrastructure to support programme delivery, including Population Health Management capability
- Engaged with staff to understand training and education needs related to population health, prevention, and health inequalities

Our Future Priorities

Population health and reducing inequalities are a key part of our overarching strategy and we have refined our plans as we look ahead over the coming years. Through Our Strategy, we have committed to:

1 Tackle inequalities in access, experience and outcomes.

- Consistently collect the data needed to identify and understand health inequalities
- Implement the national 'CORE20PLUS5' framework to reduce health inequalities
- Use population health data to reduce infant mortality, cardiovascular disease, respiratory disease, cancer, liver disease and improve vaccination uptake

2 Empower staff and patients to improve their health and wellbeing.

- Use our 'Making Every Contact Count' approach to introduce prevention as core business; targeted programmes for tobacco, alcohol and obesity
- Establish our hospitals as Smoke Free healthy campuses
- Develop personalised care to prevent complications for those living with major conditions

3 As a major employer, use our resource to improve the overall health of the population.

- Develop our pathways into employment for local people
- Listening to involve communities in decisions and learning from those exposed to social and health inequality
- Make best use of our estate and resources to improve local communities

Customer satisfaction scores

The National Adult Inpatient Survey has been an annual requirement since 2002 by the Care Quality Commission, which looks at the experiences of adults that have been an inpatient with us.

The aim is to obtain detailed patient feedback on the standards of service and care, which can then be used to help set priorities for improvement. The results are also used by the CQC to measure and monitor our performance, and as a source of intelligence to inform their inspection processes.

The latest survey was published in August 2024, and this was based upon the experiences of individuals who were discharged from hospital in November 2023. A summary of this report was considered by our Quality Governance Committee in December 2024 and the full report is available to the public on the CQC website.

The response rate was 37%, and the national average response rate was 42%. Our response rate was a 1% increase on the previous year's survey and there were six questions where we performed statistically significantly better than the previous survey. There were no questions which were statistically significantly worse than the previous year.

Of those responding to the survey:

- 96% were White British, 1% were Asian or Asian British, 2% were Black or Black British, <0.5% were Arab or another ethnic group and 1% were not known
- 49% were male and 51% were female

We have plans in place to continuously improve the experience of all of our patients, aligned with our refreshed quality priorities. This will be monitored through regular reporting to our Quality Governance Committee.

Overview of key findings

Where patient experience is best:

Sleeping: Patients being prevented from sleeping a night due to noise from other patients

Information while on virtual ward: Patients feeling they were given enough information about care and treatment on a virtual ward

Information about virtual wards: Patients getting information about risks and benefits of continuing treatment on virtual wards

Food: Patients being able to get hospital food outside of set mealtimes

Sleeping: Patients not being prevented from sleeping at night

Where patient experience could improve:

Information about medicine to take home: patients being prevented from sleeping a night due to noise from other patients

Explaining change of wards: Patients explained reasons for changing wards during the night in a way they can understand

Talking about worries and fears: Patients feeling able to talk to staff about their worries and fears

Answers from doctors: Patients getting answers to their questions from doctors in a way they can understand

Inclusion in conversation: Patients being included in conversation when nurses are speaking about their care

Environment

Climate change poses a major threat to our health as well as our planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for our patients, our population and the NHS.

Task Force on Climate Related Financial Disclosures

On 1 July 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Social Care Act 2022. The Delivering a Net Zero National Health Service report is statutory guidance. The national target set by NHS England is for all NHS Trusts to achieve Net Zero Carbon (NZC) by 2040 for emissions that we directly control, and 2045 for those that we can influence (such as medicines, supplier emissions and staff / patient travel). These targets are mandated within the NHS Standard Contract and outlined within our own UHNM Green Plan 'Our Net Zero Carbon Vision: Our Sustainable Future, which covers 2022 – 2025.

Governance: Sustainability Performance Oversight

We take our responsibility to address climate change and the transition to net zero seriously. Over the past two years we have increased our reporting of climate and sustainability performance to specifically improve disclosure of how we are progressing delivery of our Green Plan and trajectory towards the Net Zero Carbon targets. The structure of our reporting is as follows:

- Monthly operational Sustainability Working Groups (Energy and Water, Procurement, Travel and Transport and Waste)
- Monthly reporting to the Estates, Facilities and PFI Divisional Board
- Bi-annual performance reporting to the Strategy and Transformation Committee and in turn the Trust Board
- Bi-annual reporting to the Sustainable Development Steering Group

This increased disclosure brings the following benefits to us:

- More effective evaluation of risks to climate change and achievement of net zero targets
- Better assessment and evaluation of strategic opportunities
- Improved visibility of performance and prioritisation of capital resource allocation

In addition to these formal reporting arrangements, our Sustainability Team regularly takes further opportunities to engage with clinicians and senior leadership, such as:

- A 'Low Carbon Care' clinical workshop held in April 2024. Hosted by our clinical lead with the objectives of bringing together clinical teams, raising awareness, securing clinical leadership and the approach to sustainability within clinical settings. Engagement and sharing ideas and experience was positive with the output of a structure 'Low Carbon Care Framework' for use by clinicians across our organisation.
- 2024 National Healthcare Estates and Facilities Day celebrations, with the Sustainability Team hosting a sustainability workshop. This involved staff planting wildflower seeds in biodegradable containers to take home, 'SWITCH' champion recruitment and sharing of information. The even was extremely well attended with senior managers and members of the Board.

Governance: Sustainability Roles and Responsibilities

Our Transformation and Sustainability team is dedicated to specifically assessing and managing sustainability and climate change related issues and risks. The identification, assessment and management of climate related risks is undertaken in line with the process set out within the Annual Governance Statement (page 58). The teams leads the monthly Operational Working Groups and develop initiatives, in partnership with stakeholders, that respond to areas where focus is required to improve sustainability performance and risks. The team provide all required sustainability performance reporting.

Key roles comprise:

- Director of Estates, Facilities and PFI: Executive Director and Net Zero Carbon Board lead
- Speciality Doctor (Emergency Medicine) and Net Zero Carbon Clinical Lead
- Head of Transformation and Sustainability
- Sustainability Manager
- Energy Manager
- Transformation Project Managers

Governance: Staffordshire and Stoke-on-Trent Integrated Care System (ICS)

We recognise that we cannot deliver a net zero health service without support and collaboration across the NHS and with partner organisations. Given the pivotal role of integrated care systems, our Sustainability Team supports the work of the ICS Sustainability Programme Board and delivery of the ICS Green Plan which includes national, regional and local priorities. This work is facilitated through the bi-monthly ICS 'Greener Delivery Group' which has attendance from each partner organisation within the ICS.

Low Carbon Care Framework: Engaging with Our Workforce

Our staff are best placed to make a difference through small changes to their own practice and by influencing and leading others.

Our Sustainability Team has worked with our Net Zero Clinical Lead and Associate Deputy Chief Nurse to develop a staff development and recognition scheme aimed at supporting staff to act on climate change and gain recognition through accreditation and awards. The Low Carbon Care Framework is for clinical and non-clinical teams to work together to make small but impactful changes towards a sustainable organisation.

We are partnering with Students Organising for Sustainability, an independent charity from the National Student Union. Our Low Carbon Care Framework will be managed through its award-winning Green Impact Programme, which offers sustainability learning and awards to embed sustainable practices across organisations.

The Low Carbon Care Framework outlines levels of action, divided into bronze, silver and gold. Addressing these actions improves clinical sustainability and supports the attainment of net zero carbon targets, creating efficiency savings while maintaining or improving patient care.

Keep Warm, Keep Well Community Energy Scheme: Transforming Health and the Environment

Expansion of our award-winning 'Keep Warm, Keep Well' scheme has been recognised as a Staffordshire and Stoke-on-Trent ICS priority. This is due to the marked environmental, social and financial benefits that the scheme delivers.

The scheme comprises a partnership between ourselves and Staffordshire Community Energy (SCE) and Staffordshire fuel poverty 'Beat the Cold'.

The scheme seeks to prevent readmissions of vulnerable patients whose health conditions are at risk of being worsened by living in a cold and damp home. The project, through the performance of solar photovoltaic panels, accumulates and annual 'community fund' which is spent on alleviating fuel poverty in Staffordshire. This is achieved through a unique partnership whereby Staffordshire charity 'Beat the Cold' delivers an intervention to vulnerable patients.

With the energy market experiencing unprecedented cost rises. The scheme is more important than ever. Stoke-on-Trent has been identified as having amongst the highest levels of fuel poverty in the UK and fuel poverty is regarded as a driver of health and social care demand.

We are leading a proposed expansion to the scheme by identifying vacant roof space across the ICS 'one public estate'. The proposal incorporates using the One Health and Care (OHC) digital shared care record to identify patients most at risk from health deterioration due to fuel poverty. Through delivering a targeted, patient centred referral pathway, more impactful outcomes will be achieved.

Achieving Net Zero Carbon: Investment

We recognise that the net zero agenda must be prioritised and resourced if it is to succeed. In addition, efforts to mitigate and adapt to climate change also produce opportunities such as resource efficiency and cost savings. In 2024 / 25, significant investment was put into reducing cost and carbon emissions related to energy use.

Sustainability and Net Zero Capital Group

During 2024 / 25, the Sustainability and Net Zero Capital Group was allocated £100k by our Capital Investment Group. The funding was invested in the following energy saving schemes:

- £25k spent on installing loft insultation in 'A Block', one of our 19th century listed buildings; challenging but essential for ensuring such buildings can be used as we strive to reduce energy consumption and carbon emissions
- £75k to install solar photovoltaic panels on the roof of the main building at County Hospital. These will provide renewable electricity to help to power the new breast care unit, reducing the environmental impact of this development

These investments will reduce energy costs by around £15k per year and will save around 340 tonnes of carbon dioxide emissions through the lifetime of the equipment.

Public Sector Decarbonisation Scheme

2024 / 25 saw the second and final phase of the Public Sector Decarbonisation Scheme (PSDS) investment at Royal Stoke. £3m of investment was put into Air Source Heat Pumps, LED lighting and solar panels across various buildings, with 80% of this funding awarded from the Department for Energy Security and Net Zero PSDS grant funding. This is part of a £5.4m investment to reduce carbon dioxide emissions from our buildings. The overall impact is:

- 941 tonnes of annual carbon dioxide equivalent emissions
- Air quality improvements
- Replacement of end-of-life boilers (backlog improvement)
- Major sit risks removed (steam distribution)

Energy Procurement Partnership

Our Sustainability Team worked in partnership with Stoke-on-Trent City Council to procure the 2024 / 25 supply contracts for gas and electricity. Careful management, local collaboration and a successful strategy enabled a potential £10m cost pressure to be reduced to around £3m and delivered some of the lowest prices in the country.

This successful procurement partnership has been extended for another two years, with the goal of continuing to deliver great value. The partnership paves the way for future developments to deliver locally produced sustainable energy to our sites.

Reducing Emissions from Anaesthetic Gases

Across the NHS, anaesthetic gases are commonly used as part of everyday surgeries. These gases alone, along with pain management gases like nitrous oxide, are responsible for 2% of the NHS carbon footprint.

- **Nitrous Oxide:** we have been successful in securing an NHS England grant to switch to portable cylinders for pure nitrous oxide delivery and decommission all six of our piped outlets. This switch will save an estimated 350 tonnes equivalent emissions per year.
- **Penthrox:** this is an alternative to Entonox which has a carbon impact of 117.7 times less. It was rolled out to both Emergency Departments at the end of 2024 and has seen significant patient benefits such as reduced waiting and procedure time. Our audit findings showed a 78% success rate of the initial trial.

Sustainable Switches: Eco Box

Our clinical and procurement colleagues have continued to make every effort to reduce reliance on single use plastic products and engage with suppliers to reduce plastic and packaging. An example of this is the creation of the Eco Box initiative.

Our Procurement Team has worked with the supplier of anti-embolism stockings to reduce waste from the production and supply of their product. Together they reviewed the product and packaging to look at how it can be made more sustainable and developed the Eco Box. Firstly, the dye was removed from the stockings, saving energy, water and harmful chemicals. The product originally came as six individually packed items. The plastic packaging was removed ad the product now comes in a multipack cardboard box with zero plastic.

The Eco Box was trialled on our wards and our nurses were happy, however, patients preferred having their own individually wrapped take home pack, therefore the packaging was adapted so that the stockings were provided in individually wrapped cardboard packages. The projected savings for the Eco Box is 7.8 tonnes of plastic and 10 tonnes of cardboard per year.

Greener Travel

We recognise that active travel does not just have environmental benefits, exercise and being outside in nature has many mental and physical health benefits as well.

Cycle to Work Scheme
In April and June 2024, we held a series of highly successful Cycling Roadshow events for staff and members of the public. They were supported by Staffordshire Police, who provided free bike marking and security advice.

Our salary sacrifice scheme provide was also present to showcase the range of bikes and accessories available through the scheme and provide simple bike maintenance.

The event generated a lot of enthusiasm amongst staff and led to an increase in orders. 35 bikes were ordered through the scheme during 2024/2025.

Electric Vehicle Charging Points

We saved 22, 066 kilogrammes of emissions in 2024 / 25 by travelling to work in an electric vehicle. Data from our car parking operator Apcoa shows that 22, 066 kilogrammes of carbon equivalent emissions have been avoided this year as a result of staff travelling to work in an electric vehicle. This is just the tip of the iceberg – many journeys are made daily by staff travelling to work in electric vehicles without the car being plugged into a charging point, therefore much more emissions are being saved that are being captured in this data. We have a total of 48 electric vehicle charging points across both of our sites, and further charging points are being planned for next year.

Our Net Zero Carbon Vision: Our Sustainable Future

We have made significant progress in delivering our Green Plan during the year. This is testament to our commitment, and the collective support and engagement of our teams.

Our Green Plan is due to be refreshed during 2025 / 26, to take forward our strategy and plans for the next three financial years. This time there is a much greater focus on clinical transformation and staff development, with training and digital transformation as key enablers.

The Low Carbon Care Framework will be pivotal to engaging a wider range of staff in implementing low carbon, low waste models of care which will support patients to get well and stay well.

A summary of the priorities set out within our Green Plan is shown here.

Emergency Preparedness, Resilience and Response

We are required to respond to business continuity, critical and major incidents arising from a variety of causes. We produce and maintain comprehensive plans to ensure that critical functions are provided and to a pre-determined level, during an emergency and this is referred to within the NHS as Emergency Preparedness, Resilience and Response (EPRR).

Whether that be a failure of utilities or information technology, incidents caused by capacity issues within the wider health care system or incidents generating a significant number of casualties or patients, such as major transport incidents, fires or terrorism, or new and emerging diseases such as Covid-19. As such, we are a 'Category 1' responder under the Civil Contingencies Act 2004 as well as having specified requirements under the Health and Social Care Act 2022 and the NHS England EPRR Framework 2023.

Our responsibilities involve:

- Assessing the risk of emergencies occurring
- Putting in place emergency plans
- Putting in place business continuity management arrangements
- Putting in place arrangements to warn, inform and advise the public in the event of an emergency
- Sharing information with other local responders to enhance co-ordination
- Co-operating with other local responders to enhance co-ordination and efficiency

To measure compliance with these requirements, NHS England undertakes an EPRR Core Standards Assurance process each year, and we must declare a level of compliance against the following ratings and criteria:

Full Compliance	Against 100% of the relevant EPRR Core Standards (62/62)
Substantial Compliance	Fully compliant against 89 – 99% of the relevant EPRR Core Standards (55 – 61/62)
Partial Compliance	Fully compliant against 77 – 88% of the relevant EPRR Core Standards (47 – 54/62)
Non-Compliance	Fully compliant up to 76% of the relevant EPRR Core Standards (less than 47/62)

During 2024 / 25, we declared 'partial compliance' against the Core Standards, and this was independently validated by our ICB and NHS England.

Training and Testing

A comprehensive programme of training and exercising has been undertaken, which has been aligned to NHS England EPRR Minimum Occupational Standards (MOS) including provision of EPRR training to our strategic and tactical on-call managers, and a full range of business continuity impact analysis training (20 sessions delivered to 107 staff). In addition, specialist legal training has been provided, delivered by a solicitor advocate specialising in major incidents and Public Inquiries and internally a cadre of loggists have been trained. Several members of staff have also attended a multiagency training day, presented by the national Chemical, Biological, Radiological or Nuclear (CBRN) centre.

Our training exercising programme has included testing the responses to a baby abduction, large scale waste fires, biological counter-measures, pandemic, burns and contaminated illicit substances in the community, with further exercises planned in the coming year. Our business continuity plan exercising programme coincides with Business Continuity Awareness Week and will include series of exercises testing CBRN countermeasures as well as a live hazmat exercise in our Emergency Department.

Incidents During 2024 / 25

We activated our major incident plan on one occasion in response to a significant chlorine leak and we have responded to multiple other incidents including numerous critical incidents due to severe capacity issues, a heating failure in the middle of a cold weather spell, severe snow, including activation of our 4x4 service, IT outages (planned and unplanned), aseptic isolator failure, mortuary contingency arrangements, fire alarm activations and floods in clinical areas, significant public disorder following the Southport murders and storm Darragh (severe winds).

Speaking Up

We encourage and welcome speaking up and we are committed to listening to those who do. Our staff understand that by speaking up they are playing a vital role in helping us to continuously improve.

We actively encourage year-on-year our staff to speak up if they have concerns, regardless of where they work and we make every effort to ensure that staff who are harder to reach, including those with protected characteristics, feel able and safe to do so.

Our Board has a nominated Non-Executive Director for Speaking Up, and our Freedom to Speak Up Guardian provides a comprehensive report to the People, Culture and Inclusion Committee and a summary to the Trust Board bi-annually. Whilst remaining confidential, our report provides trend analysis as well as an overview of the work we have undertaken to develop the service in line with national and local priorities.

We have a Speaking Up Policy which is in line with the national policy and is available on our website and during the year, we have continued to implement the recommendations of our Internal Auditors review, to develop and continously improve our service.

During 2024 / 25 we have invested in our Speaking Up service and were successful in recruiting additional resource into the team. We actively promote speaking up throughout the organisation and have regular communications campaigns to support this, including National Speaking Up Month, which takes place every October. We are pleased to have been recognised for the work we have undertaken to promote speaking up and our Freedom to Speak Up Guardian was invited to share this at a national webinar in July 2024.

A total of 275 concerns were raised through the Freedom to Speak Up Guardian during 2024 / 25 in comparison to 215 during 2023 / 24.

The 2024 National Staff Survey findings have demonstrated a year-on-year improvement over the past three years for each of the four questions relating to Speaking Up.

Any important events since year end

There were no events after the reporting period that require disclosure.

Dr Simon Constable
Chief Executive
25 June 2025

3 Accountability Report

Directors report

Between 1 April 2024 and 31 March 2025, there were 14 meetings of the Board. In compliance with the requirements of the Health and Social Care Act 2012, the Board holds part of its meetings in public, followed by a private business session.

Meetings of the Board were held were held monthly, up to November 2024 when meetings held in public switched to bi-monthly. Separate board development sessions were held seven times.

Board meetings are facilitated as hybrid meetings, whereby members and guests day-to-day attend in person or via video-conferencing utilising Microsoft Teams software.

The Board has overall responsibility for the strategic direction of the Trust. Its role is to set strategy, lead the organisation, oversee operations and be accountable to stakeholders in an open and effective manner. It is responsible for ensuring that the day-to-day operation is as effective, economical, and efficient as possible and that all areas of risk are managed appropriately.

As well as holding the organisation to account for delivery of our strategy, the Board seeks assurance that the systems of control are robust and reliable. Corporate Governance is the system by which board led organisations are directed and controlled with non-executive directors being separate from day-to-day operational management, which is the responsibility of the executive directors and management structure they lead.

A detailed Schedule of Reservation and Delegation is in place, and it sets out explicitly those decision which are reserved for the Board, those that may be determined by standing committees and those that are delegated to managers.

We have an established governance structure with the following committees, each chaired by a non-executive director, with the exception of the Nominations and Remuneration Committee and Corporate Trustee, which are chaired by the Trust Chair.

The committees were established to provide assurance to the Board:

- Nominations and Remuneration Committee
- Audit Committee
- Corporate Trustee
- Quality Governance Committee
- Performance and Finance Committee
- People, Culture and Inclusion Committee
- Strategy & Transformation Committee

The balance, completeness and appropriateness of the members of the Board is reviewed periodically and when vacancies arise among executive or non-executive directors.

Chair and CEO

David Wakefield
Chair

David Wakefield was appointed as Chair for an initial four-year term on 3 April 2018. David is a qualified accountant and previously held several senior executive posts, including Commercial Finance Director for Royal Mail.

He has also held a number of other non-executive directorships, including the Chair at other NHS trusts, including Bolton NHS Foundation Trust prior to joining us in 2018.

