NHS
North Tees and Hartlepool
NHS Foundation Trust

North Tees & Hartlepool NHS Foundation Trust

Annual Report and Accounts 2025/26

Caring
Better
Together

South Tees Hospitals NHS Foundation Trust

Annual Report and Accounts 2025/26

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

Annual Report, 2025/26

1. Performance report

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

Overview by Joint Chair and Chief Executive

Welcome to North Tees & Hartlepool NHS Foundation Trust's Annual Report and Accounts 2025/26.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our highlights include:

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

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

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

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

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

CSU 1: Family Services:
announced the reintroduction of births at the Rowan Suite at the University Hospital of Hartlepool after low staff numbers led to a temporary suspension of deliveries

CSU 2: Digestive Health Urology and General Surgical Services:
created a cross-group complex polyp team of specialists including surgeons, nurses, radiologists and pathologists

CSU 3: Trauma & Orthopaedics, Reconstructive & Plastic Surgery, ENT & OMFS, Dermatology & Ophthalmology Services:
A patient's life was changed after receiving the first transcutaneous bone conduction implant at The James Cook University Hospital which allows her to hear

CSU 4: Theatres, Anaesthetics & Critical Care Services:
The Friarage Hospital opened its new £35.5million surgical centre

CSU 5: Cardiovascular Services:
The James Cook University Hospital selected as a minimal invasive cardiovascular centre

CSU 6: Cancer Institute:
Patients at The James Cook University Hospital are among the first to trial an experimental injection for advanced prostate cancer that no longer responds to hormone therapy

CSU 7: Clinical Support Services:
The opening of a new diagnostic facility at Redcar Primary Hospital offering patients rapid tests to aid faster diagnosis

CSU 8: General & Emergency Medical Services:
University Hospital of North named as a top performing hospital emergency unit

CSU 9: Neuroscience Services:
A world first as clinicians makes spinal cord stimulation history, delivering low levels of electricity directly into the spinal cord to disrupt pain signals before they reach the brain

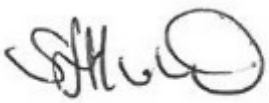
CSU 10: Community & Neighbourhood Health Services:
Celebrated 20 years of integrated occupational therapy services with local authority partners

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

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

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

Signed:



Stacey Hunter

Chief Executive and Accounting Officer

Signed:

Professor Derek Bell OBE

Chair

Introduction to North Tees and Hartlepool NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust provides high quality healthcare for nearly half a million residents across Stockton, Hartlepool and parts of County Durham.

We deliver care in a range of community settings, including Peterlee Community Hospital, our Lawson Street Health Centre hub in Stockton, and the One Life Centre in Hartlepool which are as highly valued by our patients as our acute hospitals — the University Hospital of North Tees and the University Hospital of Hartlepool.

Our new Tees Valley Community Diagnostic Hub, located on the banks of the River Tees in Stockton and delivered in partnership with the NENC ICB and Stockton-on-Tees Borough Council, has already delivered thousands of scans since opening. It is now an integral part of the local healthcare system and a vital service our communities rely on.

The University Hospital of Hartlepool is an accredited surgical hub, supported by advanced robotic surgery. It is also home to the Health and Social Care Academy, made possible by our partnership with Hartlepool Borough Council and Hartlepool College of Further Education and the Rowen Suite which will this coming year reintroduce births after a period of low staffing resulted in a temporary closure of this service. This much loved hospital remains central to how we deliver services across our communities.

This much loved hospital remains central to how we deliver services across our communities.

We continue to face the challenges of maintaining the ageing University Hospital of North Tees. However, our commitment to investing in our estate remains strong. Recent upgrades - including a new multimillion pound robotic and emergency maternity theatre suite - demonstrate that our ambitions for modern, high quality care will not be constrained by physical limitations.

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

Our Values

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

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

We believe every interaction strengthens our culture.

Respect:

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

Respect enables:

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

Respect in practice:

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

Support:

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

Support enables:

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

Support in practice:

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

Collaborate:

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

Collaboration enables:

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

Collaboration in practice:

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

Going concern

In reaching the decision to adopt the going concern basis of preparation, the directors have assessed the trust's and the group's ability to continue as a going concern. In terms of the provision of services into the future; under the Health and Care Act 2022, funding was allocated at Integrated Care System level and financial plans have been agreed across the system. This arrangement has also been confirmed for 2026/27.

These financial arrangements have no bearing on the trust's ability to operate on a going concern basis. The trust remains a going concern and the accounts have been prepared on that basis.

The cash position of the organisation is the most critical element in terms of going concern in terms of being able to meet its current liabilities over the next twelve-month period. The view from the Department of Health and Social Care is that as long as there is cash available to cover liabilities then NHS organisations remain a going concern.

The trust has a comprehensive cash management process in place with weekly cash flow forecasting that is updated on a daily basis. The trust has also reviewed the process for applying for Planned Term Support should the need arise over the course of the financial year. The trust does not intend to utilise this support, nor does it anticipate the need to do so.