At UHNM, David is Chair of the:

- Trust Board
- Nominations and Remuneration Committee
- Corporate Trustee for UHNM Charity

Dr Simon Constable
Chief Executive

Simon was appointed Chief Executive in September 2024. A consultant physician and clinical pharmacologist by background, Simon joined us from Warrington and Halton NHS Foundation Trust (WHH) where he had been Chief Executive since November 2019. Prior to that he held the position of Executive Medical Director at WHH since February 2015.

Prior to taking up the post at WHH, he worked with the NHS Leadership Academy, Harvard University and the Institute for Healthcare Improvement on clinical leadership, employee engagement and transformational change within the NHS.

Simon has also held several clinical leadership roles at the Royal Liverpool and Broadgreen University Hospitals and is a visiting professor at the University of Chester. He studied medicine at Guy's and St Thomas' Hospitals in London, before undertaking postgraduate training in the UK and New Zealand.

At UHNM, Simon is a member of the Charity Committee and Risk Management Oversight Committee and attends the Nomination and Remuneration Committee.

Non-Executive Directors

Professor Gary Crowe
Vice Chair

Gary is a university professor of Innovation Leadership attending at Keele Management School and Loughborough University. He previously held senior commercial positions in strategy, business transformation and risk & financial management as a director and management consultant in the financial services sector. Gary has served as an independent Non-Executive Director with another NHS Trust since 2015 and is a qualified Chartered Banker and Fellow of a number of professional organisations and learned societies.

Gary became Chair of Performance & Finance Committee in June 2024, is Chair of People, Culture & Inclusion Committee and was chair of Audit Committee until June 2024. Gary is also a member of the Strategy & Transformation and Nomination & Remuneration Committees.

Louise Bainbridge

Louise joined UHNM in November 2024 following retirement from her role as CEO at Nottingham CityCare, a community interest company providing NHS and Local Authority community services. Louise is an experienced finance professional, previously holding senior finance positions in NHS commissioning organisations. She is currently a trustee for 2 East Midlands based charities.

Louise is a member of the Performance & Finance, Strategy & Transformation and Charity Committees.

Tanya Bowen

Tanya is a data and digital specialist from the retail technology sector, having been on tech corporate boards driving areas of innovation and governance. She has worked in strategy and execution for both retailers and software providers and her main focus is on new technologies that improve customer experience and employee engagement, and on open systems that allow greater collaboration between partners.

Tanya is Chair of the Strategy & Transformation and Charity Committees and is also a member of the Performance & Finance and Audit Committees.

Non-Executive Directors

Professor Katie Maddock

Katie has been Head of School at the School of Pharmacy and Bioengineering, Keele University, since 2018 and a Reader in Clinical Pharmacy since 2016, having previously been the MPharm Course Director and Associate Dean for Education for the Faculty of Medicine and Health Sciences. Her research interests lie within the field of pharmacy education, particularly technology enhanced learning, augmented reality simulation, and interprofessional education.

Prior to her career in academia, Katie was a hospital pharmacist working extensively across the Black Country.

Katie is a member of the People, Culture and Inclusion and Quality Governance Committees.

Margaret Monckton

Margaret joined UHNM in October 2024 and is a qualified chartered accountant with a breadth of experience across the private and public sector. She is currently Chief Finance Officer at Great Ormond Street Hospital and before that, she spent 8 years as Chief Financial Officer at the University of Nottingham. As well as finance she has led teams across all of the resource areas including estates and information technology. She has been an executive leader for the past 15 years as well a variety of non-executive roles. In addition to being a Non-Executive Director at UHNM, she is also Chair of the Nova Education Trust.

Margaret became Chair of Audit Committee in October 2024 and is a member of the Performance & Finance and Nomination & Remuneration Committees.

Professor Sunita Toor

Sunita is Professor of Human Rights and Gender Justice Practice at the world leading Helena Kennedy Centre for International Justice, Sheffield Hallam University. She is an award-winning academic, activist and advocate who is passionate about combatting gender-based violence, advancing women and girls rights across the world and shaping justice sector reform and architecture to promote human rights for all. She is a cutting-edge thought leader who champions rights, equality, diversity, and inclusion.

Sunita is Chair of the Risk Management Oversight Committee and is a member of the People, Culture & Inclusion, Quality Governance and Strategy & Transformation Committees.

Associate Non-executive Directors

Professor Andrew Hassell
Senior Independent Director

Until his retirement from clinical practice in September 2021, Andrew was a consultant rheumatologist at the Haywood Hospital and Head of the School of Medicine at Keele University.

He held a national role as curriculum lead for the UK Specialist Advisory Committee for Rheumatology and spent five years as Chair of the Education sub-committee of the Arthritis Research Campaign.

Locally, Andrew was Chair of the Haywood Foundation for 15 years focussing on local rheumatology research and development. He is married to a retired GP and has four children and four grandchildren. Since retirement he has taken up the piano, ballroom dancing and rowing.

Andrew joined another NHS Trust as Non-executive Director in 2024.

Andrew is Chair of the Quality Governance Committee and is also a member of the Nomination & Remuneration, Risk Management Oversight and Audit Committees.

Wendy Nicholson MBE

Wendy joined UHNM in October 2024 and is a registered nurse (adult and child) and educator, who previously held the position as Deputy Chief Nurse and Head of the WHO Collaborating Centre for public health nurses and midwives within the Office of Health Improvement and Disparities at the Department of Health and Social Care and Public Health England. Wendy has led numerous national programmes and policy developments including the modernisation of the Healthy Child Programme, the implementation of one of the first Sure Start programmes in England and the Teenage Pregnancy Programme for the North-West.

Wendy has worked with Ministers, across government departments, NHS England, regulators and social care and her experience spans local, regional, national, and international working. She has also led research and innovation to improve health outcomes, service improvements and to tackle inequalities. Wendy is an Executive Coach and Mentor, and she was a visiting lecturer at Keele University focussing on leadership and political awareness. Wendy has served as a Non-Executive Director with another NHS Trust since 2024 and she also has volunteered as an independent visitor for looked after children and been a member of the BBC Children in Need Grants Committee.

Wendy became a member of the Quality Governance and People, Culture & Inclusion Committees in October 2024 and is also a member of the Risk Management Oversight Committee.

Executive Directors (voting)

Dr Matthew Lewis
Chief Medical Officer

Matthew joined us following a position at Wallsall Healthcare NHS Trust as Executive Medical Director, as well as being a Consultant in Gastroenterology since 2018.

Prior to that he worked as a consultant at Sandwell and West Birmingham between 2002 to 2018 and during that time was the Group Director for Medicine and Emergency Care at the same Trust. Among his broader regional roles, he was the Black Country and West Birmingham ICS Acute Trust Lead for Cancer, and the ICS Community Diagnostic Hubs (CDH) Clinical Lead.

Matthew was a member of the Quality Governance and Strategy & Transformation Committees.

Ann-Marie Riley
Chief Nursing Officer

Ann-Marie became a registered nurse in the early 1990's and has a clinical background in critical care nursing. She has held a number of nursing leadership roles, including Deputy Chief Nurse at Nottingham University Hospitals where she supported the organisation to attain both internationally accredited Pathway to Excellence and Magnet Designations, and Director of Nursing at Walsall Healthcare NHS Trust.

She is passionate about creating positive practice environments, supported by collective leadership approaches and patient co-design, to positively impact on patient outcomes, patient experience and staff experience.

Ann-Marie is a member of the Quality Governance, Strategy & Transformation, People, Culture & Inclusion and Risk Management Oversight Committees.

Katy Thorpe
Chief Operating Officer

Katy was appointed as Chief Operating Officer in September 2024. She has nearly two decades of experience in healthcare, having held significant roles in various NHS trusts. She has a proven record of leading and transforming services, with key skills in leadership, service improvement and emergency preparedness.

She is committed to personal and professional development and completed the Oxford Executive Leadership Programme and the NHS Leadership Academy's Nye Bevan programme and holds and MSc in Leadership for Health Service Improvement from Birmingham University. Throughout her career Katy has achieved significant milestones including leading UHNM through elective and non-elective recovery, service reconfiguration and Covid-19 response.

Katy became member of the Performance & Finance Committee in September 2024.

Mark Oldham
Chief Finance Officer

Mark is an experienced Director of Finance who Joined the Trust in June 2019 having moved from Mid Cheshire Hospitals NHS Foundation Trust where he served 10 years as their Finance Director.

Originally joining the NHS from Local Government in 1990 Mark has 30 over years' experience in both the acute and community sector in a wide range of finance roles.

Mark is a member of the Performance & Finance Committee and also attends the Audit Committee.

Executive Directors (non-voting)

Helen Ashley
Deputy Chief Executive & Director of Strategy

Helen joined the Trust in 2016 following nearly seven years as Chief Executive at neighbouring Burton Hospitals NHS Foundation Trust. Helen has a strong finance background and is leading on the transformational aspects of finances at UHNM.

Helen is a member of the Performance & Finance and Strategy & Transformation Committees.

Claire Cotton
Director of Governance

Claire has 24 years NHS experience, starting out administration and progressing through her career in a range of governance, assurance and risk management related roles. Claire has driven many improvements within UHNM and is passionate about ensuring that governance is welcomed as an enabler and not a barrier, through continuous improvement and an agile and responsive approach. Using her coaching skills and engaging style of teaching, she provides leadership development up to Board level and as a risk management practitioner, has led the organisation through significant improvements in risk management policy and practice. Examples of her work have been held up as national best practice, including her more recent work with the Integrated Care System in the development of a system wide Board Assurance Framework. Her portfolio beyond Corporate Governance extends to Legal Services, Health and Safety and Speaking Up.

Claire is a member of all Trust Committees.

Amy Freeman
Chief Digital Information Officer

Amy has worked in the field of information technology (IT) support and digital since 1998, she joined the NHS in 2002. She has held senior IT and digital leadership roles at NHS Connecting for Health (now NHS Digital), NHS Commissioning Board (now NHS England), Staffordshire and Stoke-on-Trent Partnership NHS Trust (now Midlands Partnership NHS Foundation Trust) and Mid Cheshire Hospitals NHS Foundation Trust.

Amy moved to work for NHS provider organisations to be closer to frontline care (community and acute) to help make a difference to the safety and quality of care provided to patients. This has included the delivery of a range of clinical systems most notably electronic patient record systems, patient portals and a virtual clinic solutions.

Amy is a member of the Risk Management Oversight Committee.

Executive Directors (non-voting)

Jane Haire
Chief People Officer

Jane has more than 30 years' experience in the NHS, starting out in administration and as a people professional since 1998. She has worked in both Staffordshire and Cheshire health and social care systems including Cheshire and Merseyside Strategic Health Authority, East Cheshire NHS Trust, Cheshire HR Services, Staffordshire and Stoke on Trent Partnership Trust. As UHNM Deputy Chief People Officer she had led on strategic and operational HR, transforming people practices, workforce development, workforce planning and playing a lead role in the workforce response to the Covid-19 pandemic.

Jane has an MSc from Manchester Business School in Leadership and is a Fellow of the Chartered Institute of Personnel and Development.

Jane is a member of the People, Culture & Inclusion and Risk Management Oversight Committees and attends Nomination and Remuneration Committee.

Lisa Thomson
Director of Communications & Charity

Lisa is a highly experienced communications, strategy and corporate affairs director, with a diverse background working in both highly regulated private and public sectors. She has worked as an executive director in the NHS for over 20 years in acute trusts, community services and at a national level working with Lord Darzi on High Quality Care for All. Passionate about communications, Lisa has led on a wide range of areas including patient experience, outpatient and community services, and fundraising.

Lisa is a member of the People, Culture & Inclusion, Risk Management Oversight and Charity Committees.

Lorraine Whitehead
Director of Estates, Facilities & PFI

Lorraine has worked for the Trust for many years commencing as an admin trainee in Trust Headquarters in 1985. Exposure to the executive agenda gave her an appetite to pursue senior management in the NHS as a career path. Lorraine subsequently worked in various managerial roles at all levels across the organisation and has a MSc in Facilities Management from Reading University.

Lorraine was appointed to the Director role in 2017 and is passionate about the development of Estates, Facilities and PFI services recognising the vital role these services play in supporting and enhancing patient care and staff experience at UHNM.

Declarations of Interest

Board Member	Declaration
David Wakefield Chair	Director of Pewterspear Green Trust (charitable trust) (2022 to present)
Simon Constable Chief Executive	Visiting Professor University of Chester (2015 onwards) | General Medical Council Responsible Officer, Designated Body is Dr Eileen Marks and Liverpool University Hospitals NHS Foundation Trust (2019 onwards)
Gary Crowe Vice Chair / Non-Executive Director	Deputy Chair and Non-Executive Director (paid) The Dudley Group of Hospitals NHS Foundation Trust | Independent Member and Non-Executive Director (paid) Human Tissue Authority | Independent Governor (unpaid) Reaseheath College and University Centre
Louise Bainbridge Non-Executive Director	Charity Trustee Active Partners Trust Nottingham and Derbyshire (2020 to present) | Charity Trustee Nottingham CityCare Community Charity (June 2024 to present)
Tanya Bowen Non-Executive Director	Nothing to declare
Andrew Hassell Associate Non-Executive Director	Non-Executive Director Countess of Chester NHS Foundation Trust (2024 to 2027)
Katie Maddock Non-Executive Director	Chair of Health Education England Advancing Clinical Practice Accreditation Panel (March 2021 to present) | Employee of Keele University (2007 to present)
Margaret Monkton Non-Executive Director	Chief Finance Officer Great Ormand Street Hospital (2025 to present) | husband is Director at Nottingham University Hospitals (loyalty interest)
Wendy Nicholson Non-Executive Director	Non-Executive Director Shrewsbury and Telford NHS Trust (2024 to 2026)
Sunita Toor Non-Executive Director	Associate Non-Executive Director Nottingham University Hospitals NHS Trust (2023 to present) | Toor's Properties Ltd (director, ownership and shareholdings) (2014 to present)

Board Member	Declaration
Helen Ashley Deputy Chief Executive / Director of Strategy	Member of Derbyshire Community Health Services Foundation Trust (2011 to present)
Matthew Lewis Chief Medical Officer	Nothing to declare.
Ann-Marie Riley Chief Nursing Officer	Nothing to declare.
Katy Thorpe Chief Operating Officer	Husband was Managing Partner and Director at Clive Henry Group (loyalty interest) (2024)
Mark Oldham Chief Finance Officer	Trustee of North Staffordshire Postgraduate Education Centre (2025 to present)
Claire Cotton Director of Governance	Two family members employed as senior nurses within UHNM (loyalty interest)
Amy Freeman Chief Digital Information Officer	Bridge Farm Court Management Company (2013 to present)
Jane Haire Chief People Officer	Nothing to declare.
Lisa Thomson Director of Communications	Nothing to declare.
Lorraine Whitehead Director of Estates, Facilities & PFI	Member of Orchard Community Trust, Schools Academy Trust (2022 to present) | son employed as Mechanical and Engineering Apprentice at UHNM (loyalty interest) (2021 to 2026)

The work of the Audit Committee

The Audit Committee is required to report annually to the Board outlining the work it has undertaken during the year and where necessary, highlighting any areas of concern.

The Audit Committee is responsible on behalf of the Board for independently reviewing the systems of integrated governance, risk management, assurance and internal control. The committee's activities cover the whole of our governance agenda, not just the finances and is in support of the achievement of our strategic priorities.

During the reporting period the committee has been composed of at least four non-executive directors, with a quorum of two. During the year, the committee met five times, with an additional extraordinary meeting held in March 2025. At the end of the financial year, Margaret Monkton held the position of Chair of the Audit Committee. However, due to some turnover amongst non-executive directors during the year, Gary Crowe chaired his final meeting in May 2024, and Alison Rodwell chaired the meetings in June, August and October before she left the organisation and handed the position over to Margaret.

The required relevant and recent financial experience and background necessary for membership of the Audit Committee is met through its membership. The Chair of the Trust is not a member of the Audit Committee, in line with best practice. In addition to those named as Chair of the Committee, members during the year were Tanya Bowen, Andrew Hassell and Leigh Griffin (who completed his final term of office during the year with his last meeting being June 2024).

Regular attendees at the committee meetings were our external auditors, Grant Thornton (External Auditors), our internal auditors and counter fraud service from RSM, the Chief Finance Officer and the Director of Governance.

In year, addition to the Board Assurance Framework, the significant issues that the committee considered in relation to the financial statements, operations and compliance were addressed through inclusion in the Internal Audit Programme and assurance sought for each element. Their findings were as follows:

- **Reasonable Assurance** for nurse e-rostering, medical staff rostering, key financial controls and clinical effectiveness.
- **Partial Assurance** for ambulance handover data, planned care framework and transformation and major change project management.
- There were no areas reported as providing limited or no assurance.

Each committee of the Board, including the Audit Committee undertakes an annual review which provides an opportunity to reflect on its performance and effectiveness, to prepare a business cycle for the forthcoming year and to propose any revisions to its Terms of Reference and Membership. The Terms of Reference for the Audit Committee are aligned with the NHS Audit Committee Handbook.

In the annual review of the Audit Committee covering its activities undertaken during 2024 / 25, key conclusions were:

- There were no specific actions required following the members self-assessment
- The Committee determined that it had been effective in the discharge of its duties although work would be undertaken to ensure that executive directors are invited to join meetings where items relevant to their responsibility are being considered
- No changes to the Terms of Reference were proposed

The Committee has an annual business cycle which its aligned to its Terms of Reference, covering a range of reports produced internally and by our internal and external auditors. The annual review identified that 87% of items identified within the business cycle were reported as planned although some were delayed by one month. Work undertaken during the year included:

- Reviewed and approved relevant disclosure statements including the Annual Governance Statement (AGS) as part of the Annual Report and Head of Internal Audit Opinion Reviewed the Board Assurance Framework and the risk management system
- Received regular updates in relation to policies, use of the Trust Seal, declarations of interest, gifts, hospitality and sponsorship
- Approved policies for Anti-bribery and fraud, Standards of Business Conduct and Policy Development

- Reviewed and approved the internal audit plan, considered major findings and monitored progress against recommendations
- Reviewed and agreed the external audit plan and fees, considered external audit reports including signing of the letter of representation and the annual audit letter
- Reviewed and approved the Counter Fraud Plan and the considered the outcomes of their work
- Approved the Clinical Audit Programme
- Reviewed the annual financial statements and considered them to be prepared on a going concern basis as well as noting the annual accounts timetable
- Regularly reviewed losses and special payments, Single Tender Waivers and Standing Financial Instruction breaches
- Approved the Standing Financial Instructions

In November 2022, the Audit Committee undertook an assessment of the independence and effectiveness of the external audit process as part of its approach to tendering. At that point, the Committee approved a proposal to appoint Grant Thornton LLP for the provision of External Audit services for the financial years 2022/23 to 2024/25, at which point a retendering exercise will be undertaken.

Code of Governance

The Code of Governance describes numerous requirements which are to be disclosed within our annual report. We have assessed our position against the Code of Governance on a comply or explain basis.

Comply or Explain Assessment

In our 2023 / 24 Annual Report, we described four requirements which we had determined as requiring an explanation. Of those four requirements:

- Two have been resolved during 2024 / 25 as the Vice Chair is no longer the Chair of the Audit Committee
- Two remain requiring explanation as we do not have plans to introduce a policy for performance related pay and the structure of remuneration for our first level of senior management is not considered by the Nominations and Remuneration Committee as their Terms and Conditions are in line with Agenda for Change.

Disclosure Requirements

Disclosure requirements stipulated within the Code of Governance are addressed throughout this report. For ease of identification, these can be cross referenced as follows:

- How opportunities and risks to future sustainability have been considered and addressed and how its ongoing governance is contributing to the delivery of our strategy (pages 14, 58)
- The Board's activities and any action taken in relation to culture, and our approach to investing in, rewarding and promoting the wellbeing of our workforce (pages 6, 77)
- How the interests of stakeholders, including system and place-based partners have been considered in our discussions and decision making, and our key partnerships for collaboration with other providers (pages 4, 8, 12, 13)
- Each non-executive director we consider to be independent (pages 45, 46, 47, 48))
- The number of times the board and its committees have met, and individual director attendance (pages 44 to 51))
- A description of each directors' skills, expertise and experience along with a statement about the board's balance, completeness and appropriateness to our requirements (pages 44 – 51)
- The external reviewer of the Well Led Framework and a statement made about any connection with the Trust or individual directors (page 64)
- The work of the Nominations and Remuneration Committee (page 66)
- Significant issues relating to the financial statements, an explanation of how the audit committee has assessed the independence of external audit process and the approach to appointment reappointment of the external auditor, length of tenure and current audit firm, when a tender was last conducted and advance notice of any retendering plans (page 55)
- Directors' responsibility for preparing the annual report and accounts and that they consider taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess our performance, business model and strategy (page 44)
- A robust assessment of emerging and principal risks (pages 14, 58)
- Internal control through the Annual Governance Statement (page 57)
- That the Board has considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties to going concern (page 15)
- A statement about any director released to serve elsewhere, a statement as to whether or not they will retain such earnings (page 52)

Statement of Responsibilities

Directors have confirmed that they know of no information which would be relevant to the auditors for the purpose of their audit report and of which the auditors are not aware. Directors have taken all the steps they ought to have taken to make themselves aware of any such information and to establish that the authors are aware of it.

Statement of Accountable Officers Responsibilities

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out within the NHS Trust Accountable Officer Memorandum. These including ensuring that:

- There are effective management systems in place to safeguard public funds and assist in the implementation of corporate governance
- Value for money is achieved from the resources available to the Trust
- The expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- Effective and sound financial management systems are in place and
- Annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year

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

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

Simon Constable
Chief Executive
25 June 2025

Statement of Director's Responsibilities in Respect of the Accounts

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts. The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy
By order of the Board.

Simon Constable
Chief Executive
25 June 2025

Mark Oldham
Chief Finance Officer
25 June 2025

Annual Governance Statement (AGS)

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that our Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the University Hospitals of North Midlands NHS Trust, to evaluate the likelihood of those risks being realised and the impact should the be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place at the University Hospitals of North Midlands NHS Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

As Accounting Officer, supported by the Board, I have responsibility for the overall direction of our risk management systems and processes. I have delegated responsibility to the Director of Governance for the development, review and monitoring compliance of our Risk Management Policy, provision of education, training and expertise and facilitation of risk reporting.

Committees of the Board have specific responsibility for oversight of risk:

- Quality Governance Committee oversees all aspects of risk relating to quality and clinical risk management
- Performance and Finance Committee oversees all risk relating to our financial position and operational delivery
- People, Culture and Inclusion Committee oversees all risk relating to our workforce including culture
- Strategy and Transformation Committee oversees all risk relating to our estate, digital services, sustainability and population health

This is done through a range of reporting including the risk register and Board Assurance Framework.

The Audit Committee oversees the entire risk management system. It commissions an annual audit of the Board Assurance Framework and risk register, as part of the internal audit plan, to satisfy itself that the system of internal control is effective. It examines the assurances on the effectiveness of controls for all strategic risks received from the chairs of committees, and from internal and external auditors.

During 2024 / 25 the Board Assurance Framework was included in the Internal Audit Plan, received a Significant Assurance rating.

The Risk and Control Framework

Our Risk Management Policy provides a framework for managing risk throughout the organisation. This includes the way that risks are identified, evaluated, transferred and controlled. It describes the process for managing risks, the roles and responsibilities of the Board and its committees and that of all staff and provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of our clinical, managerial and financial processes.

Identification of risk is usually done in one of two ways:

- Proactive risk identification focusses on our objectives and the consideration of any risks which may threaten their achievement – this approach is used when developing the Board Assurance Framework
- Reactive risk identification is undertaken following an adverse event or ongoing issue which presents a further risk for the future – this approach is used within our risk register

Evaluation of risk is done using our Risk Scoring Matrix. We use a national tool, which we have modified to include data security risk. Risk is evaluated based on a combination of the likelihood of the risk occurring and the impact or consequence.

Transfer of risk is a type of risk control and is defined as when risk is passed over to a third party, who bears or shares the impact.

Other types of **risk control** include *termination* of risk, where it is completely eliminated, *treatment* of risk where it is either contained or a contingent is introduced or *tolerated*, where a risk is accepted subject to monitoring**.**

Our policy also includes a Risk Appetite Statement, which we use to determine target risk scores and the level of risk reduction by introducing additional controls. We have reviewed the Risk Appetite Statement during the year and in line with best practice.

Risks are mapped to the Board Assurance Framework and are reviewed through our governance arrangements within our directorates, divisions, through to our Executive Groups, Committees and the Board.

We use a simple 'alarm bell' approach in our reporting, to draw attention to any risks that may not have been reviewed in line with our policy or may require further action to ensure that risks are being sufficiently managed.

Quality Governance Arrangements

Our quality governance arrangements are led jointly by the Chief Nurse and Chief Medical Officer. This forms part of our broader corporate governance structure from 'ward to board' and includes:

- Quality Governance Committee
- Executive Quality & Safety Oversight Group
- Executive Clinical Effectiveness Group
- Specialist Quality Groups
- Divisional and Directorate Quality Governance Groups

Assurance is obtained routinely throughout this structure on compliance with our CQC registration requirements, including a regular review of our action plan in response to inspection and the findings of our internal ward accreditation programme 'Care Excellence Framework'.

The Care Excellence Framework (CEF) process involves a programme of assurance visits to each of our wards and departments using a tool which is based upon CQC key lines of enquiry. It provides us with the ability to triangulate quality information and assurance and to identify areas where improvements need to be made. Areas that require support meet with the Chief Nurse / Deputy Chief Nurse alongside a patient representative until the appropriate level of improvement is achieved.

Assessing the Quality of Performance Information

The quality of our performance information is assessed through our internal validation processes, which vary dependent upon the indicator. Our Internal Auditors also review the quality of our data as part of their annual programme of work.

During 2024 / 25, we continued to use our 'STAR' assurance model. This model was developed in collaboration with data quality teams across a number of NHS trusts, along with NHS Digital and the East and West Midlands Academic Health Science Networks. The STAR model is a framework of 'assurance domains' with each domain having a series of questions which are used to attribute a score to the quality of data. This covers:

- S – sign off and validation
- T – timely and complete
- A – audit and accuracy
- R – robust systems and data capture

Risks to Data Security

Our policy for Data Protection Security and Confidentiality provides a framework to preserve the security of information and information systems, including confidentiality, integrity and availability. This is just one of numerous policies in place to ensure the effective governance of our information.

Risks to data security are managed in accordance with our Risk Management Policy, with risks scoring 12 or above being escalated to our Executive Digital and Data Security and Protection Group which is chaired by the Senior Information Risk Officer (SIRO) and has the Caldicott Guardian as a member.

Breaches in data security are classified as an adverse incident and are managed in accordance with our Incident Reporting Policy. These incidents are also escalated to our Executive Digital and Data Security and Protection Group for oversight of any actions and sharing of lessons learned.

The Executive Digital and Data Security and Protection Group is also responsible for monitoring compliance with the Cyber Assurance Framework (previously Data Security and Protection Toolkit), which is reviewed by our Internal Auditors on an annual basis. Their review undertaken during 2024 / 25 concluded with having low risk identified and a high level of confidence in the veracity of the self-assessment.

Major Risks

Our major risks are reported through the Board Assurance Framework. During the year, we managed nine major in-year risks which threatened the achievement of our strategic priorities. These were in relation to:

- Delivering positive patient outcomes (clinical risk)
- Workforce sustainability and culture
- Improving population health
- Responsive patient care
- Digital transformation
- Fit for purpose estate
- Financial in-year delivery
- Financial sustainability
- Research and Innovation

Of those risks, the most significant as we reached the end of the year were in relation to:

Risk		How we manage the risk	How we assess the outcome of actions
Financial sustainability	**Ext 20**	• Financial plan • Policies and procedures • Cost Improvement Programme	• Financial reporting • Performance reviews • Internal and external audit
High quality and responsive patient care	**Ext 20**	• Strategies and plans • Policies and procedures • Capacity and demand management • Risk assessment	• Incident reporting • Delivery of quality indicators / metrics • Internal and external audit • Performance reviews
Digital transformation	**Ext 20**	• Investment • Training • Policies and procedures • Continuity planning	• Internal audit • Digital maturity assessments • Incident reporting

Looking ahead at risks for the future, the Board has determined that whilst those nine in-year risks remain a threat, focus through the Board Assurance Framework for 2025 / 26 will be around the following:

Primary Risks
- Culture, capacity and capability
- System and infrastructure
- Finance and affordability constraints

With additional risks identified to the achievement of our strategic plans:
- Quality, access and performance
- People
- Population health
- Digital
- Research and innovation
- Estates and facilities

NHS Provider Licence

The NHS Provider Licence forms part of the oversight arrangements for the NHS. In October 2023, we were issued with regulatory undertakings by NHS England in relation to CQC findings following their review of our maternity services, the findings of the 2022 Staff Survey and operational performance issues in urgent and emergency care, elective recovery and cancer. Specific expectations were also set in relation to governance, oversight, capacity and reporting.

We developed a plan to mitigate those risks, which was subject to scrutiny by NHS England and the Integrated Care Board through regular performance reviews, as well as through our own internal governance arrangements through the Board and its committees.

An independent review of our undertakings was undertaken by NHS England towards the end of 2024. They were assured that there was sufficient evidence to issue compliance certificates against the undertakings for governance and reporting, Staff Survey and maternity. However, undertakings for operational performance will remain in place as we move into 2025 / 26, and we expect to receive additional undertakings in relation to financial performance.

Governance

Our governance structure ensures that the Board has an overarching responsibility through its leadership and, to ensure and be assured that the organisation operates with openness, transparency, and candour, particularly in relation to its patients, the wider community and its staff. The Board holds itself to account including with a wide range of stakeholders.

The Board has developed a culture across the organisation which supports open dialogue and includes non-executive directors and executive directors visiting wards and departments to personally listen to feedback from staff, patients, their carers and relatives when possible.

The effectiveness of our governance structure is reviewed on an annual basis, through a robust programme of effectiveness reviews. All board members participate in this process and the outcome is used to inform any changes to the structure itself, or the terms of reference and membership.

All of the committees, which comprise of the Quality Governance Committee, Performance and Finance Committee, People, Culture and Inclusion Committee and Strategy and Transformation Committee have non-executive director membership and chairs. The Audit Committee is a significant statutory committee of the Board that is chaired by a non-executive director.

The Board receives Highlight Reports from each of the committees which provide timely and accurate information and highlight areas of escalation. This facilitates an overarching and durable framework that allows the Board to make sense of the effective use of information and data to gain further assurance of good practice in governance and provides confidence that the organisation provides patient centred care or provides alerts to where further investigation and monitory may be required. To further support the Board, each of the committees receive regular updates and Highlight Reports from the Executive Groups which are chaired by the executive directors. There is an opportunity at each meeting for scrutiny of the work undertaken through those groups and where needed, further details requested and clarified.

The Board and committees demonstrate leadership and the rigour of oversight of our performance by having formulated an effective strategy for the organisation, ensuring accountability by robustly challenging the control systems in place and where appropriate seeking further intelligence on the trend analysis and performance indicators.

Embedding Risk Management

Risk management is a key component of our practice and is embedded into the activities of our organisation. It aims to:

- Maintain safety, provide better patient outcomes and increase quality of service
- Ensure risk is maintained within specific limits
- Aid consistent decision making and increase the ability to achieve strategic targets
- Maintain reputational value and increase confidence

We apply the principles of risk management in a variety of ways, including:

- Through incident reporting to manage clinical risk. This is openly encouraged so that we can continuously learn and improve.
- Equality impact assessment, which is integral to our policy development process and enables us to identify and mitigate any potential discriminatory risk.

Risk management forms part of our day-to-day practice, the way that we provide care, our operational planning, governance arrangements, workforce planning, complaints and claims handling, performance management, financial management and investments, strategy development, accreditation and assessment planning, audit planning and prioritisation.

Workforce Sustainability

Developing Workforce Safeguards

Developing Workforce Safeguards supports us to deliver high quality care through safe and efficient staffing. The National Quality Boards guidance in relation to safe staffing states that providers:

- Must deploy sufficient suitably qualified, competent and experienced staff to meet care and treatment needs safely and effectively.
- Should have a systematic approach to determining the number of people using the service and keep them safe at all times.
- Must use an approach that reflects current legislation and guidance where it is available.

We have a range of mechanisms to support the efficient and effective **short-term workforce management** across various professional groups. This includes:

- Employee rostering, using a digital platform to manage staffing for doctors, nurses, midwives, nursing assistants, and some allied health professionals. This ensures consistent staffing levels and addresses any staffing pressures promptly.
- Daily oversight; senior nurses and matrons use digital systems and a staffing dashboard to monitor and manage daily nursing demands.
- Temporary staffing; dedicated teams manage temporary shifts, supported by expert rostering teams.
- Doctor deployment, managed through centralised rota systems and a digital platform for temporary shifts.
- Administration services, managed through a digital platform providing a pool of trained administrators.
- Absence management, using Empactis, which streamlines unplanned absence reporting and supports employee wellbeing.
- Integrated support; the Integrated Care System People function co-ordinates mutual aid and temporary workers to optimise resource allocation during escalations.

Systems and processes in place to support our **medium-term workforce management** include:

- Annual workforce planning; aligning with financial and activity planning rounds, with reporting to NHS England. The Trust Board, via the People, Culture and Inclusion Committee scrutinises our strategic workforce plans.
- Balancing short-term and future needs; detailed planning processes balance immediate deliverable with long-term workforce development.
- Workforce reporting; comprehensive reports are compiled for our Executive Workforce Assurance Group and the People, Culture and Inclusion Committee providing insights into workforce sustainability and shortage mitigation.
- Our Medical Workforce Advisory Group addresses issues such as doctor bank rates, agency utilisation, job planning and workforce demographics.
- Annual nursing and midwifery establishment reviews are undertaken with ongoing monitoring to inform recruitment strategies and investment planning.
- Recruitment days and social media campaigns support the reduction of vacancies, including dedicated campaigns for international recruitment.

Longer term workforce management is set out through our refreshed People Plan which we have refreshed during 2024 / 25. This aligns with the national NHS People Plan and the Long-Term Workforce Plan and sets out our ambitions over the next five years.

Formal audits are undertaken into staffing processes such as recruitment and payroll, which are reported to our Audit Committee.

Board oversight of staffing processes is also achieved via the workforce elements of our Board Assurance Framework and the Integrated Performance Report, which includes key indicators such as absence, turnover and training compliance.

Care Quality Commission

We are fully compliant with the registration requirements of the Care Quality Commission with an overall rating of Requires Improvement and Good for Well Led.

Conflicts of Interest

We have published on our website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the ‘Managing Conflicts of Interest in the NHS guidance.

NHS Pensions Scheme

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, employers' 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.

Equality, Diversity and Human Rights

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

Sustainability

We have undertaken risk assessments on the effects of climate change and severe weather and have developed a Green Plan following the guidance of the Greener NHS Programme. We ensure that our obligations under the Climate Change Act and the Adaptation Reporting Requirements are complied with.

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

We have performance management processes in place that review the economy, efficiency and effectiveness of the use of resources. The Chief Finance Officer reports to the Performance and Finance Committee which reviews financial performance and supports the Board in gaining assurance.

Our policy and governance framework is in place to guide staff on the appropriate use of resources through standing orders, standing financial instructions and scheme of reservation and delegation. There is a robust system for developing and routinely reviewing policies and procedures and ensuring that staff are appropriately updated or trained in their application.

Each of our divisions is managed through our devolved structure, governed through our scheme of delegation, which defines key roles and responsibilities. Each division has dedicated financial and human resources input, and our executive-led performance management arrangements provide the means through which divisions are held to account for delivery of financial and other performance targets.

Independent assurance is provided through our internal audit programme and the work undertaken by counter fraud. Reports are presented to the Audit Committee in each meeting. In addition, further assurance on the use of resources is obtained from external agencies, including external auditors and our regulators.

Information Governance

Organisations that have access to NHS patient information must provide assurance that best practice data security and protection mechanisms are in place. We are contractually obliged to undertake assessments against the NHS England Data Security and Protection Toolkit (now Cyber Assurance Toolkit) on an annual basis.

During 2024 / 25, our internal auditors conducted their annual review of our arrangements to ensure data, security and protection. Their review undertaken during 2024 / 25 concluded with having low risk identified and a high level of confidence in the veracity of the self-assessment.

Data, security and protection breaches are reported via our incident management system. Our Data, Security and Protection Team monitor and review all incidents to ensure that they are investigated appropriately and where necessary, a root cause analysis is undertaken to identify any action required and lessons to be learned.

When an incident is deemed serious, the Information Commissioners Office (ICO) is notified. There was one incident reported to the ICO during 2024/2025 which related to information sent via email and was subject to investigation by the ICO.

Data Quality and Governance

Our Data Quality Assurance Group oversees the effective implementation of our Data Quality Policy, which is available to all staff via our intranet. This policy, along with our Data Quality Strategy and a programme of audit form a Data Quality Assurance Framework which sits within a wider overarching Data Security and Protection Framework.

All staff, including clinicians and administrative staff who collect and record data, both manually and digitally, are responsible for ensuring adherence to the relevant data standards and for ensuring good quality data that is accurate, valid, reliable, timely and relevant.

Our policy makes explicit expectations including the reporting of any data quality issues, concerns or breaches of policy to be reported to management or our Data Quality Team.

Elective Waiting Time Data
We have a corporate validation team in place to conduct daily validations on elective waiting time data, with a focus on data quality flags which suggest that some of the pathway data may not be accurate. Divisional management teams also conduct validation, with a focus on tracking patients through pathway milestones. Our Data Quality Team monitor several indicators around waiting times, and these are discussed at monthly Operational Data Quality Groups, with cross-cutting themes escalated to the Data Quality Assurance Group.

Training is offered to all staff who input data into our patient management systems including training on Referral to Treatment (RTT) rules and their application, as well as training on validation, clinic outcome form completion, with bespoke training provided for specific staff groups or those who require more in depth knowledge.

All data reported externally by the information team is signed off by an executive director and audits of data quality form part of our internal audit programme, reported to the Audit Committee.

During 2024 / 25, our internal auditors undertook a data quality review of our planned care framework and ambulance handover data and concluded with partial assurance for both elements. Recommendations were made which will be monitored by the Audit Committee.

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the information provided within this annual report and other performance information that is 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 effectiveness of the system of internal control by the board, the audit committee and the Quality Governance Committee and a plan to address weaknesses and ensure continuous improvement is in place.

Trust Board: The Board Assurance Framework provides an overview of the internal control environment and evidence of the effectiveness of the controls that manage the risks to the Trust in achieving it strategic priorities as identified in the annual plan.

Audit Committee: The Audit Committee reviews the effectiveness of internal control through the delivery of the internal audit plan.

Clinical Audit: Clinical Audit is an integral part of our internal control framework. An annual audit programme is developed involving all clinical divisions. Audit priorities are aligned to our clinical risk profile, compliance requirements under the provisions of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and national clinical audit priorities.

Internal Audit: RSM acted as internal auditors for us during the year. Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to our risk environment, subject to Audit Committee approval. A detailed programme of work is discussed with the Executive Team and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit programme, the Committee uses a mapping framework to ensure all areas are reviewed at the appropriate frequency. Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented at each meeting by Internal Audit throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

Head of Internal Audit provides an annual internal audit opinion, on the overall adequacy and effectiveness of our risk management, control and governance processes. For the twelve months ended 31 March 2025, the opinion was that we have an adequate and effective framework for risk, management, governance and internal control although further enhancements were identified to ensure it remains adequate and effective.

External Audit: External Audit provides independent assurance on the Accounts, Annual Report, Annual Governance Statement. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

The effectiveness of the system of internal control is maintained and reviewed by the Board via its committees and individual management responsibilities at director and senior manager level. Regular reports have been reviewed by the Committees of the Board and individuals in relation to all key risks.

Clinical governance and processes to ensure quality of patient care were overseen by the Quality Governance Committee under the leadership of the Chief Nurse and Chief Medical Officer. Assurance reports from this Committee were received by the Board, together with ad hoc reports, as required and an annual report summarises the work undertaken by this Committee.

The Director of Governance has delegated lead responsibility for risk management across the Trust. Individual directors and senior managers are empowered to review and manage risks within their own areas of responsibility, linking closely with other Trust processes. Significant support has been provided via training, advice, and guidance and documentation to enable senior staff to effectively fulfil their functions.

An analysis of control and assurance in relation to key organisational risks has been undertaken via the Board Assurance Framework.

Conclusion

In preparing this statement I have considered the corporate, quality and clinical governance infrastructure, functionality and effectiveness in place. The Board remain committed to continuous improvements and enhancement of the systems of internal control. In line with the guidance on the definition of no significant control issues, I have no significant control issues to declare within this year's statement. My review confirms that University Hospitals of North Midlands NHS Trust has a good system of governance and stewardship that supports the achievement of its policies, aims and objectives.

Dr Simon Constable
Chief Executive
25 June 2025

Well Led Framework

As part of a commitment to simplifying regulatory approaches, NHS England worked closely with the Care Quality Commission (CQC) to bring together their respective approaches to the well-led key lines of enquiry (KLOE). This resulted in a joint well-led framework structured around eight key lines of enquiry, which were introduced in 2017 / 18.

Key Lines of Enquiry

1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
2. Is there a clear vision and credible strategy to delivery high quality sustainable care to people and robust plans to deliver?
3. Is there a culture of high-quality, sustainable care?
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing risks, issues and performance?
6. Is appropriate and accurate information that is being effectively processed, challenged and acted upon?
7. Are the people who use services, public, staff and external partners being engaged and involved to support high-quality, sustainable care?
8. Are there robust systems and processes for learning, continuous improvement and innovation?