Following review with the Board of Directors, the trust has a reasonable expectation that the North Tees and Hartlepool NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Performance analysis

Performance against the 4-hour standard exceeded the agreed trajectory by 0.09% achieving 86.19% against the plan for March 2026 of 86.05%. During 2025/26 the trust opened a new bespoke Emergency Assessment Suite, taking direct ambulance arrivals and seeing on average 55 patients per day providing alternative access to emergency medical care than the Emergency Department. The capital investment was facilitated by the award of additional funding from the UEC incentive scheme for the trust's high performance against the 4-hour standard across previous years which has often seen the trust ranked in the top five trusts nationally that provide adult and paediatric emergency care. The shift to the left continued as a core principle during 2025/26 with collaborative working towards developing virtual ward capacity and piloting a Care Co-ordination Centre for North and South Tees patients with senior physician input to support patients accessing the most suitable emergency pathway available to best suit their individual needs. Collaborative working with regional partners also supported patients to be discharged in a timely manner with a safe handover of care so that wherever possible extended lengths of stays in hospital beds are avoided for patients that are medically fit.

For elective care (referral to treatment standard), there has been continued focus on reducing the number of patients waiting over 52 weeks for treatment. Patients over 52 weeks as at end March represented 0.98% of the overall waiting list achieving the national target of 1%. In relation to compliance with the 92% referral to treatment standard, performance was 70.52% as at end March 2026, falling short of the trust plan of 76.5% and national ambition to deliver a 5% improvement across the year. The trust demonstrated strong performance across the first 5 months of the year, with improvements driven by additional activity above plan. The plan for 2026/27 is to achieve 83.5% compliance for the referral to treatment standard, with a view to returning to 92% compliance by March 2029 in line with the government’s national ambition.

In relation to the cancer standards, the trust saw improvements in the proportion of patients that received a diagnosis or ruling out of cancer reaching 83.2% in December 2025 against a plan of 80%. Performance against this faster diagnosis (28 day) standard has deteriorated in Q4 to 75.6% as at end of March, due to an increase in demand, particularly in the breast pathway. The trust has seen a 27% growth in referrals to the breast service linked to challenges within the wider region and is working closely with the Northern Cancer Alliance and other provider organisations on the future model for breast services. For patients with a diagnosis of cancer the number of patients being investigated and treated for cancer within the 62-day constitutional standard was 66.6% in March, with growth in demand associated with the regional challenges in relation to the breast service a key driver of this deterioration. The trust was placed in Tier 2, with external mandated support from NHS England and the ICB in November 2025 due to the deterioration in performance. Significant work is underway to develop and deliver robust clinically led improvement plans to improve performance to 76% by the end of March 2027. Additional funding from the Northern Cancer Alliance has supported the provision of additional surgical capacity in lung and breast pathways. In May 2025, the University Hospital of North Tees became the first hospital in the region to launch a pilot programme using an Ion robotic-assisted bronchoscope. The state-of-the-art tool was funded by the Northern Cancer Alliance. It allows clinicians to reach previously inaccessible areas of the lung using a 3.5mm catheter and shape sensing technology. It means that healthcare staff can collect tissue samples from hard-

to-reach nodules deep in the lungs – where over 70% of early lung cancers are typically found. The technology aligns with NHS England's 10-year health plan, improving early diagnosis and reducing health inequalities.

Performance Summary

Single Oversight Framework Indicators	Standard / Agreed Trajectory	2025-26 Performance	2024-25 Performance	Achieved
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (Mar 26)	86.05%	86.19%	85.53%	✓
Receipt of two week wait / screening referral to date patient is informed of a diagnosis (FDS) or ruling out cancer (Mar 26)	81.00%	75.6%	78.74%	x
31-day wait from decision to treat/earliest clinically appropriate date to treatment of cancer (Mar 26)	96.00%	97.8%	96.06%	✓
62-day wait from urgent GP referral for urgent suspected cancer or breast symptomatic referral or urgent screening referral or consultant upgrade to first definitive treatment of cancer (Mar 26)	75.00%	66.6%	66.98%	x
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (Mar 26)	76.48%	70.52%	75.46%	x
Referral to Treatment 52 Week Waits as a percentage of overall waiting list (Mar 26)	1.00%	0.98%	0.83%	✓

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

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

Activity

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

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

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

Key issues and risks

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

Risks arising from non-compliance with the referral to treatment standard: NTHFT ended the year 25/26 non-compliant with the plan for RTT standard. This remains open as a strategic risk given the challenge of a further 13% improvement expected next year on a background of increasing demand and financial constraints. Development of pathways for appropriate alternatives to outpatients, and a focus on productivity and efficiency will mitigate the risk in 26/27.

Risks arising from non-compliance with the diagnostic 6-week standard: NTHFT ended the year 25/26 non-compliant with the diagnostic standard trajectory set for the Trust and this remains open as a strategic risk as there is an expectation of maintaining a high level of compliance. Recovery trajectories will be closely monitored.