Care Quality Commission

The CQC carried out a well-led inspection during 2021. It rated us 'Good' for well-led because:

- Leaders had the experience, capacity, and capability to ensure that the strategy could be delivered and risks to performance addressed
- Leadership was knowledgeable about issues and priorities for the quality and sustainability of services and understood what the challenges were and acted to address them
- We had a vision for what we wanted to achieve and a strategy to turn it into action
- The board understood the challenges that staff were facing and worked to support colleagues and led in a compassionate way, staff were focussed on the needs of patients receiving care
- The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately
- Leaders and teams used systems to manage performance, senior staff contributed to decision making to help avoid financial pressures compromising the quality of care
- We collected reliable data and analysed it, staff could find the data they needed to understand performance, make decisions and improvements
- Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services, they collaborated with partner organisations to help improve services for patients
- All staff were committed to continually learning and improving services, we were implementing a quality improvement programme to empower staff to make improvements in care for patients, leaders encouraged innovation and participation in research and strived to influence patient outcomes
- There were governance processes in place to identify issues which enabled the board to know where the risks are and take action to make improvements which should deliver sustainable change
- Financial governance processes were robust, and oversight was provided by established committees reporting into the board
- The work on the digital strategy, staff engagement and plans to engage with patients was impressive
- The trust board and senior leadership team displayed integrity on an ongoing basis, staff side representatives said they viewed the senior leadership team as approachable, in touch with frontline staff and listed when staff raised concerns

Independent Developmental Review

During 2024 / 25 we commissioned an independent well-led review which was undertaken by Deloitte. Their findings, which were presented to the Board were consistent with those of the CQC and have formed the basis of our development plan throughout the year.

Dr Simon Constable
Chief Executive
25 June 2025

4 Remuneration Report

Annual Statement on remuneration

The Board delegates the responsibility to a Board Nominations and Remuneration Committee to make decisions regarding the nomination, appointment, remuneration and conditions of service for executive directors including the Chief Executive.

The Committee also has general oversight of our pay policies but only determines the reward package for directors who are not covered by agenda for change. The majority of staff remuneration, including the first layer of management below Board level, is covered by the NHS Agenda for Change pay structure.

The Committee monitors and evaluates the annual performance of individual directors, with the advice of the Chief Executive in relation to executive directors.

The membership of the committee consists of the Trust Chair and three non-executive directors, although all non-executive directors are invited to attend. The Chief Executive, Director of Governance and Chief People Officer also attend as appropriate.

During the period 1 April 2024 to 31 March 2025, the committee met on 6 occasions.

The annual work programme for the Committee includes evidence-based review and benchmarking of executive director salaries in comparison to national lower and upper quartile benchmarks. This exercise is undertaken to maintain awareness of arrangements in other organisations, which may be of relevance and any changes to executive director salaries are considered by the Committee on receipt of this information.

Where there is a vacancy in a permanently established post, it is usual practice to make a permanent appointment. All senior managers have a notice period of three months and executive directors have a notice period of six months.

Non-executive directors are public appointments made by NHS England on a fixed 'term of office' basis, which may be renewed in line with the Code of Governance.

Compensation for early termination of executive directors provides payment in lieu of notice, except in cases of summary / immediate dismissal.

Severance packages which fall outside the standard provisions of the contract of employment must be calculated using standard guidelines and any proposals to make payments outside the current guidelines are subject to the approval of HM Treasury via NHS England.

Committee members attendance at meetings is given in the table below:

Member	Attendance (actual v max)
David Wakefield, Chair	
Professor Gary Crowe, Vice Chair / Non-Executive Director	
Dr Leigh Griffin, Non-Executive Director	
Mrs Margaret Monkton, Non-Executive Director	
Mrs Alison Rodwell, Non-Executive Director	

Nominations

In year, the committee considered and approved the following:

- Process for the appointment of the Chief Executive
- Process for the appointment of Interim Chief Operating Officer and Interim Chief Medical Officer
- Process for appointment of non-executive directors

Remuneration

In year, the committee considered and approved the following:

- Remuneration of the Chief People Officer, Chief Digital Information Officer, Chief Medical Officer and Chief Executive
- Very Senior Managers pay – following acceptance of the Senior Salaries Review Body recommendations

Salaries and allowances (audited)

		2024 / 2025					2023 / 2024				
		Salary	Pension Recycling Payment (Taxable)	Expense payments (taxable) total to nearest £100	All pension-related benefits	TOTAL	Salary	Pension Recycling Payment (Taxable)	Expense payments (taxable) total to nearest £100	All pension-related benefits	TOTAL
		Bands of £5,000	Bands of £5,000	£000	Bands of £2,500	Bands of £5,000	Bands of £5,000	Bands of £5,000	£000	Bands of £2,500	Bands of £5,000
Trust Board Members as at 31st March 2025:											
Simon Constable	Chief Executive (from 01/09/24)	145-150			295-297.5	440-445					
Matthew Lewis	Medical Director	225-230			65-67.5	290-295	220-225			0v	220-225
Mark Oldham*	Chief Financial Officer	200-205	20-25			225-230	190-195	20-25			210-215
Ann-Marie Riley	Chief Nurse	160-165			25-27.5	190-195	155-160			5-10	160-165
Simon Evans*~	Chief Operating Officer (from 16/06/23 to 30/08/24 - on secondment at NHSE)	75-80	5-10			85-90	115-120				115-120
Katy Thorpe	Interim Chief Operating Officer (from 02/09/24)	90-95			65-67.5	155-160					
Jane Haire^	Chief People Officer	145-150			15-17.5	160-165					
Helen Ashley^	Director of Strategy & Deputy CEO (Interim CEO from 01/07/24 to 31/08/24)	190-195	20-25			215-220					
Lorraine Whitehead^	Director of Estates, Facilities & PFI	145-150			0v	145-150					
Amy Freeman^	Chief Digital Information Offcier	145-150			45-47.5	190-195					
Lisa Thomson^	Director of Communications	125-130			20-22.5	145-150					
Claire Cotton*^	Director of Governance	110-145				110-145					
David Wakefield	Chairman	60-65				60-65	60-65				60-65
Gary Crowe	Non-Executive Director	15-20		0.2		15-20	15-20		0.3		15-20
Tanya Bowen	Non-Executive Director	10-15		0.6		15-20	10-15				10-15
Katie Maddock	Non-Executive Director	10-15				10-15	10-15				10-15
Sunita Toor	Non-Executive Director (from 01/04/23)	10-15		0.9		10-15	10-15		0.6		10-15
Margaret Monckton	Non-Executive Director (from 07/10/24)	5-10				5-10					
Louise Bainbridge	Non-Executive Director (from 04/11/24)	5-10				5-10					
Andy Hassell^	Associate Non-Executive Director	15-20				15-20					
Wendy Nicholson^	Associate Non-Executive Director (from 07/10/24)	5-10				5-10					
Previous Board Members:											
Paul Bytheway	Chief Operating Officer (until 24/05/23)						80-85			0v	80-85
Peter Akid	Non-Executive Director (until 29/09/23)						5-10				5-10
Tracy Bullock*	Chief Executive (until 30/06/24)	60-65	5-10			65-70	240-245	25-30			270-275
Leigh Griffin	Non-Executive Director (until 31/08/24)	5-10		0.2		5-10	15-20		0.2		15-20
Arvinda Gohil	Non-Executive Director (from 01/11/23 to 31/10/24)	0-5				0-5	5-10				5-10
Alison Rodwell^	Associate Non-Executive Director (until 31/10/24)	5-10		0.2		5-10					

**Board member is not a member of the NHS Pension Scheme and so there are no pension benefits to report.*

^Non-voting board members were not included in this report in previous years and so there are no prior year comparative figures available.

~Simon Evans is currently on secondment to NHSE. His salary for the entire year is in the band £205,000-£210,000.

vWhere pension benefits result in a negative figure they have been substituted with "0" in accordance with the DHSC Group Accounting Manual.

There has been no performance pay, or bonuses paid to any of the directors in either financial year.

Pension recycling payments have been made to directors who have exited the pension scheme. These are non-contractual payments and subject to annual review.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

All taxable expenses paid during the year were in relation to home or work mileage claims.

Pension benefits (audited) and Cash Equivalent Transfer Value

Board Member at 31 March 2025		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2025 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March 2025 (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2024 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March 2025 £000
Simon Constable	Chief Executive (from 01/09/24)	12.5-15	32.5-35	55-60	150-155	737	294	1,324
Matthew Lewis	Medical Director	2.5-5	0-2.5	90-95	255-260	2,136	87	2,394
Mark Oldham	Chief Financial Officer	0	0	0	0	0	0	0
Ann-Marie Riley	Chief Nurse	0-2.5	0v	50-55	130-135	1,124	31	1,251
Simon Evans	Chief Operating Officer (from 16/06/23 to 30/08/24 - on secondment at NHSE)	0	0	0	0	0	0	0
Katy Thorpe	Interim Chief Operating Officer (from 02/09/24)	2.5-5	0	30-35	0	316	38	429
Jane Haire	Chief People Officer	0-2.5	0v	50-55	130-135	1,060	19	1,168
Helen Ashley	Director of Strategy & Deputy CEO (Interim CEO from 01/07/24 to 31/08/24)	0	0	0	0	0	0	0
Lorraine Whitehead	Director of Estates, Facilities & PFI	0-2.5	0v	55-60	140-145	1,194	5	1,297
Amy Freeman	Chief Digital Information Offcier	2.5-5	0-2.5	40-45	95-100	692	37	793
Lisa Thomson	Director of Communications	0-2.5	0v	35-40	90-95	817	24	912
Claire Cotton	Director of Governance	0	0	0	0	0	0	0

As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive directors.

The pensions information disclosed in this table has been subject to audit.

Cash Equivalent Transfer Value (CETV)

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV reflects the increase in CETV effectively funded by the employer. This calculation does not take account of any increase due to inflation or contributions paid by the employee.

Pay multiples (audited)

We are required to disclose the relationship between the remuneration of the highest paid director in the organisation against the 25th percentile, median and 75th percentile of remuneration against the organisation's workforce.

The banded remuneration of the highest paid director in the trust in the financial year 2024 / 25 was £250, 000 to £255, 000 (2023 / 24 £240, 000 to £245, 000). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

Year	25th Percentile Ratio	Median Ratio	75th Percentile Ratio
2024 / 25	8.84:1	6.53:1	4.78:1
2023 / 24	8.80:1	6.45:1	4.71:1

The highest paid director's salary range mid-point was £252, 500 (2023 / 24: £242,500). This is an increase of 4.12% (2023/ 24: 6.59%). The overall average remuneration of the organisation increased from £51,971 in 2023 / 24 to £53,533 in 2024 / 25. This represents a percentage increase of 3.01% (2023 / 24: 9.69%).

Based on annualised, full-time remuneration the 25th percentile of pay at 31 March 2025 was £28, 574, the median was £38, 656 and the 75th percentile was £52, 809. In this calculation, only salary costs are included in total remuneration.

In 2024 / 25 17 employees (2023 / 24 11 employees) received remuneration in excess of the highest paid director. The Range of staff remuneration during 2024 / 25 was £10,000 - £15,000 to £420,000 - £425,000 (2023/24 £10,000-£15,000 to £370,000- £375,000).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include employer pension contributions, the cash equivalent transfer value of pensions or severance payments.

Analysis of other departures and exit packages (audited)

Reporting of compensation schemes: Exit Packages 2024 / 25

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages by cost band	Total cost of exit packages by cost band
	Number	£000	Number	£000	Number	£000
Less than £10,000	0	0	31	95	31	95
£10,001-£25,000	0	0	3	37	3	37
£25,001-£50,000	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type	**0**	**0**	**34**	**132**	**34**	**132**

Reporting on compensations schemes: Exit Packages 2023 / 2024

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages by cost band	Total cost of exit packages by cost band
	Number	£000	Number	£000	Number	£000
Less than £10,000	0	0	37	137	37	137
£10,001-£25,000	0	0	2	26	2	26
£25,001-£50,000	1	33	0	0	1	33
£50,001-£100,000	0	0	1	56	1	56
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type	**1**	**33**	**40**	**219**	**41**	**252**

- Redundancy and other departure costs have been paid in accordance with standard NHS terms and conditions.
- This disclosure reports the number and value of exit packages agreed with staff during the year.
- The remuneration information disclosed in the tables above have been subject to audit.

Exit Packages: other (non-compulsory) departure payments

	2024/25		2023/24	
	Payments agreed		Payments agreed	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	34	132	40	219
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**34**	**132**	**40**	**219**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	**0**	**0**	**0**

Reporting high paid off-payroll arrangements

Consultancy

Expenditure on consultancy services for the year 2024 / 25 was £1.206m, compared to £0.143m in 2023 / 24.

Off Payroll Engagements

As part of the Treasury's Annual Reporting Guidance 2012 / 13, Government Departments are required to report information relating to off-payroll engagements. Therefore, NHS bodies are required to include information on any such engagements allowing for consolidation.

The table here shows all off-payroll engagements as of 31 March 2025, for more than £245 per day and that last longer than 6 months.

Number of existing engagements as of 31 March 2025	Number
Number of existing engagements as of 31 March 2025	0
Of which, the number that have existed:	0
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	0

For all new off-payroll engagements between 1 April 2024 and 31 March 2025, for more than £245 per day.

New Off Payroll Engagements	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2024 and 31 March 2025	0
Of which:	0
number not subject to off-payroll legislation	0
number not subject to off payroll legislation and determined as in scope IR35	0
number subject to off payroll legislation and determined as out of scope IR35	0
number 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

All existing off-payroll engagements have at some point been subject to a risk- based assessment as to whether assurance is required that the individual is paying the right amount of tax and where necessary, that assurance has been sought.

For any off-payroll engagements of board members, and / or senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025:

Board Member / Senior Official Off Payroll Engagementgs	Number
Number of off payroll-engagements of board members, and / or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off payroll, that have been deemed 'board members, and / or senior officials with significant financial responsibility during the financial year. This figure must include noth on payroll and off payroll engagements	0

Dr Simon Constable
Chief Executive
25 June 2025

5 Staff Report

Our People

We employ more than 12, 500 staff comprising more than 70 nationalities. Most of these staff are employed and paid under national pay arrangements established under Agenda for Change or medical and dental provisions.

A small number of staff, which comprises the Trust Board and very senior managers, are employed under local pay and terms and conditions of service which are established by the Nomination and Remuneration Committee of the Trust Board.

All staff are employed subject to meeting the NHS Standards on Employment Checks, which includes references, health checks, DBS checks, immigration checks and identity checks. In addition, we have developed several values and behaviours which are embedded into our organisation, and we have refreshed these during the year for a relaunch during 2025 / 2026. We expect our existing staff to comply with these standards and this is taken into account as part of our recruitment process. This ensure that we can be confident, before staff commence employment, that we know some background about our staff and that they have a legal right to work with us.

By adopting the national pay, terms and conditions of service, we have the assurance that all staff will be treated fairly and will comply with the various legislation. This includes that assurance that staff will receive at least the National Living Wage.

We have various employment policies and procedures in place designed to provide guidance and advice to staff and managers but also to comply with employment legislation. Every policy is impact assessed from an equality and diversity perspective.

We have specific policies in place to deal with the safeguarding of children and vulnerable adults. We have an extensive training and development programme which is based on a minimum requirement to complete all statutory and mandatory training and other training which staff are required to undertake relevant to their role. Training needs are identified through individual performance development reviews and a personal development plan produced.

We have a dedicated lead for Equality, Diversity and Inclusion within our Organisational Development Team. Where possible, we support awareness raising events both locally and nationally to support disability, anti-racism and the LGBT+ community.

Our People Plan

We recognise that our workforce is central to achieving our vision of providing the best joined-up care for *all*. By harnessing the talents of our workforce and creating the conditions for staff to provide excellent care, we believe that we will be recognised as being a place where people want to be cared for, and somewhere where people want to work.

Throughout 2024 / 25 we have spent time refreshing Our Strategy and its underpinning People Plan, to set out our key priorities for the next ten years. In doing this, we have set out a clear commitment to continually strive to improve the sustainability of our workforce and look to develop those who work for us, in any roles, from any nationality and who work on any contract. We also recognise our indirect workforce as essential to the delivery of our services such as our volunteers, contractors and agency workers and as part of our plans for the future, we remain committed to engage them in continuing to work in partnership.

We have invested in our people and will continue to prioritise their safety, health and wellbeing, ensuring equal access to opportunities. We will continue to develop our in-house bespoke training and development offer so that our staff become effective, values-led leaders, who understand and advance diversity and are equipped to take on the challenges we face, now and in the future.

As an anchor institution, we will make sure we provide opportunities to all our population from school leavers, graduates, military, retirees and volunteers. We will continue to support our population and our people to live better through our already well-established wellbeing offers and staff networks which we will develop further.

We recognise that we cannot do this alone. We are a lead employing organisation in our Integrated Care System and we will continue to work collaboratively on people, culture and inclusion priorities with our system partners.

Breakdown each year end of each gender by directors, other senior managers and employees

On 31 March 2025, we had a workforce of 11, 735 whole time equivalents (WTE). This excludes bank workers, honorary contracts and staff out on secondment. Our workforce is made up of a variety of roles and pay scales and below provides an analysis of average staff numbers and costs.

Senior Managers

	Headcount		WTE	
Pay Scale	Female	Male	Female	Male
Band 8a	352	123	320	118
Band 8b	87	42	80	41
Band 8c	31	18	28	17
Band 8d	11	13	11	13
Band 9	13	4	13	4
Director	7	5	7	5
Total:	**501**	**205**	**458**	**198**

Average Number of Employees (WTE basis) (audited)

			2024/25	2023/24
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	734.00	863.00	1,597.00	1,471.00
Ambulance staff	-	-	-	-
Administration and estates	2,468.00	120.00	2,588.00	2,500.00
Healthcare assistants and other support staff	2,364.00	105.00	2,469.00	2,470.00
Nursing, midwifery and health visiting staff	3,567.00	82.00	3,649.00	3,356.00
Nursing, midwifery and health visiting learners	16.00	10.00	26.00	26.00
Scientific, therapeutic and technical staff	989.00	28.00	1,017.00	955.00
Healthcare science staff	380.00	9.00	389.00	386.00
Social care staff	-	-	-	-
Other	-	-	-	-
Total average numbers	**10,518.00**	**1,217.00**	**11,735.00**	**11,164.00**
Of which:				
Number of employees (WTE) engaged on capital projects	27.00	-	27.00	29.00

Staff Costs (audited)

	2024/25			2023/24
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	549,423	50,386	599,809	523,109
Social security costs	53,319	5,279	58,598	54,765
Apprenticeship levy	2,899	-	2,899	2,661
Employer's contributions to NHS pension scheme	105,249	3,501	108,750	84,738
Pension cost - other	117	11	128	160
Temporary staff	-	18,665	18,665	29,073
Total staff costs	**711,007**	**77,842**	**788,849**	**694,506**
Of which				
Costs capitalised as part of assets	1,527	-	1,527	1,629
Total employee benefits excl. capitalised costs	**709,480**	**77,842**	**787,322**	**692,877**

Staff Composition

Staff Group	Part Time		Full Time		Total
	Male	Female	Male	Female	
Director	0	0	5	7	12
Senior Managers (Band 8a - 9 and Senior Manage	14.98	101.64	178	349	643.62
Other Employees	514.03	3,634.33	2,285	4,643	11,079.16
Total:	**529.01**	**3,735.97**	**2,468**	**4,999**	**11,731.98**

Sickness absence and turnover

Sickness Absence

We have a clear and robust framework within which managers are supported to address the issues of attendance and sickness with a consistent, supportive and fair approach through our Attendance Policy. There is a strong focus on workforce health and wellbeing across our organisation, as set out within our People Strategy.

Initiatives such as health and wellbeing drop in events have successfully been held, with targeted approaches for those areas with higher sickness absence rates and signposting to appropriate support. Our appraisal framework is also designed to focus on the health and wellbeing of individuals.

These preventative measures support our workforce to remain healthy in the workplace.

The sickness rate on 31 March 2025 (cumulative for the 12 months from 1 April 2024 to 31 March 2025) was 5.29% (5.21% on 31 March 2024).

Staff Turnover

We have seen a reduction in staff turnover when compared to last year, which is a positive outcome of our focus on staff wellbeing and personal development. We continue to support individuals to return to the workplace following retirement, recognising their invaluable skills and experience.

We support staff to achieve a work/life balance by offering both flexible and agile working arrangements. Individuals and line managers are encouraged to reflect upon the flexibility of roles and are supported to do so through dedicated policies and toolkits.

The turnover rate on 31 March 2025 (cumulative for the 12 months from 1 April 2024 to 31 March 2025) was 7.08% (7.91% on 31 March 2024). This excludes junior doctors on rotation.

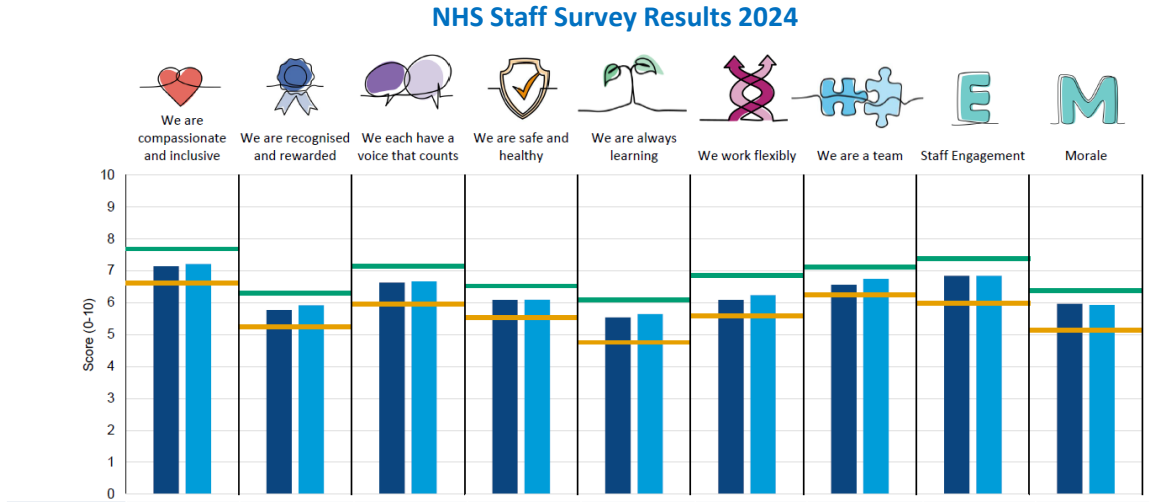
NHS Staff Survey

Staff engagement is measured through the annual NHS Staff Survey. At 6.84, the staff engagement score increased slightly in 2024, and our score is now equal to the benchmarking group average for acute and acute and community trusts.

The 2024 NHS Staff Survey was carried out between September and November 2024 and our response rate was 45% which was the same as the 2023 survey. The results of the survey are measures against seven 'People Promise' elements and against two themes, 'Staff Engagement' and 'Morale'.

At 6.84, our staff engagement score increased slightly from 6.83 in 2024. We are now equal to the benchmarking group average for acute and acute and community trusts. Staff Morale increased from 5.97 to 5.93 in 2024 and is just above the benchmarking group for acute and acute and community trusts of 5.93.

The benchmarked findings are show in the graph here.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.14	5.77	6.63	6.09	5.54	6.09	6.56	6.84	5.97
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	5660	5657	5592	5618	5423	5607	5647	5658	5666

Staff policies and actions applied during the year

Our People Plan outlines how we will make UHNM a great place to work and set out our aims to provide a positive work environment that promotes an open, supportive and fair culture which helps our staff to do their job to the best of their ability and ensure delivery of high-quality care.

We have a number of policies in place to ensure that as an organisation, we fulfil our obligations under equality, diversity and human rights legislation. We want staff to work to the very highest of standards, to be able to communicate openly in an organisation which respects people's views, and values individuals and teams. We encourage and recognise high performance in a results-driven environment and support individual and team development to deliver our goals.

We know that excellent staff experience leads to excellent patient experience and improved patient outcomes. Our People Plan is supported by our workforce plan and is aligned to both our learning and education strategy and our organisational development strategy.

We operate a full suite of human resources policies, covering the whole employee life cycle. These can be made available to the public and our website www.uhnm.nhs.uk provides guidance on how to access them.

- **Recruitment and Selection Policy**: We believe that unlawful discrimination is unacceptable, and we are committed to recruiting staff in accordance with our Equality and Diversity Policy. Applicants are selected solely on objective, job related criteria and their ability to do the job applied for with no discrimination on the grounds of ethnic origin, nationality, disability, gender, gender reassignment, marital status, age, sexual orientation, trade union activity or political or religious beliefs. We provide appropriate assistance to ensure equality for all.
- For **Appointments Advisory Committees** to recruit permanent consultant posts, all members of the panel are required to have received training in equal opportunities.
- **Occupational Health Policy**: The role of occupational health is to help protect and promote the health and wellbeing of our workforce. Workplace health assessment checks are also carried out to provide advice to managers, where necessary, on employee needs or any reasonable adjustments required to the work environment or structure in accordance with the Equality Act 2010.
- Appropriate mandatory training is provided to ensure that all staff and managers understand their responsibilities and equality, diversity and inclusion themes are integrated into other learning and development programmes as appropriate.
- The principles of our **Equality, Diversity and Inclusion Policy** are incorporated into our corporate induction course and included in all local induction packages for new employees. This is also included within our **Statutory and Mandatory Training Policy**. A training record is held electronically.
- Our Resolution Policy supports our commitment to providing an environment that fosters a culture of positive behaviours. We recognise that it is of mutual interest that issues affecting employees are dealt with effectively in an atmosphere of mutual trust and confidence. The purpose of our Resolution Policy is to preserve and maintain the employment relationship and to work in the spirit of resolving issues within the workplace.

Equality, Diversity and Inclusion (EDI)

As referenced earlier within this report, we have developed a comprehensive strategy which sets out our longer-term ambitions for Equality, Diversity and Inclusion.

As a major employer and health service provider we are committed to building an inclusive workforce which is valued and whose diversity reflects the community we serve. Our ambition has been set out within our organisational strategy, which is to create an inclusive workforce where everyone learns, thrives and makes a positive difference.

This is underpinned by our Equality, Diversity and Inclusion Strategy where we have outlined our specific priorities:

1. **Inclusive Patient Feedback:** Listen to and act on the lived experiences of our patients
2. **Inclusive Patient Access:** Ensure Equality Impact Assessment is a robust process that offers both assurance and opportunities for improvement that address inequalities in access to services
3. **Inclusive Patient Involvement:** Patients and service users will be actively involved in service design and governance structures with increased feedback from hard-to-reach groups
4. **Listen to, Understand and Learn from the Experience of all Staff:** To promote diversity and encourage at all levels throughout the Trust, particularly promoting diversity at board level
5. **Respect and Value:** Respect and value all colleagues and their contribution and have a strategic focus on civility and respect
6. **Develop a Culture of Inclusive and Compassionate Leadership:** Continue to build, strengthen and develop initiatives focussed on staff experience, wellbeing and engagement and culture and leadership development
7. **Recruitment, Training and Promotion:** Ensuring that people are recruited, trained and promoted according to their abilities and in the proportions you would expect for the populations represented

Each year we produce an annual Equality, Diversity and Inclusion report which demonstrates how we have undertaken our responsibilities under the Public Sector Equality Duty and our performance against our strategic priorities. In addition to the annual report, we produce the mandated Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the Gender Pay Gap Report. These are all made available publicly via our website.

For 2024, our data showed improvement across the majority of metrics, and we have seen the impact of equality and inclusion activities in improved performance across race, gender and disability. Our Staff Survey data demonstrated that for Diversity and Equality (People Promise 1), we have a better than sector average score. NHS England awarded us with 'good progress' ratings against each of the six high impact actions for the NHS EDI improvement plan, based on the assurance we were able to provide.

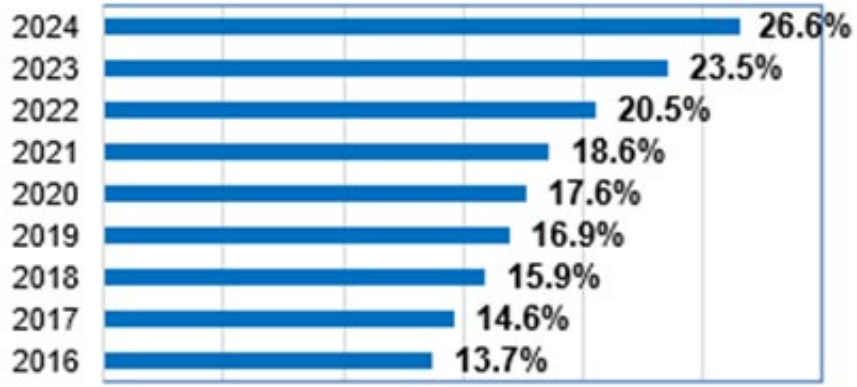
By working in partnership with our Diversity Staff Networks, we listen to the experiences of our colleagues and take actions that will deliver tangible improvements in workplace experiences. During the year we have focussed our actions around:

- Anti-racism and race equality including development of our anti-racist statement and masterclass, supported the WRES Champions Programme and held awareness raising events
- Disability and long-term conditions including introduction of a new reasonable adjustments policy and refreshed other policies and associated training, empowered colleagues through a Confident Conversations project, held a disability inclusion conference, increased Disability Champions, undertaken awareness raising campaigns and secured Disability Confident status
- Leadership development and inclusion, through introduce of EDI dashboards and the launch of our Women's Network and health groups
- Establishment of a Flexible Working Task and Finish Group and reviewed our recruitment and disciplinary processes

Our workforce demographics and national staff survey show that there are barriers to overcome for marginalised representation in more senior roles. There are worse experiences of global majority and disabled colleague experience of harassment, bullying and abuse and we do have a gender pay gap, driven by an under representation of women in the medical and dental workforce group. We have developed plans to help us to overcome these barriers.

We undertake an annual analysis of our demographics, which is published in our annual EDI report.

The graph below shows the year-on-year trend for the black, Asian and minority ethnic representation throughout our workforce:



- There was an increase in the number of black, Asian and minority ethnic colleagues with a headcount of 3, 347 (an increase of 574) (2023 / 24).
- Black, Asian and minority ethnic colleagues represent 25% of our clinical workforce, 9% of our non-clinical workforce and 66.7% of our medical and dental workforce

Trade Union facility time and other employee matters

Our statistics relating to trade union (Facility Time Publication Requirements) Regulations for the period ending 31 March 2025 is set out below.

2024 / 25 Trade Union Facility Time

Staff Group	Fixed Term Temporary
Employees in Organisation	10,000 and above
Number of TU Representatives	41
FTE of TU Representatives	34.74
Number of TU representatives that spend 0% working hours	15
Number of TU representatives that spend 1-50% working hours	23
Number of TU representatives that spend 51-99% working hours	1
Number of TU representatives that spend 100% working hours	2
Total pay bill	788849000
Total cost of facility time	169646.02
Percentage of pay spent on facility time	0.02
Percentage of hours spent on TU activities	0

Other Employee Matters

We have a formal agreement in place between ourselves and the Trade Unions representing our workforce, which is set out in our policy on Recognition and Local Collective Bargaining Arrangements. This sets out our commitment to develop local collective bargaining machinery and agreeing a range of industrial relations policies. We work in partnership with our Trade Unions and Recognise our Joint Staff Side as the main body through which all local industrial relations mattes are considered. In addition to this, all matters that affect the contract of employment tor terms and conditions for medical staff of all grades are dealt with through the Local Negotiating Committee (LNC).

Dr Simon Constable
Chief Executive
25 June 2025

6 Financial Statements

Summary Financial Statements

A commentary on our financial position is included earlier in this report. The following pages are our Summary Financial Statements.

The Statement of Comprehensive Income shows how much money we earned and how we spent it. The main source of our income is from Integrated Care Systems (ICS), with which we have agreements to provide services for their patients.

Our biggest expense is on the salaries and wages of our staff. On average during this year, we employed the equivalent of 11, 459 full time staff (10, 800 2023 / 24). The actual number of people working for the Trust is more because some staff work part-time (therefore the full-time equivalent is less).

We buy clinical and general supplies, maintain our premises, some of the costs of which are payable to our PFI partner, and pay for gas and electricity, rent and rates. We also allow for depreciation, the wearing out of buildings and equipment which need to be replaced.

Our Statement of Financial Position summarises our assets and liabilities. It tells us the value of the land, buildings and equipment we own and of supplies we hold in stock for the day to day running of the hospital. It also shows money owed to us and the money we owe to others, mainly for goods and services received but not yet paid for. Under International Financial Reporting Standards, it also shows buildings and equipment that are legally owned by our PFI partner and related borrowings which will be settled through the unitary payments we make over the term of the PFI contracts.

Our valuation approach is to have a full valuation including a full site inspection every five years with interim 'desktop' valuations on an annual basis. A full valuation was undertaken as at 31st March 2022, which included site valuations to provide assurance that the value of land and building assets within the accounts are not materially misstated at the balance sheet date. An interim valuation was undertaken as at 31st March 2025 as well as a site visit at the Acute Medical Rapid Assessment Unit and the Elective Hub as these were a significant capital scheme that was completed during the year and would impact the valuation.

The net book value of our land and buildings as at 31st March 2025 is £619,684 million. If we had not revalued the estate, at 31st March 2025 the value of land, buildings and dwellings would have been £593.177 million.

We obtain valuations for our land, buildings and dwellings from a qualified independent valuer. These valuations are performed at a point in time and take into account conditions and circumstances relevant to that date. In future years, conditions may change resulting in uplifts or impairments being required to the value of land, buildings and dwellings. The valuation has been completed based on the depreciated replacement cost and the remaining useful economic life of the assets.

The Better Payment Practice Code shows how quickly we pay our bills.

Summary Financial Statements

Statement of Comprehensive Income for the year ended 31 March 2025

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	3	1,186,037	1,055,578
Other operating income	4	106,840	96,227
Operating expenses	7,9	(1,271,731)	(1,130,192)
Operating surplus from continuing operations		**21,147**	**21,613**
Finance income	11	6,054	5,780
Finance expenses	12	(35,422)	(75,118)
PDC dividends payable		(3,530)	(3,171)
Net finance costs		**(32,898)**	**(72,509)**
Other gains / (losses)	13	70	(78)
Deficit for the year from continuing operations		**(11,681)**	**(50,974)**
Deficit for the year		**(11,681)**	**(50,974)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(16,421)	-
Revaluations	17	20,050	31,267
Total comprehensive expense for the period		**(8,052)**	**(19,707)**

Financial Performance for the year		
Surplus for the year	**(11,773)**	**(50,974)**
Remove net impairments not scoring to the Departmental expenditure limit	360	7,026
Remove I&E impact of capital grants and donations	(4,293)	(2,300)
Remove impact of IFRS 16 on IFRIC 12 schemes	(2,442)	46,189
Remove net impact of DHSC provided inventories for COVID response	92	288
Reported NHS financial performance position	**(18,056)**	**229**

Statement of Financial Position as at 31 March 2025

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	14	15,985	16,258
Property, plant and equipment	15	715,699	686,251
Right of use assets	18	23,087	18,143
Receivables	20	1,105	1,079
Total non-current assets		**755,876**	**721,732**
Current assets			
Inventories	19	19,219	17,715
Receivables	20	43,518	44,353
Non-current assets held for sale and assets in disposal groups	22	10,900	-
Cash and cash equivalents	23	84,186	82,024
Total current assets		**157,823**	**144,092**
Total Assets		**913,699**	**865,824**
Current liabilities			
Trade and other payables	24	(128,900)	(108,116)
Provisions	27	(8,469)	(5,669)
Borrowings	25	(20,801)	(17,471)
Total current liabilities		**(158,170)**	**(131,256)**
Total assets less current liabilities		**755,529**	**734,568**
Non-current liabilities			
Borrowings	26	(490,255)	(477,104)
Provisions	27	(2,783)	(2,294)
Total non-current liabilities		**(493,038)**	**(479,398)**
Total assets employed		**262,491**	**255,169**
Financed by			
Public dividend capital		734,943	693,901
Revaluation reserve		208,297	204,668
Income and expenditure reserve		(680,749)	(669,068)
Total taxpayers' equity		**262,491**	**229,501**

Summary Financial Statements

Statement of cash flows for the year ended 31 March 2025

	2024/25 £000	2023/24 £000
Cash Flows from Operating Activities		
Operating surplus	21,055	21,613
Non-cash income and expense:		
Depreciation and amortisation	39,720	37,704
Net impairments / (reversal of impairments)	360	7,026
Income recognised in respect of capital donations	(6,047)	(4,581)
(Increase)/decrease in inventories	(1,504)	(880)
(Increase)/decrease in receivables and other assets	(1,010)	16,453
Increase/(decrease) in payables and other liabilities	4,173	(12,485)
Increase/(decrease) in provisions	3,258	(322)
Net cash generated from / (used in) operating activities	**60,005**	**64,528**
Cash flows from investing activities		
Interest received	6,054	5,780
Purchase of intangible assets	(6,266)	(3,358)
Purchase of property, plant and equipment	(63,650)	(56,943)
Sales of property, plant and equipment	88	415
Receipt of capital donations to purchase capital assets	3,823	4,581
Net Cash Inflow/(Outflow) from Investing Activities	**(59,951)**	**(49,525)**
Cash flows from financing activities		
Public dividend capital received	41,042	28,862
Capital element of finance lease rental payments	(4,001)	(3,742)
Capital element of PFI	(21,964)	(21,114)
Other interest	(1)	(2)
Interest paid on finance lease liabilities	(286)	(256)
Interest paid on PFI	(13,011)	(12,983)
PDC dividend (paid) / refunded	329	(7,745)
Net cash generated from / (used in) financing activities	**2,108**	**(16,980)**
Increase / (decrease) in cash and cash equivalents	**2,162**	**(1,977)**
Cash and cash equivalents at 1 April - brought forward	**82,024**	**84,001**
Cash and cash equivalents at 31 March	**84,186**	**82,024**

Statement of changes in Taxpayers Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**693,901**	**204,668**	**(669,068)**	**229,501**
Deficit for the year	-	-	(11,681)	**(11,681)**
Impairments	-	(8,095)	-	**(8,095)**
Revaluations	-	11,724	-	**11,724**
Public dividend capital received	41,042	-	-	**41,042**
Taxpayers' and others' equity at 31 March 2025	**734,943**	**208,297**	**(680,749)**	**262,491**

Note 35 Better Payments Practice Code

	2024/25 Number	2024/25 £000	2023/24 Number	2023/24 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	129,880	714,550	129,976	657,380
Total non-NHS trade invoices paid within target	127,660	700,695	127,424	644,543
Percentage of non-NHS trade invoices paid within target	**98.3%**	**98.1%**	**98.0%**	**98.0%**
NHS Payables				
Total NHS trade invoices paid in the year	2,756	44,377	2,712	27,189
Total NHS trade invoices paid within target	2,458	38,564	2,459	21,706
Percentage of NHS trade invoices paid within target	**89.2%**	**86.9%**	**90.7%**	**79.8%**

The Better Payments Practice Code requires us to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. We have not signed up to the Prompt Payments Code.

Summary Financial Statements

Cumulative Breakeven Position

Year	Turnover £000	Surplus/ (deficit) £000
1997/98	152,393	(1,199)
1998/99	165,535	(1,246)
1999/00	182,744	1,279
2000/01	193,823	1,225
2001/02	212,576	18
2002/03	235,801	4
2003/04	257,641	3
2004/05	295,327	41
2005/06	299,619	(15,059)
2006/07	333,855	311
2007/08	393,915	3,990
2008/09	371,299	3,008
2009/10	408,938	5,312
2010/11	418,078	4,141
2011/12	426,319	1,050
2012/13	473,558	235
2013/14	475,330	(19,301)
2014/15	623,395	3,782
2015/16	702,917	(26,936)
2016/17	739,279	(27,773)
2017/18	696,630	(69,717)
2018/19	713,838	(63,607)
2019/20	840,636	5,231
2020/21	915,076	7,085
2021/22	980,348	9,126
2022/23	1,064,132	47
2023/24	1,151,805	(8,375)
2024/25	1,292,878	(15,614)
Cumulative breakeven position		**(202,939)**

Our External Auditor

To demonstrate that we are running the Trust properly we are required to publish a number of statements which are signed off by our Chief Executive on behalf of our Trust Board. These statements cover our financial affairs as well as a number of other aspects of managing our Trust.

Our external auditor also checks our accounts and other aspects of our work, and we are required to publish statements from them confirming that they are satisfied with what we have done. These formal statements are reproduced on these pages.

Our accounts are externally audited by Grant Thornton UK LLP, to meet the statutory requirements of the Department of Health. They receive fees of £198k (including VAT).

Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the discretion of the Secretary of State, in England and Wales. As a consequence, it is not possible for our Trust to identify our share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

Full Accounts

A full set of audited accounts for University Hospitals of North Midlands NHS Trust is available on request or can be viewed and downloaded on our website www.uhnm.nhs.uk .

Dr Simon Constable
Chief Executive Officer
25 June 2025

Mr Mark Oldham
Chief Finance Officer
25 June 2025

7

Annual Accounts 2024 / 25

University Hospitals of North Midlands NHS Trust

Annual accounts for the year ended 31 March 2025

Statement of Comprehensive Income

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	3	1,186,037	1,055,578
Other operating income	4	106,840	96,227
Operating expenses	7,9	(1,271,731)	(1,130,192)
Operating surplus from continuing operations		**21,147**	**21,613**
Finance income	11	6,054	5,780
Finance expenses	12	(35,422)	(75,118)
PDC dividends payable		(3,530)	(3,171)
Net finance costs		**(32,898)**	**(72,509)**
Other gains / (losses)	13	70	(78)
Deficit for the year from continuing operations		**(11,681)**	**(50,974)**
Deficit for the year		**(11,681)**	**(50,974)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(16,421)	-
Revaluations	17	20,050	31,267
Total comprehensive expense for the period		**(8,052)**	**(19,707)**

The note below does not form part of the primary statement of accounts. It is included here to show that the deficit for the year of £11.773 million is adjusted for reporting against the breakeven duty (Note 37) and also adjusted for reporting to NHS England on a control total basis which is the primary mechanism for financial control. The adjusted deficit reported to NHS England reflects the Trust's actual financial performance in accordance with NHS England financial measures. Details of the adjustments are provided in note 36.

Breakeven duty and adjusted financial performance		2024/25 £000	2023/24 £000
Breakeven duty financial performance deficit	37	(15,614)	(8,375)
Adjusted financial performance (control total basis) surplus / (deficit)	37	(18,056)	229

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	14	15,985	16,258
Property, plant and equipment	15	715,699	686,251
Right of use assets	18	23,087	18,143
Receivables	20	1,105	1,079
Total non-current assets		**755,876**	**721,732**
Current assets			
Inventories	19	19,219	17,715
Receivables	20	43,518	44,353
Non-current assets held for sale and assets in disposal groups	22	10,900	-
Cash and cash equivalents	23	84,186	82,024
Total current assets		**157,823**	**144,092**
Current liabilities			
Trade and other payables	24	(108,614)	(108,116)
Borrowings	26	(20,286)	(25,668)
Provisions	27	(8,469)	(5,669)
Other liabilities	25	(20,801)	(17,471)
Total current liabilities		**(158,170)**	**(156,924)**
Total assets less current liabilities		**755,529**	**708,900**
Non-current liabilities			
Borrowings	26	(490,255)	(477,104)
Provisions	27	(2,783)	(2,294)
Total non-current liabilities		**(493,038)**	**(479,398)**
Total assets employed		**262,491**	**229,501**
Financed by			
Public dividend capital		734,943	693,901
Revaluation reserve		208,297	204,668
Income and expenditure reserve		(680,749)	(669,068)
Total taxpayers' equity		**262,491**	**229,501**

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

…….

Simon Constable, Chief Executive

25th June 2025

Statement of Changes in Taxpayers Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**693,901**	**204,668**	**(669,068)**	**229,501**
Deficit for the year	-	-	(11,681)	**(11,681)**
Impairments	-	(8,095)	-	**(8,095)**
Revaluations	-	11,724	-	**11,724**
Public dividend capital received	41,042	-	-	**41,042**
Taxpayers' and others' equity at 31 March 2025	**734,943**	**208,297**	**(680,749)**	**262,491**

Public Dividend Capital of £41.042 million was received in 2024/25 for a number of capital schemes, including:

- £17.982 million Community Diagnostic Centres funding for CDC phase 1
- £9.344 million Elective Recovery/Targeted Investment Fund funding for County Breast care unit
- £7.102 million Elective Recovery/Targeted Investment Fund funding for County Day Case Unit
- £3.500 million Front Line Digitisation funding for Digital EPR
- £0.880 million Critical Infrastructure Risk funding for critical risks
- £0.848 million Increasing Capacity funding for Endoscopy equipment
- £0.500 million Diagnostic Imaging Capacity funding for Mobile breast screening
- £0.383 million Diagnostic Imaging Capacity funding for Pathology cancer reporting
- £0.313 million Diagnostic Imaging Capacity funding for MT training scanner
- £0.190 million Digital Technology funding for Cyber security

Statement of Changes in Taxpayers Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**665,039**	**174,203**	**(427,495)**	**411,747**
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	(191,401)	**(191,401)**
Deficit for the year	-	-	(50,974)	**(50,974)**
Revaluations	-	31,267	-	**31,267**
Transfer to retained earnings on disposal of assets	-	(802)	802	**-**
Public dividend capital received	28,862	-	-	**28,862**
Taxpayers' and others' equity at 31 March 2024	**693,901**	**204,668**	**(669,068)**	**229,501**

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus		21,055	21,613
Non-cash income and expense:			
Depreciation and amortisation	7.1	39,720	37,704
Net impairments	8	360	7,026
Income recognised in respect of capital donations	4	(6,047)	(4,581)
(Increase) / decrease in receivables and other assets		(1,010)	16,453
Increase in inventories		(1,504)	(880)
Increase / (decrease) in payables and other liabilities		4,173	(12,485)
Increase / (decrease) in provisions		3,258	(322)
Net cash flows from operating activities		**60,005**	**64,528**
Cash flows from investing activities			
Interest received		6,054	5,780
Purchase of intangible assets		(6,266)	(3,358)
Purchase of PPE and investment property		(63,650)	(56,943)
Sales of PPE and investment property		88	415
Receipt of cash donations to purchase assets		3,823	4,581
Net cash flows used in investing activities		**(59,951)**	**(49,525)**
Cash flows from financing activities			
Public dividend capital received		41,042	28,862
Capital element of lease rental payments		(4,001)	(3,742)
Capital element of PFI, LIFT and other service concession payments		(21,964)	(21,114)
Other interest		(1)	(2)
Interest paid on lease liability repayments		(286)	(256)
Interest paid on PFI, LIFT and other service concession obligations		(13,011)	(12,983)
PDC dividend (paid) / refunded		329	(7,745)
Net cash flows from / (used in) financing activities		**2,108**	**(16,980)**
Increase / (decrease) in cash and cash equivalents		**2,162**	**(1,977)**
Cash and cash equivalents at 1 April - brought forward		**82,024**	**84,001**
Cash and cash equivalents at 31 March	23	**84,186**	**82,024**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Interests in other entities

Under the provisions of IFRS 10 Consolidated Financial Statements, those Charitable Funds that fall under common control with NHS bodies should be consolidated within the entity's financial statements. The Trust has a Charitable Fund, the 'UHNM Charity' that falls under the definition of common control. Common control is defined within IFRS 10 as "the power to govern the financial and operational policies of an entity so as to obtain benefits from its activities". Control is presumed to exist where a parent owns directly or indirectly more than half of the voting power of an entity, including where a body acts as a Corporate Trustee.

The Trustees of the Charitable Fund are all members of the Trust Board. The purpose of an NHS Charity is to assist NHS patients, and HM Treasury view this as the "benefit" link as per the IFRS 10 guidance. The Trust has reviewed the financial statements of the 'UHNM Charity' and it is deemed that the income, expenditure, assets and liabilities of the Charitable Fund are not material. IAS 1 Presentation of Financial Statements states that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material. The consolidation of the Charitable Fund would not have a material impact on the financial statements of the Trust and has therefore not been consolidated into the Trust's financial statements.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The Trust applies standard NHS terms and conditions of 30 day payment terms for all invoices raised to customers and does not offer any further credit terms. Payment is expected once the performance obligations are satisfied and within 30 days of the invoice being raised.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are 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) which 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. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, 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.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trust's do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

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

Education and Training

The Trust receives income from Health Education England (HEE) in relation to medical and non medical trainees. Revenue is in respect of training provided and is recognised when performance obligations are satisfied when training has been performed. All performance obligations are undertaken within the financial year and is agreed and invoiced to HEE. Where training occurs across financial years the income is deferred to match the expenditure.

High cost devices

High cost drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

Note 1.5 Other forms of income

Grants and donations

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

Apprenticeship service income

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

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both These schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The schemes are is not designed in a way that would enable NHS Bodies employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes is are accounted for as though they were it is a defined contribution schemes: the cost to the Trust of participating in a scheme is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the schemes except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Value added tax

Most of the Trust's activities are outside the scope of value added tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT. Entities for which the above is not appropriate should specify an alternative policy

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

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

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

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

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

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

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

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

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

All land (including surplus land) and buildings, are valued at fair value using independent professional valuations in accordance with IAS16 at least every five years, with interim revaluations carried out annually also by independent professional valuers. The full asset valuation includes a full site inspection by the professional valuer whilst interim valuations only include a site inspection where deemed necessary due to significant changes in the year. A full asset valuation was undertaken as at 31st March 2022 and the next full valuation is due in 2027.

Depreciation

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

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

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which The Trust expects to obtain economic benefits or service potential from the asset. This is specific to the 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 finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

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

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated and grant funded assets

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

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

They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as property, plant and equipment, together with an equivalent PFI liability measured in alignment with the principles of IFRS 16.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
• payment for the fair value of services received
• repayment of the PFI liability, including finance costs, and
• payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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

PFI assets, liabilities and finance costs

The PFI assets are initially measured using the principles of IFRS 16. Subsequently, the assets are measured at current value in existing use per the policies applied under IAS 16.

A PFI liability equal to the capital value of the contract is recognised at the same time as the PFI assets are recognised. This does not include service elements and interest charges within the PFI contract which are expensed in accordance with IFRIC 12 as adapted and interpreted by the FReM and as detailed below.

An annual finance cost is calculated by applying the implicit interest rate in the contract to the opening PFI liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive [Income / Net Expenditure].

An element of the annual unitary payment is therefore allocated as a financing cost when repaying the PFI liability over the life of the contract.

Where there is a change in future lease payments resulting from a change in an index or a rate used to determine those payments, including for example a change to reflect changes in market rental rates following a market rent review. The entity remeasures the PFI liability to reflect those revised payments only when there is a change in the cash flows (i.e. when the adjustment to the payments takes effect). The entity shall determine the revised payments for the remainder of the PFI arrangement based on the revised contractual payments. As subsequent measurement of the PFI asset is per IAS 16 than IFRS 16, the opposite entry to adjustment of the PFI liability for such remeasurements is charged to Finance Costs.

Initial recognition

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 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

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.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS 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 short-term accrual or prepayment is recognised respectively.

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.

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

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

Other assets contributed by the NHS Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Useful lives of property, plant and equipment

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

	Min life Years	**Max life Years**
Buildings, excluding dwellings	15	80
Plant & machinery	5	20
Transport equipment	4	7
Information technology	2	10
Furniture & fittings	5	16

Note 1.10 Intangible assets

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 trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

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

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	**Max life Years**
Software licences	2	15

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to the fair value due to the high turnover of stocks.

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

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

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 adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

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

Derecognition

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

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

Note 1.14 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.

HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The Trust is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

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.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is 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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

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 assets, unless 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.

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.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

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

Operating leases

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

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 27.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 28 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 28, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.17 Public dividend capital

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

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

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

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

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

Note 1.18 Value added tax

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

Note 1.19 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.

Note 1.20 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM* .

Note 1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2024/25. These Standards are still subject to HM Treasury FReM adoption.

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FReM which is expected to be from the 1 April 2025. Early adoption is not permitted.

IFRS 18 Presentation and Disclosure in Financial Statements - 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. 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. Early adoption is not permitted.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:
• Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
• Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.
These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:
• A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
• Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £619.684 million as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £204.058 million at 31 March 2025.

Although the impact has not been quantified, the revised valuation assumption may have a material or significant impact on PPE measurement in future periods.

Note 1.25 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

PFI Assets

The Trust's PFI scheme is deemed under International Financial Reporting Standards to be classed as on Statement of Financial Position on the basis that the asset is under the control of the Trust and all risks and rewards sit with the Trust. This is deemed to be a critical judgement that impacts on the financial statements.

The Trust's PFI assets have been valued using the Modern Equivalent Asset (MEA) method at depreciated replacement cost excluding VAT. By excluding VAT the Trust is accurately reflecting the depreciated replacement cost of the PFI assets. Our judgement based on the assumption that any replacement assets would be funded by PFI provider which is a requirement under the PFI project contract agreement. In these circumstances, by the nature of the contract, VAT would be recoverable by the Trust.

Note 1.26 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Provisions

The Trust may be required to review many of the role profiles of its staff paid on band 2 to ensure those profiles accurately reflect the duties and responsibilities of those staff. It is probable that many of these band 2 staff will be found to be undertaking duties typically performed at band 3 level as defined by national NHS Pay Profiles . In such cases those the employees are likely to be rebanded to band 3 and applied retrospectively with an anticipation that pay arrears may be paid accordingly. The Trust has estimated the cost of this review and has included an amount within other provisions in Note 27, however there is uncertainty over the final cost as the review is ongoing.

Estate Valuation

The Trust's valuation approach is to have a full valuation including a full site inspection every 5 years with interim "desk top" valuations on an annual basis. A full valuation was undertaken as at 31st March 2022, which included site valuations to provide assurance that the value of land and building assets within the accounts are not materially misstated at the balance sheet date. An interim valuation was undertaken as at 31st March 2025 as well as a site visit at the Acute Medical Rapid Assessment Unit and the Elective Hub as these were a significant capital scheme that was completed during the year and would impact the valuation.

The net book value of the Trust's Land and buildings as at 31st March 2025 is £619.684 million. If the Trust's management had not revalued the estate, at 31st March 2025 the value of Land, Buildings and Dwellings would have been £593.177 million.

The Trust's valuation adopts the MEA approach for its depreciated replacement cost DRC valuations rather than the identical replacement method. The MEA approach used to value the property is based on the cost of a modern equivalent asset that has the same service potential as the existing asset and then adjusted to take account of functional obsolescence. Functional obsolescence examines a building's design or specification and whether it may no longer fulfil the function for which it was originally designed or whether it may be much more basic than the MEA. The asset will still be capable of use but at a lower level of efficiency than the MEA, or may be capable of modification to bring it up to a current specification. Other common causes of functional obsolescence include advances in technology or legislative change. The obsolescence adjustment will reflect either the cost of upgrading, or if this is not possible, the financial consequences of the reduced efficiency compared with the modern equivalent.

The Trust has made the judgement that the modern equivalent asset would be based around the use of an "optimised alternative site" in that all services would be based at a single site at Royal Stoke. The overall size of the modern equivalent asset includes an examination of building design or specification and makes assumptions around efficiencies. The resulting judgement is that under this approach a number of clinical and administrative areas would be combined into a "notional building" and would result in efficiencies in the overall footprint of the site. As a result the overall footprint provided to the valuer is lower than it would have been on a direct replacement basis.

The Trust obtains valuations for its land, buildings and dwellings from a qualified independent valuer. These valuations are performed at a point in time and take into account conditions and circumstances relevant to that date. In future years, conditions may change resulting in uplifts or impairments being required to the value of land, buildings and dwellings. The valuation has been completed based on the depreciated replacement cost and the remaining useful economic life of the assets.

Note 1.25 sets out the key judgements that impact on the estate valuation provided by the external valuer. Within the external valuation provided by the valuer the major sources of estimation uncertainty are around building indices and the location factor which form part of the overall valuation of assets.

A 1% movement in the BCIS cost indices or location factor for Staffordshire would have an impact of increasing or reducing the valuation of the Trusts estate by £6.042 million based on an overall valuation of building assets of £604.187 million.

PFI

The Trust uses appropriate estimations to allocate the annual unitary payment into the relevant component parts. The Trust obtained professional advice at the beginning of the PFI contract to review and allocate the payments appropriately as set out in note 29.

Note 2 Operating Segments

The Trust operates in a single segment, which is healthcare.

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)	2024/25	2023/24
	£000	£000
Acute services		(Restated)
Income from commissioners under API contracts - variable element*	228,253	206,633
Income from commissioners under API contracts - fixed element*	795,681	723,565
High cost drugs and devices income from commissioners	107,133	92,785
Other NHS clinical income	7,248	4,687
All services		
Private patient income	1,722	1,497
National pay award central funding***	2,352	452
Additional pension contribution central funding**	43,647	25,959
Total income from activities	**1,186,037**	**1,055,578**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2024/25 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1st April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Restatement of prior year comparatives

We have restated the prior period comparators in note 3.1 for two rows of income within Acute Services. We have moved £19.749 million from 'Income from commissioners under API contracts - fixed element' into 'High cost drugs and devices income from commissioners'. We have also amended the name of the latter row to include the words "and devices".

Following work undertaken in 2024/25 to analyse and classify our fixed and variable income we concluded that income related to high cost devices should not be included within fixed income under API contracts. This income is actually reimbursed on a cost and volume basis and, in line with NHSE guidance, the amended row should include both high cost drugs and devices.

Note 3.2 Income from patient care activities (by source)

	2024/25	2023/24
Income from patient care activities received from:	**£000**	**£000**
NHS England (NHSE)	188,626	343,010
Integrated Care Boards (ICBs)	979,240	697,075
Department of Health and Social Care	53	-
Other NHS providers	12	-
Non-NHS: private patients	1,722	1,497
Non-NHS: overseas patients (chargeable to patient)	4,342	1,496
Injury cost recovery scheme	2,842	3,191
Non NHS: other	9,201	9,309
Total income from activities	**1,186,037**	**1,055,578**
Of which:		
Related to continuing operations	1,186,037	1,055,578

Income from NHSE has reduced by £154.384 million and income from ICBs has increased by £282.165 million from the prior year. This is mainly due to the delegation of the majority of specialised commissioning services from NHSE to ICBs, as well as the delegation of the commissioning of dental services.

Non NHS: Other mainly relates to income received from NHS bodies within Wales which are classified as non NHS as such bodies are outside NHS England.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2024/25	2023/24
	£000	£000
Income recognised this year	4,342	1,496
Cash payments received in-year	215	264
Amounts added to provision for impairment of receivables	4,422	1,585
Amounts written off in-year	1,359	13

The Trust wrote off £1.359 million of overseas debt where a number of separate debts were deemed irrecoverable after all forms of debt recovery (including referral to solicitors) had become exhausted.

Note 4 Other operating income

	2024/25			2023/24 (Restated)		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	3,200	-	**3,200**	3,221	-	**3,221**
Education and training	42,052	1,715	**43,767**	35,156	1,630	**36,786**
Non-patient care services to other bodies	40,862	-	**40,862**	39,703	-	**39,703**
Receipt of capital grants and donations and peppercorn leases	-	6,047	**6,047**	-	4,581	**4,581**
Charitable and other contributions to expenditure	-	404	**404**	-	719	**719**
Revenue from operating leases	-	901	**901**	-	898	**898**
Other income	11,660	-	**11,660**	10,319	-	**10,319**
Total other operating income	**97,774**	**9,067**	**106,840**	**88,399**	**7,828**	**96,227**
Of which:						
Related to continuing operations			106,840			96,227

We have reclassified £2.881 million of other income for 2023/24 within Note 4 as non-patient care services to other bodies.

Note 4.1 Analysis of Other Income

		2024/25	2023/24
		£000	£000
Car Parking charges		3,730	3,364
Catering		236	210
Clinical Excellence Awards		426	323
External contribution to Community Diagnostic Centre landlord works		2,433	-
Overseas nurse recruitment		-	580
Pharmacy sales		405	512
Pharmacy services		794	725
Staff accommodation rental		576	573
Other income not identified above	-	3,060	4,032
Total other contract income		**11,660**	**10,319**

Note 5 Fees and charges

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

	2024/25	2023/24
	£000	£000
Income	3,806	3,413
Full cost	(4,590)	(3,052)
Surplus / (deficit)	**(784)**	**361**

The income and full cost shown in the above table relate to the Trust's car parking activities. The impact of significant capital investment has increased the capital charges and other costs incurred relating to the Trust's car parks in 2024/25.

Note 6 Operating leases - University Hospitals of North Midlands NHS Trust as lessor

This note discloses income generated in operating lease agreements where University Hospitals of North Midlands NHS Trust is the lessor.

The Trust receives rental income from commercial retail outlets within the Hospital reception areas and from rental of buildings owned by the Trust.

Note 6.1 Operating lease income

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	901	898
Total in-year operating lease income	**901**	**898**

Note 6.2 Future lease receipts

	31 March 2025	31 March 2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	327	466
- later than one year and not later than two years	332	323
- later than two years and not later than three years	168	328
- later than three years and not later than four years	150	248
- later than four years and not later than five years	133	147
- later than five years	1,010	1,253
Total	**2,120**	**2,765**

Note 7.1 Operating expenses

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	13,537	12,749
Purchase of healthcare from non-NHS and non-DHSC bodies	20,675	8,827
Staff and executive directors costs	783,504	689,689
Remuneration of non-executive directors	178	178
Supplies and services - clinical (excluding drugs costs)	123,979	116,128
Supplies and services - general	9,891	8,593
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	136,775	122,919
Inventories written down	745	531
Consultancy costs	1,206	143
Establishment	5,172	5,588
Premises	43,159	33,296
Transport (including patient travel)	6,030	6,080
Depreciation on property, plant and equipment	34,800	32,828
Amortisation on intangible assets	4,920	4,876
Net impairments	268	7,026
Movement in credit loss allowance: contract receivables / contract assets	4,033	1,296
Increase in other provisions	3,469	151
Change in provisions discount rate(s)	6	(70)
Fees payable to the external auditor		
audit services- statutory audit	198	204
Internal audit costs	169	145
Clinical negligence	26,042	25,458
Legal fees	131	182
Insurance	97	92
Research and development	3,818	3,188
Education and training	4,511	4,064
Expenditure on short term leases	316	347
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	41,444	43,493
Car parking & security	833	683
Hospitality	138	117
Losses, ex gratia & special payments	38	-
Other services, eg external payroll	761	620
Other	888	771
Total	**1,271,731**	**1,130,192**
Of which:		
Related to continuing operations	1,271,823	1,130,192

[1]Staff and executive directors costs include £43.647 million (2023/24: £25.959 million) in respect of central funding of additional pension contributions.

[2]The fees payable to the external auditor are inclusive of VAT, and the net fee is £165k.

Note 7.2 Other auditor remuneration

The Trust did not incur any other audit costs.

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2,000k (2023/24: £2,000k).

Note 8 Impairment of assets

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	425	275
Changes in market price	(157)	6,751
Total net impairments charged to operating surplus / deficit	**268**	**7,026**
Impairments charged to the revaluation reserve	8,095	-
Total net impairments	**8,363**	**7,026**

Impairments in the above table represent a reduction in the value of individual assets following the valuations of the Trust's land and building assets as at 31st March 2025. Changes in market prices of £0.157 million is the net of an impairment of £2.467 million and a reversal of impairment of £2.624 million. Reversals of impairments are due to an increase in the valuation of assets where there has been a previous reduction in value that has been charged to the SOCI. The increase in the value of building assets is due to an increase in price indices, changes in the location factor and the impact of capital work undertaken by the Trust included in the valuation at the end of the 2024/25 financial year.

Impairments charged to the revaluation reserve of £8.095 million include a £6.160 million impairment on the Trust's MEA asset following the completion of major estates schemes during 2024/25 and subsequent revaluation as at 31st March 2025.

Note 9 Employee benefits

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	599,809	523,109
Social security costs	58,598	54,765
Apprenticeship levy	2,899	2,661
Employer's contributions to NHS pensions	108,750	84,738
Pension cost - other	128	160
Temporary staff (including agency)	18,665	29,073
Total gross staff costs	**788,849**	**694,506**
Total staff costs	**788,849**	**694,506**
Of which		
Costs capitalised as part of assets	1,527	1,629

Costs in the above table relating to salaries and wages, social security costs and employer's contribution to NHS Pensions have increased due to the impact of the staff pay award and increase in the pension contribution from 6.3% to 9.4% in 2024/25.

Note 9.1 Retirements due to ill-health

During 2024/25 there were 5 early retirements from the Trust agreed on the grounds of ill-health (9 in the year ended 31st March 2024). The estimated additional pension liabilities of these ill-health retirements is £392k (£1,516k in 2023/24).

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

Note 10 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. 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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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.

Additional defined contribution scheme

The Trust offers an additional defined contribution workplace pension scheme - the National Employment Savings Scheme (NEST). This is not material.

Note 11 Finance income

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

	2024/25 £000	2023/24 £000
Interest on bank accounts	6,054	5,780
Total finance income	**6,054**	**5,780**

Note 12.1 Finance expenditure

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

	2024/25 £000	2023/24 £000
Interest expense:		
Interest on lease obligations	286	256
Interest on late payment of commercial debt	1	2
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	13,011	12,983
Remeasurement of the liability resulting from change in index or rate[1]	22,093	61,845
Total interest expense	**35,391**	**75,086**
Unwinding of discount on provisions	31	32
Total finance costs	**35,422**	**75,118**

[1]The PFI lease liability remeasurement is based on the RPI indexation applicable to the PFI unitary payment each year and is applied to the opening liability. The RPI applicable to the unitary payment in 2024/25 was 4.5% (13.83% in 2023/24).

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2024/25 £000	2023/24 £000
Amounts included within interest payable arising from claims made under this legislation	1	2

Note 13 Other gains / (losses)

	2024/25 £000	2023/24 £000
Gains on disposal of assets	70	38
Losses on disposal of assets	-	(116)
Total gains / (losses) on disposal of assets	**70**	**(78)**
Total other gains / (losses)	**70**	**(78)**

Note 14.1 Intangible assets - 2024/25

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**52,846**	**1,067**	**53,913**
Additions	3,670	977	**4,647**
Reclassifications	535	(535)	**-**
Disposals / derecognition	(2,510)	-	**(2,510)**
Valuation / gross cost at 31 March 2025	**54,541**	**1,509**	**56,050**
Amortisation at 1 April 2024 - brought forward	**37,655**	**-**	**37,655**
Provided during the year	4,920	-	**4,920**
Disposals / derecognition	(2,510)	-	**(2,510)**
Amortisation at 31 March 2025	**40,065**	**-**	**40,065**
Net book value at 31 March 2025	**14,476**	**1,509**	**15,985**
Net book value at 1 April 2024	**15,191**	**1,067**	**16,258**

Note 14.2 Intangible assets - 2023/24

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2023	**52,618**	**419**	**53,037**
Additions	2,291	854	**3,145**
Impairments	(177)	-	**(177)**
Reclassifications	(1)	(206)	**(207)**
Disposals / derecognition	(1,885)	-	**(1,885)**
Valuation / gross cost at 31 March 2024	**52,846**	**1,067**	**53,913**
Amortisation at 1 April 2023	**34,644**	**-**	**34,644**
Provided during the year	4,876	-	**4,876**
Impairments	(54)	-	**(54)**
Disposals / derecognition	(1,811)	-	**(1,811)**
Amortisation at 31 March 2024	**37,655**	**-**	**37,655**
Net book value at 31 March 2024	**15,191**	**1,067**	**16,258**
Net book value at 1 April 2023	**17,974**	**419**	**18,393**

Note 15.1 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**26,567**	**576,140**	**17,630**	**134,610**	**28**	**23,268**	**7,376**	**785,619**
Additions	-	23,354	20,925	14,322	-	8,963	133	**67,697**
Impairments	(175)	(17,646)	-	(376)	-	(925)	-	**(19,122)**
Reversals of impairments	5	1,264	-	-	-	-	-	**1,269**
Revaluations	-	4,210	-	-	-	-	-	**4,210**
Reclassifications	-	16,865	(17,918)	774	-	200	79	**-**
Transfers to / from assets held for sale	(10,900)	-	-	-	-	-	-	**(10,900)**
Disposals / derecognition	-	-	-	(12,613)	-	(1,465)	(164)	**(14,242)**
Valuation/gross cost at 31 March 2025	**15,497**	**604,187**	**20,637**	**136,717**	**28**	**30,041**	**7,424**	**814,531**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**-**	**-**	**79,811**	**28**	**13,526**	**6,003**	**99,368**
Provided during the year	-	15,994	-	11,132	-	3,058	374	**30,558**
Impairments	-	(7,259)	-	(177)	-	(699)	-	**(8,135)**
Reversals of impairments	-	(1,355)	-	-	-	-	-	**(1,355)**
Revaluations	-	(7,380)	-	-	-	-	-	**(7,380)**
Disposals / derecognition	-	-	-	(12,595)	-	(1,465)	(164)	**(14,224)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**78,171**	**28**	**14,420**	**6,213**	**98,832**
Net book value at 31 March 2025	**15,497**	**604,187**	**20,637**	**58,546**	**-**	**15,621**	**1,211**	**715,699**
Net book value at 1 April 2024	**26,567**	**576,140**	**17,630**	**54,799**	**-**	**9,742**	**1,373**	**686,251**

Note 15.2 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023	**25,910**	**519,594**	**16,820**	**142,406**	**701**	**18,935**	**8,790**	**733,156**
Additions	-	11,056	38,698	9,198	-	4,835	103	**63,890**
Impairments	(5,053)	(2,762)	-	(897)	-	-	-	**(8,712)**
Reversals of impairments	-	221	-	-	-	-	-	**221**
Revaluations	360	16,876	-	-	-	-	-	**17,236**
Reclassifications	5,350	31,475	(37,888)	1,060	-	197	13	**207**
Disposals / derecognition	-	(320)	-	(17,157)	(673)	(699)	(1,530)	**(20,379)**
Valuation/gross cost at 31 March 2024	**26,567**	**576,140**	**17,630**	**134,610**	**28**	**23,268**	**7,376**	**785,619**
Accumulated depreciation at 1 April 2023	**-**	**-**	**-**	**86,052**	**701**	**11,681**	**7,150**	**105,584**
Provided during the year	-	14,604	-	11,570	-	2,524	357	**29,055**
Impairments	-	(72)	-	(745)	-	-	-	**(817)**
Reversals of impairments	-	(771)	-	-	-	-	-	**(771)**
Revaluations	-	(13,761)	-	-	-	-	-	**(13,761)**
Disposals / derecognition	-	-	-	(17,066)	(673)	(679)	(1,504)	**(19,922)**
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**79,811**	**28**	**13,526**	**6,003**	**99,368**
Net book value at 31 March 2024	**26,567**	**576,140**	**17,630**	**54,799**	**-**	**9,742**	**1,373**	**686,251**
Net book value at 1 April 2023	**25,910**	**519,594**	**16,820**	**56,354**	**-**	**7,254**	**1,640**	**627,572**

Note 15.3 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	15,497	351,799	20,623	43,651	12,759	1,178	**445,507**
On-SoFP PFI contracts and other service concession arrangements	-	247,481	-	7,960	2,684	-	**258,125**
Owned - donated/granted	-	4,907	14	6,935	178	33	**12,067**
Total net book value at 31 March 2025	**15,497**	**604,187**	**20,637**	**58,546**	**15,621**	**1,211**	**715,699**

Note 15.4 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	26,567	331,092	16,237	39,129	9,110	1,335	**423,470**
On-SoFP PFI contracts and other service concession arrangements	-	241,019	-	7,979	340	-	**249,338**
Owned - donated/granted	-	4,029	1,393	7,691	292	38	**13,443**
Total net book value at 31 March 2024	**26,567**	**576,140**	**17,630**	**54,799**	**9,742**	**1,373**	**686,251**

Note 16 Donations of property, plant and equipment

The UHNM Charity donated £3.520 million to the Trust in 2024/25 (2023/24: £2.351 million) in respect of assets acquired in the financial year. The Trust has acquired £2.527 million of Government Granted assets in 2024/25 (2023/24: £2.230 million).

Note 17 Revaluations of property, plant and equipment

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuation as at 31st March 2025 in relation to our operational land and buildings was carried out by a qualified independent valuer from the District Valuation Service. The valuation of our surplus land at the Royal Stoke Infirmary and the Central Outpatient Department (COPD) sites as at the 15th November 2024 was undertaken by a qualified independent valuer.

Valuation approach
As set out in the accounting policies the Department of Health has adopted the Modern Equivalent Asset (MEA) approach for its Depreciated Replacement Cost (DRC) valuations rather than the previous identical replacement method. The MEA approach used to value the property will normally be based on the cost of a modern equivalent asset that has the same service potential as the existing asset and then adjusted to take account of obsolescence.

The MEA approach incorporates the Building Cost Information Service Index to determine an increase or decrease in building costs which impact on the asset valuation. The Trust's land and building valuation was carried out by the Trust's current valuer (District Valuer), on a MEA "Optimised Alternative Site" method valuation.

The valuation has been undertaken having regard to IFRS as applied to the UK public sector and in accordance with HM Treasury guidance.

All land and buildings are restated to current value using independent professional valuations in accordance with IAS16 and in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. at least every five years, with interim revaluations carried out annually also by independent professional valuers. The full asset valuation includes a full site inspection by the professional valuer whilst interim valuations only include a site inspection where deemed necessary due to significant changes in the year. An interim valuation was undertaken of our operational land and buildings as at 31st March 2025 including a site visit to the Trust's newly completed Acute Medical Rapid Assessment Unit (AMRAU) and the Elective Hub, both of which would have a significant impact on the valuation. The last full valuation of these assets was as at 31st March 2022.

A separate, full asset valuation was undertaken of the surplus land at the Royal Infirmary and Central Outpatient Department sites as at 15th November 2025. We subsequently reclassified this land as held for sale and both the valuation and classification remain applicable as at 31st March 2025.

The value of land, buildings and dwelling assets provided by the District Valuer at 31st March 2025 was £619.684 million (2023/24: £591.633 million), the valuation is reflected in note 15.1 and reflects an increase of £28.051 million from the previous valuation at 31 March 2024. Note 15.1 reflects the impact of the valuation of the former Royal Infirmary site surplus land (£8.150 million) and COPD site surplus land (£2.750 million) prior to the reclassification to an asset held for sale as stated above.

The carrying values of PPE are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. Further information is provided in Note 7 to explain the impairments resulting from the valuation.

The asset lives relating to buildings and dwellings are provided as part of the independent valuation of the Trusts assets by the external valuer.

Asset lives for dwellings are no longer disclosed as all of the Trust's dwellings are leased and have been reclassified as Right of Use (RoU) assets.

Note 18 Right of use assets - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**13,266**	**12,148**	**427**	**1,799**	**27,640**	**2,746**
Additions	4,655	220	56	2,885	**7,816**	572
Remeasurements of the lease liability	48	711	-	477	**1,236**	(55)
Revaluations	(4)	-	-	-	**(4)**	(4)
Reclassifications	-	-	-	-	**-**	2,135
Disposals / derecognition	(666)	(961)	(12)	(14)	**(1,653)**	-
Valuation/gross cost at 31 March 2025	**17,299**	**12,118**	**471**	**5,147**	**35,035**	**5,394**
Accumulated depreciation at 1 April 2024 - brought forward	**2,048**	**6,074**	**127**	**1,248**	**9,497**	**-**
Provided during the year	1,867	1,655	141	579	**4,242**	292
Revaluations	(138)	-	-	-	**(138)**	(91)
Reclassifications	-	-	-	-	**-**	331
Disposals / derecognition	(666)	(961)	(12)	(14)	**(1,653)**	-
Accumulated depreciation at 31 March 2025	**3,111**	**6,768**	**256**	**1,813**	**11,948**	**532**
Net book value at 31 March 2025	**14,188**	**5,350**	**215**	**3,334**	**23,087**	**4,862**
Net book value at 1 April 2024	**11,218**	**6,074**	**300**	**551**	**18,143**	**2,746**

Net book value of right of use assets leased from other NHS providers	2,490
Net book value of right of use assets leased from other DHSC group bodies	2,367

Note 18.1 Right of use assets - 2023/24

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**11,610**	**11,141**	**176**	**1,799**	**24,726**	**2,312**
Additions	1,222	1,260	279	-	**2,761**	-
Remeasurements of the lease liability	359	-	1	-	**360**	278
Revaluations	142	-	-	-	**142**	156
Disposals / derecognition	(67)	(253)	(29)	-	**(349)**	-
Valuation/gross cost at 31 March 2024	**13,266**	**12,148**	**427**	**1,799**	**27,640**	**2,746**
Accumulated depreciation at 1 April 2023 - brought forward	808	4,498	32	622	**5,960**	-
Provided during the year	1,413	1,610	124	626	**3,773**	82
Revaluations	(128)	-	-	-	**(128)**	(82)
Disposals / derecognition	(45)	(34)	(29)	-	**(108)**	-
Accumulated depreciation at 31 March 2024	**2,048**	**6,074**	**127**	**1,248**	**9,497**	**-**
Net book value at 31 March 2024	**11,218**	**6,074**	**300**	**551**	**18,143**	**2,746**
Net book value at 1 April 2023	**10,802**	**6,643**	**144**	**1,177**	**18,766**	**2,312**

Net book value of right of use assets leased from other NHS providers	2,468

Note 18.2 Revaluations of right of use assets

The Trust has applied the revaluation model in IAS 16 and revalued several right of use assets in 2024/25 including peppercorn leases and areas leased at other Trusts relating to the pathology service. An overall valuation increase of £0.134 million is broken down as £0.087 million relating to property leased from other NHS providers and £0.047 million relating to other property leases.

Note 18.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 26.1.

	2024/25	2023/24
	£000	£000
Carrying value at 1 April	**13,183**	**14,083**
Lease additions	7,816	2,761
Lease liability remeasurements	1,236	360
Interest charge arising in year	286	256
Early terminations	-	(279)
Lease payments (cash outflows)	(4,287)	(3,998)
Carrying value at 31 March	**18,234**	**13,183**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 18.4 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	5,672	213	4,800	191
- later than one year and not later than five years;	9,072	1,140	6,188	745
- later than five years.	5,684	1,202	2,781	1,272
Total gross future lease payments	**20,428**	**2,555**	**13,769**	**2,208**
Finance charges allocated to future periods	(2,194)	(181)	(586)	(119)
Net lease liabilities at 31 March 2025	**18,234**	**2,374**	**13,183**	**2,089**
Of which:				
Leased from other NHS providers		26		3
Leased from other DHSC group bodies		2,348		2,086

Note 19 Inventories

	31 March 2025	31 March 2024
	£000	£000
Drugs	5,952	5,085
Consumables	13,114	12,501
Energy	153	129
Total inventories	**19,219**	**17,715**

Inventories recognised in expenses for the year were £264.234 million (2023/24: £241,519k). Write-down of inventories recognised as expenses for the year were £0.745 million (2023/24 £0.531 million).

Note 20.1 Receivables

	31 March 2025	31 March 2024
	£000	£000
Current		
Contract receivables	34,343	35,164
Capital receivables	2,224	-
Allowance for impaired contract receivables / assets	(9,995)	(7,187)
Prepayments (non-PFI)	12,837	7,332
PFI lifecycle prepayments	177	361
PDC dividend receivable	93	3,952
VAT receivable	3,804	4,721
Other receivables	35	10
Total current receivables	**43,518**	**44,353**
Non-current		
Other receivables	1,105	1,079
Total non-current receivables	**1,105**	**1,079**
Of which receivable from NHS and DHSC group bodies:		
Current	11,770	15,888
Non-current	1,105	1,066

Current and non current other receivables relate to the clinician pension tax provision reimbursement funding receivable from NHS England.

Capital receivables of £2.224 million relate to grant monies owed to the Trust in relation to the Public Sector Decarbonisation Scheme.

Note 20.2 Allowances for credit losses

	2024/25	2023/24
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**7,187**	**5,997**
New allowances arising	4,091	3,355
Changes in existing allowances	480	(163)
Reversals of allowances	(538)	(1,896)
Utilisation of allowances (write offs)	(1,225)	(106)
Allowances as at 31 Mar 2025	**9,995**	**7,187**

In line with IFRS 9 the Trust has reviewed the likelihood non receipt of income for, overseas patients, private patients, payroll reclaims and other commercial income and has agreed the probability to use for the recognition of doubtful debts. For RTA accruals the Trust has used the prescribed rate of 24.45% (2023/24: 23.07%). The Trust's management considers that this is a reasonable estimate of the value of asset.

The increase or decrease for allowance for credit losses is reviewed on a monthly basis and increased or decreased dependent upon the Trust's view of receivables deemed to be potentially at risk of being collected in full.

Note 20.3 Exposure to credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2025 are in receivables from customers, as disclosed in the trade and other receivables note.

Note 21 Finance leases (University Hospitals of North Midlands NHS Trust as a lessor)

The Trust has no finance leases where it acts as lessor.

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

	2024/25	2023/24
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**
Assets classified as available for sale in the year	10,900	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**10,900**	**-**

The Trust has reclassified surplus land at the former Royal Infirmary and COPD sites as assets held for sale as this now meets the definition under IFRS 5 and the Trust has commenced a sales process for the land.

Note 23 Cash and cash equivalents movements

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

	2024/25	2023/24
	£000	£000
At 1 April	**82,024**	**84,001**
Net change in year	2,162	(1,977)
At 31 March	**84,186**	**82,024**
Broken down into:		
Cash at commercial banks and in hand	7	7
Cash with the Government Banking Service	84,179	82,017
Total cash and cash equivalents as in SoFP	**84,186**	**82,024**
Total cash and cash equivalents as in SoCF	**84,186**	**82,024**

Note 23.1 Third party assets held by the Trust

University Hospitals of North Midlands NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2025	31 March 2024
	£000	£000
Bank balances	10	30
Total third party assets	**10**	**30**

Note 24 Trade and other payables

	31 March 2025	31 March 2024
	£000	£000
Current		
Trade payables	5,167	4,795
Capital payables	15,045	15,390
Accruals	62,837	63,798
Social security costs	16,099	15,333
Pension contributions payable	9,466	8,800
Total current trade and other payables	**108,614**	**108,116**
Of which payables from NHS and DHSC group bodies:		
Current	6,495	6,771

The Trust had no non-current trade and other payables.

The total for accruals above includes an annual leave accrual of £8.597 million (2023/24: £7.099 million).

Note 25 Other liabilities

	31 March 2025	31 March 2024
Current	£000	£000
Deferred income: contract liabilities	20,801	17,471
Total other current liabilities	**20,801**	**17,471**

The Trust had no other non-current liabilities.

Note 26.1 Borrowings

	31 March 2025	31 March 2024
Current	£000	£000
Lease liabilities	5,213	4,607
Obligations under PFI, LIFT or other service concession contracts	15,073	21,061
Total current borrowings	**20,286**	**25,668**
Non-current		
Lease liabilities	13,021	8,576
Obligations under PFI, LIFT or other service concession contracts	477,234	468,528
Total non-current borrowings	**490,255**	**477,104**

Note 26.2 Reconciliation of liabilities arising from financing activities

	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2024	**13,183**	**489,589**	**502,772**
Cash movements:			
Financing cash flows - payments and receipts of principal	(4,001)	(21,964)	**(25,965)**
Financing cash flows - payments of interest	(286)	(13,011)	**(13,297)**
Non-cash movements:			
Additions	7,816	2,589	**10,405**
Lease liability remeasurements	1,236	-	**1,236**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	22,093	**22,093**
Application of effective interest rate	286	13,011	**13,297**
Carrying value at 31 March 2025	**18,234**	**492,307**	**510,541**

	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2023	**14,083**	**256,726**	**270,809**
Cash movements:			
Financing cash flows - payments and receipts of principal	(3,742)	(21,114)	**(24,856)**
Financing cash flows - payments of interest	(256)	(12,982)	**(13,238)**
Non-cash movements:			
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	191,401	**191,401**
Additions	2,761	730	**3,491**
Lease liability remeasurements	360	-	**360**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	61,845	**61,845**
Application of effective interest rate	256	12,983	**13,239**
Early terminations	(279)	-	**(279)**
Carrying value at 31 March 2024	**13,183**	**489,589**	**502,772**

Note 27 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2024	**218**	**1,112**	**1,348**	**5,285**	**7,963**
Change in the discount rate	-	6	-	(10)	**(4)**
Arising during the year	31	48	96	6,553	**6,728**
Utilised during the year	(35)	(78)	(168)	(14)	**(295)**
Reversed unused	-	-	(827)	(2,400)	**(3,227)**
Unwinding of discount	4	27	-	56	**87**
At 31 March 2025	**218**	**1,115**	**449**	**9,470**	**11,252**
Expected timing of cash flows:					
- not later than one year;	31	73	-	8,365	**8,469**
- later than one year and not later than five years;	118	276	-	109	**503**
- later than five years.	69	766	449	996	**2,280**
Total	**218**	**1,115**	**449**	**9,470**	**11,252**

The Trust has provided £1.333 million (2023/24: £1.329 million) in respect of post employment pension obligations for 18 former employees (2023/24: 20). The Trust has reassessed these provisions during 2024/25 and updated the assumptions around the calculation of the provision in line with up to date life expectancy tables. The Trust has also applied the applicable discount rate for 2024/25 of 2.40% (2023/24 2.45%).

The Trust has provided £0.449 million (2023/24 £1.348 million) in respect of legal cases. This includes £0.252 million which relates to current employment legal cases and £0.197 million relating to the insurance excess on public and employer liability cases being administered by the NHS Litigation Authority.

In all these cases the timing and the value of the payments are uncertain and the Trust has provided based on the advice provided by legal advisors and the NHS Litigation Authority.

Other provisions includes £7.575 million in relation to the potential cost of uplifting some band 2 staff to band 3 (2023/24: £3.454 million); lease dilapidations of £0.755 million (2023/24: £0.755 million) and the clinicians' pension reimbursement £1.141 million (2023/24: £1.077 million). Lease dilapidations are the works estimated to be required to put back a property at the end of the lease into the same condition it was when the lease commenced. The clinicians' pension reimbursement provision covers the estimated costs of reimbursing clinicians who face a tax charge in respect of their NHS pension benefits.

Note 27.1 Clinical negligence liabilities

At 31 March 2025, £280,057k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of University Hospitals of North Midlands NHS Trust (31 March 2024: £134,525k).

Note 28 Contingent assets and liabilities

	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities		
NHS Resolution legal claims	(53)	(68)
Gross value of contingent liabilities	**(53)**	**(68)**
Net value of contingent liabilities	**(53)**	**(68)**

The Trust had no contingent assets as at 31st March 2025.

The above relates to the member contingent liability relating to the excess due on clinical negligence cases covered by the NHS Litigation Authority.

Note 29 Contractual capital commitments

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	32,353	9,686
Intangible assets	-	224
Total	**32,353**	**9,910**

Property plant and equipment contractual commitments include £20.616 million in relation to the Community Diagnostic Centre (CDC) and £9.071 million in relation to the Breast Care Unit.

Note 30 On-SoFP PFI service concession arrangements

The scheme covers the redevelopment of the Royal Stoke (formerly City General) site, facilities management services, PACS equipment, and a managed equipment service.

The Trust retains its existing estate at the Royal Stoke (formerly City General) site in addition to new buildings covered by the PFI scheme.

The main PFI contract ends in August 2044. A monthly unitary payment will be paid up to that point. Historically, bullet payments have been made to reduce the monthly unitary payment. The unitary payment is subject to annual increases in line with RPI. Services are subject to market testing in line with the contract. The arrangement requires the operator to deliver services to the Trust in accordance with the service delivery specification. Non delivery of quality or performance can lead to a reduction in the service charge being paid by the Trust. The Trust retains step in rights should the contractor fail to meet minimum standards as set out within the contract. Under IFRIC 12 the asset is treated as an asset of the Trust. The substance of the contract is that the Trust has a lease and payments comprise 2 elements – imputed lease charges and service charges. Details of the imputed lease charges are included within the table below.

Note 30.1 On-SoFP PFI service concession arrangement obligations

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

	31 March 2025 £000	31 March 2024 £000
Gross PFI service concession liabilities	**631,716**	**635,402**
Of which liabilities are due		
- not later than one year;	27,559	33,503
- later than one year and not later than five years;	130,707	119,444
- later than five years.	473,450	482,455
Finance charges allocated to future periods	(139,409)	(145,813)
Net PFI service concession arrangement obligation	**492,307**	**489,589**
- not later than one year;	15,073	21,061
- later than one year and not later than five years;	85,687	74,435
- later than five years.	391,547	394,093

Note 30.2 Total on-SoFP PFI service concession arrangement commitments

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

	31 March 2025	31 March 2024
	£000	£000
Total future payments committed in respect of the PFI service concession arrangements	**1,614,881**	**1,616,007**
Of which payments are due:		
- not later than one year;	80,744	76,953
- later than one year and not later than five years;	322,976	307,811
- later than five years.	1,211,161	1,231,243

Note 30.3 Analysis of amounts payable to service concession operator

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

	2024/25	2023/24
	£000	£000
Unitary payment payable to service concession operator	**79,947**	**80,879**
Consisting of:		
- Interest charge	13,011	12,983
- Repayment of balance sheet obligation	21,964	21,113
- Service element and other charges to operating expenditure	41,444	43,493
- Capital lifecycle maintenance	3,351	3,290
- Addition to lifecycle prepayment	177	-
Total amount paid to service concession operator	**79,947**	**80,879**

Note 31 Financial instruments

Note 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with ICBs and the way those ICBs are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

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

Currency risk

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

Interest rate risk

The Trust may borrow from government for revenue financing subject to approval by NHS Improvement at rates set by the Department of Health (the lender).

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2023 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

Note 31.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	26,572	26,572
Cash and cash equivalents	84,186	84,186
Total at 31 March 2025	**110,758**	**110,758**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	27,990	27,990
Cash and cash equivalents	82,024	82,024
Total at 31 March 2024	**110,014**	**110,014**

Note 31.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	18,234	18,234
Obligations under PFI, LIFT and other service concession contracts	492,307	492,307
Trade and other payables excluding non financial liabilities	74,452	74,452
Total at 31 March 2025	**584,993**	**584,993**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	13,183	13,183
Obligations under PFI, LIFT and other service concession contracts	489,589	489,589
Trade and other payables excluding non financial liabilities	76,883	76,883
Total at 31 March 2024	**579,655**	**579,655**

Note 31.4 Maturity of financial liabilities

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

	31 March 2025	31 March 2024
	£000	£000
In one year or less	107,683	115,186
In more than one year but not more than five years	139,779	125,632
In more than five years	479,134	485,236
Total	**726,596**	**726,054**

Note 31.5 Fair values of financial assets and liabilities

The Trust has assessed its financial assets and liabilities in line with the requirements of IFRS 7 and for financial assets and liabilities that fall within the scope the Trust has deemed that book value (carrying value) is a reasonable approximation of fair value.

Note 32 Losses and special payments

	2024/25		2023/24	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	613	1,392	97	54
Stores losses and damage to property	6	746	6	850
Total losses	**619**	**2,138**	**103**	**904**
Special payments				
Ex-gratia payments	48	38	53	21
Special severance payments	-	-	1	19
Total special payments	**48**	**38**	**54**	**40**
Total losses and special payments	**667**	**2,176**	**157**	**944**

Note 33 Related parties

UHNM Charity

We are required to disclose the UHNM Charity as a related party under IAS 24 (payments, receipts, income and expenditure).

The Trust received revenue and capital payments from the UHNM Charity during 2024/25, and all of the Trustees are also members of the Trust board. In 2024/25 the total amount received from the UHNM Charity was £3.520 million (2023/24: £2.570 million). At the end of the year £1.244 million (2023/24: £1.878 million) was outstanding and is included within trade and other receivables. The income received relates mainly to the purchase by the UHNM Charity of equipment that enhances the service provided by the Trust. For practical purposes these purchases are administered via the Trust's established ordering and payment procedures with the UHNM Charity reimbursing the cost to the Trust. The charitable and other contributions to revenue expenditure income disclosed in Note 4 relates to services provided by the Trust to the UHNM Charity, i.e. the running of the Appeals Dept.

Post Graduate Medical Centre (PGMC)

The PGMC is a charity that provides conference, seminar, library and IT facilities for the Trust to enable education of general practitioners, hospital doctors and dentists, medical students and other members of the multi-disciplinary team in Mid and North Staffordshire. The Trust's Chief Financial Officer is also a Trustee of the PGMC. During 2024/25 the Trust received £14k from the PGMC for administrative support and paid them £97k for the facilities provided.

Department of Health and Social Care (DHSC)

The Department of Health and Social Care (DHSC) is regarded as a related party as it is our governing body. During the year the Trust has had a significant number of material transactions with the DHSC and with other entities for which the DHSC is also regarded as the governing body - including NHS England; other NHS Trusts; NHS Foundation Trusts; and Integrated Care Boards (ICBs).

DHSC transactions

The Trust received total NHS income of £1,208.793 million in 2024/25 (2023/24: £1,092.417 million).

The majority of this income was received from Integrated Care Boards: £979.239 million and NHS England (including Health Education England): £188.626 million.

Other government departments

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. The majority of these transactions have been with HM Revenue and Customs (£61.467 million expenditure; £16.099 million payables; £3.804 million VAT receivables); and the NHS Pension scheme (£108.878 million expenditure; £9.438 million payables).

Note 34 Prior period adjustments

Linked with an adjusted misstatement of £24.502 million in relation to income classification, an adjustment of £19.749 million is also required to the comparatives in note 3.1 for two rows of income within Acute Services. We have moved £19.749 million from 'Income from commissioners under API contracts - fixed element' into 'High cost drugs and devices income from commissioners'. We have also amended the name of the latter row to include the words "and devices".

Following work undertaken in 2024/25 to analyse and classify our fixed and variable income we concluded that income related to high cost devices should not be included within fixed income under API contracts. This income is actually reimbursed on a cost and volume basis and, in line with NHSE guidance, the amended row should include both high cost drugs and devices.

Note 35 Better Payment Practice code

	2024/25	2024/25	2023/24	2023/24
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	129,880	714,550	129,976	657,380
Total non-NHS trade invoices paid within target	127,660	700,695	127,424	644,543
Percentage of non-NHS trade invoices paid within target	**98.3%**	**98.1%**	**98.0%**	**98.0%**
NHS Payables				
Total NHS trade invoices paid in the year	2,756	44,377	2,712	27,189
Total NHS trade invoices paid within target	2,458	38,564	2,459	21,706
Percentage of NHS trade invoices paid within target	**89.2%**	**86.9%**	**90.7%**	**79.8%**

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

Note 36 Capital Resource Limit

	2024/25	2023/24
	£000	**£000**
Gross capital expenditure	81,396	70,156
Less: Disposals	(18)	(772)
Less: Donated and granted capital additions	(6,047)	(4,581)
Charge against Capital Resource Limit	**75,331**	**64,803**
Capital Resource Limit	90,982	64,803
Under / (over) spend against CRL	**15,651**	**-**

Note 37 Breakeven duty financial performance	2024/25	2023/24
	£000	**£000**
Deficit for the period	**(11,773)**	**(50,974)**
Remove net impairments not scoring to the Departmental expenditure limit	360	7,026
Adjust for I&E impact of IFRIC 12 schemes on former UK GAAP basis (IFRIC 12 breakeven adjustment)	-	37,585
Remove I&E impact of capital grants and donations	(4,293)	(2,300)
Remove net impact of DHSC centrally procured inventories	92	288
Breakeven duty financial performance deficit	**(15,614)**	**(8,375)**
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis (IFRIC 12 breakeven adjustment)	75,937	74,828
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis (IFRIC 12 breakeven adjustment)	(78,379)	(37,585)
Add back I&E impact of IFRIC 12 schemes on an IAS 17 basis	-	(28,639)
Adjusted financial performance (control total basis) surplus / (deficit)	**(18,056)**	**229**

Note 38 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		5,312	4,141	1,050	235	(19,301)	3,782	(26,936)	(27,773)
Breakeven duty cumulative position	(7,625)	(2,313)	1,828	2,878	3,113	(16,188)	(12,406)	(39,342)	(67,115)
Operating income		408,938	418,078	426,319	473,558	475,330	623,835	702,917	739,279
Cumulative breakeven position as a percentage of operating income		(0.6%)	0.4%	0.7%	0.7%	(3.4%)	(2.0%)	(5.6%)	(9.1%)

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(69,717)	(63,607)	5,231	7,085	9,126	47	(8,375)	(15,614)
Breakeven duty cumulative position	(136,832)	(200,439)	(195,208)	(188,123)	(178,997)	(178,950)	(187,325)	(202,939)
Operating income	696,630	713,838	840,636	915,076	980,348	1,064,132	1,151,805	1,292,878
Cumulative breakeven position as a percentage of operating income	(19.6%)	(28.1%)	(23.2%)	(20.6%)	(18.3%)	(16.8%)	(16.3%)	(15.7%)

The Trust has a statutory duty to break even on a cumulative basis.

Due to the significant deterioration in the Trust's financial performance and forecast position, the Trust's auditors issued a section 30 referral to the Secretary of State for Health on 22 May 2017 reporting that the Trust's expenditure is likely to continue to exceed income for the foreseeable future. A further referral was made for 2024/25 on the 28/05/2025 as the Trust remains in deficit on a cumulative basis.

The Trust ended the 2024/25 financial year with a deficit of £11.773 million against a breakeven plan for the year. The Trust achieved an adjusted financial deficit of £18.056 million for the year, and this was further adjusted to an £15.614 million deficit for the year (as shown in note 37) against the breakeven duty in-year financial performance.

It should be noted that the position relied heavily on non-recurrent CIP delivery and other one-off benefits and the Trust will need to focus on recurrent cost control and efficiency programmes to ensure long term financial sustainability.

Throughout the course of the year, delivery of our financial plan has been subject to scrutiny and oversight each month via the Performance and Finance Committee and the Board.

We have a range of key financial policies in place, which are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness; these remained in place throughout the year.

Our services are organised into 7 Divisions (including the North Staffordshire and Cheshire Pathology Network as a hosted function within UHNM's governance structure) and are managed through a devolved structure, which is governed by our Scheme of Delegation, defining all key roles and responsibilities. Each Division has dedicated financial and human resources input to support delivery of their plans.

We maintain a strong focus on performance management, as a means by which clinical Divisions are held to account for the delivery of financial and other performance targets. Performance is monitored through our monthly performance management review process, which is chaired by an Executive Director.

During 2024/25, our Internal Auditors have reviewed our key financial systems and controls in relation to expenditure and concluded with 'reasonable assurance with minor improvements required'. A number of recommendations were made, which will remain a focus throughout 2025/26.

Our external auditors give an expert and independent opinion on whether our financial statements are a true and fair view of the Trust's financial position at the end of the financial year. They also provide an expert and independent opinion on whether the financial statements comply with relevant laws. In carrying out their audit, they must have regard to aspects of corporate governance and securing economy, efficiency and effective use of resources.

Although a surplus has been achieved in the last four years, due to previous years deficits we breached the requirement under section 30 of the Local Audit and Accountability Act 2014 to achieve break-even on a cumulative basis. As such, our External Auditors made a referral to the Secretary of State for Health in June 2021 which remains in place in 2024/25 as we still have a cumulative deficit. This referral was made under Section 30 of the 2014 Act.

We recognise that this position is set within the context of a wider sustainability gap across the local health and social care economy. To address this challenge, work remains on-going with our system partners, via the Integrated Care Board.

INDEPENDENT AUDITOR'S STATEMENT TO THE DIRECTORS OF UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST ON THE NHS TRUST CONSOLIDATION SCHEDULES

We have examined the consolidation schedules of University Hospitals of North Midlands NHS Trust, version 1.24.12.2A for the year ended 31 March 2025, which have been prepared by the Director of Finance and acknowledged by the Chief Executive. Our examination of the consolidation schedules covers the following:

- Designated TAC02 to TAC29 for tables outlined in red, excluding TAC05A, TAC014B and TAC23.

This statement is made solely to the Board of Directors of University Hospitals of North Midlands NHS Trust in accordance with Part 5 paragraph 20(5) of the Local Audit and Accountability Act 2014 and paragraph 4.12 of the Code of Audit Practice and for no other purpose.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the consolidation schedules which are also included in the audited financial statements.

Auditors are required to report on any differences over £1m between the audited financial statements and the consolidation schedules, with the following exceptions as set out in NHS England TAC completion instructions and financial reporting guidance:

- PPE inventory – where trusts do not recognise consumables in inventory on the grounds of materiality, and inventory remains immaterial, the receipt and utilisation may be omitted from the inventory note in local accounts. However, trusts should record the receipt of items in inventory with an equivalent figure in utilisation within the TAC form.
  (footnote on page 57 of the TAC-Completion-Instructions-M12-202425-25-March.pdf).

Unqualified audit opinion on the audited financial statements; no differences identified:

The figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.

Grant Thornton UK LLP

Grant Thornton UK LLP
17th Floor
103 Colmore Row
Birmingham
B3 3AG
26 June 2025

Independent auditor's report to the directors of University Hospitals of North Midlands NHS Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of University Hospitals of North Midlands NHS Trust (the 'Trust') for the year ended 31 March 2025, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been 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, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. 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 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

We are responsible for concluding on the appropriateness of the directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual

report and accounts. 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 themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the 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:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters, except on 28 May 2025 we referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to University Hospitals of North Midland's Trust's ongoing breach of its break-even duty for the year ending 31 March 2025. In addition, we referred a matter under section 30(a) as the Trust does not have a formal plan to return to financial balance in the foreseeable future.

Responsibilities of directors

As explained more fully in the Statement of Director's Responsibilities, the directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions and for being satisfied that they give a true and fair view, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

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. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud, is detailed below.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the audit committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We rebutted the presumed risk of fraud in revenue recognition. We determined that the principal risks were in relation to:
  - journal entries posted by senior members of the finance team
  - journal entries posted using generic user accounts
  - journals that altered the Trust's financial performance for the year
  - potential management bias in determining accounting estimates, especially in relation to:
    - the valuation of the Trust's land and buildings
    - accruals of income and expenditure at the end of the financial year
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on significant journals at the end of the financial year which had an impact on the Trust's financial performance, those entries made by generic user accounts and any journals posted by senior members of the finance team;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations and accruals of income and expenditure at the end of the financial year;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members.. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates
  - understanding of the legal and regulatory requirements specific to the Trust including:

- the provisions of the applicable legislation
- NHS England's rules and related guidance
- the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matters on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter except on 21 June 2024 we identified a significant weakness in the Trust's arrangements to deliver financial sustainability for the year ended 31 March 2024. We reported that without additional non-recurrent income from the ICB and with no medium-term plan there was no trajectory toward a sustainable breakeven position. We recommended the Trust finalise, as soon as possible, a robust, medium-term plan that sets a realistic trajectory to a sustainable position, without undue reliance on non-recurrent measures. It also needs to improve its delivery of recurrent savings.

As part of our work on the Trust's arrangements for financial sustainability for the year ended 31 March 2025, we have reviewed the Trust's progress implementing this recommendation. The Trust did not deliver its 2024-25 financial plan and, although it set a breakeven plan for 2025-26, it is reliant on a significantly higher amount of efficiency savings than delivered in 2024-25. The system medium-term plan, under development for the last two years, remains work in progress. We have concluded that there remains a significant weakness in the Authority's arrangements to deliver financial sustainability for the year ended 31 March 2025. We recommended that the Trust ensures that it is using all the levers it reasonably can to suitably reduce its costs. Key to this is increase its recurrent CIP delivery and identifying realistic and achievable longer-term measures to manage down demand and acuity, as part of a fully worked-up system medium-term plan.

Responsibilities of the Accountable Officer

As explained in the Statement of Accountable Officer's Responsibilities, the Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(2A)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and

- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for University Hospitals of North Midlands NHS Trust for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's directors as a body, for our audit work, for this report, or for the opinions we have formed.

Avtar Sohal, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham
26 June 2025