Risks arising from non-compliance with the cancer waiting time standards: NTHFT ended the year 25/26 non-compliant with the 28-day and 62-day standards but compliant for 31-day standard. This remains open as a strategic risk given the challenge of a further improvement on a recovery trajectory to 76% compliance. Changes to patient flows generating demand have been a particular issue for both trusts to manage in year, and planning for sustainable capacity to meet demand will mitigate the risk in 26/27.

Taskforce on Climate related Financial Disclosures (TCFD)

Compliance Statement

North Tees & Hartlepool NHS Foundation Trust is preparing for full implementation of the Task Force on Climate-related Financial Disclosures (TCFD) requirements, in line with the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) 2025–26. Reporting is required on a comply or explain basis, and the trust continues to build the governance, processes, and evidence required to meet these expectations. The trust is able to comply with elements of the Governance and Metrics and Targets pillars, while further development is required to achieve compliance under the Strategy and Risk Management pillars.

Governance

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

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

Strategy

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

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

Risk Management

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

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

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

- National Severe Weather Warnings, providing risk-based forecasts of events such as heavy rain, snow, wind, fog and ice

- Weather Health Alerts, issued on behalf of the UK Health Security Agency, highlighting risks associated with prolonged temperature extremes
- Met Office Civil Contingencies updates, offering localised intelligence and forward planning insights

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

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

Metrics and Targets

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

Key adaptation metrics include:

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

Green Plan Summary

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

Green Plan Governance

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

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

Key areas of progress include:

Workforce and Leadership

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

Net Zero Clinical Transformation

The Trust is progressing net zero clinical transformation through the development of Hospital at Home and wider out-of-hospital care models, enabling clinically appropriate patients to receive care in their own homes. This approach supports admission avoidance, earlier discharge and improved patient experience, while reducing reliance on the acute estate and associated carbon emissions.

The Hospital at Home service forms part of a broader system-wide approach across UHT, with similar models delivered through virtual wards and community-based services, supporting pathway redesign across acute and community care. These initiatives align with national priorities to deliver digitally enabled, preventative and lower-carbon care, embedding sustainability considerations into clinical transformation and service development.

Digital transformation

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

Medicines

The Pharmacy team has delivered key sustainability progress. There has been significant advancement in IV-to-oral medication switching, reducing both carbon impact and resource use. Work to optimise respiratory care and inhaler use remains at an early stage, with further review and reporting required to strengthen this priority area. Efforts to reduce waste continue, with UHT-wide campaigns on medication waste planned for October 2026, alongside initial steps to cut single-use plastics, including the transition to paper pharmacy bags and exploration of wider procurement opportunities. Internally, the department is strengthening sustainability through improved staff awareness and promotion of active travel, supported by a staff survey and initiatives such as the Cycle to work scheme.

Travel and Transport

The successful inclusion in the Modeshift STARS Healthcare programme will support a more structured and evidence-based approach to improving travel and transport. Through access to

the STARS platform, training, and accreditation framework, UHT will be able to better understand staff and patient travel behaviours, identify opportunities to reduce single-occupancy car use, and implement targeted initiatives that promote active travel, public transport, and sustainable commuting. This will help reduce congestion, lower carbon emissions, and improve access to sites, while also supporting staff wellbeing and contributing to wider Green Plan objectives.

A staff travel survey is planned for 2026, which will inform the development of a UHT wide travel strategy, to be delivered by December 2026.

We have expanded the existing EV charging infrastructure at University Hospital of North Tees through the install of a 200KW EV charger to support the transition by NEAS (North East Ambulance Service) to a low-emission fleet.

Estates and Facilities

The Salix-funded decarbonisation schemes has been delivered at University Hospital of Hartlepool, supporting the Trust's transition to low-carbon energy infrastructure. The programme includes the installation of ground source heat pump, de-steaming of heating systems, and wider system optimisation, with additional measures at UHH such as solar photovoltaic panels, upgraded air handling systems and enhanced controls.

The scheme is expected to deliver significant carbon reductions alongside long-term energy efficiency improvements. Works have been carefully managed within live hospital environments, with ongoing monitoring and maintenance arrangements in place to ensure sustained performance.

This investment represents a major step forward in reducing emissions from the Trust estate while maintaining resilient and effective heating systems to support patient care.

The Trust have a completed a decarbonisation plan which will put us in the best position to be able to take advantage of future funding opportunities, enabling further progress towards our net zero targets.

Partnerships with community organisations and social prescribing teams are helping to connect patients and staff with nature-based activities, while proposals such as walking routes and "walking waiting rooms" aim to further embed green space use into care and wellbeing. Ongoing work is also addressing safety, accessibility and infrastructure improvements to maximise the benefit of these environments across UHT sites.

Significant progress has been made in improving community waste management across the Trust. All community sites now have dry mixed recycling in place, exceeding the original target and supporting improved segregation of waste streams. Clinical waste performance has been maintained in line with national standards, with further opportunities identified to increase recycling rates beyond the current 32%. In addition, food waste collection has been established at larger community sites, with plans in place to expand this provision more widely. These initiatives demonstrate continued progress in reducing waste, increasing recycling, and supporting UHT's wider sustainability objectives.

Food and nutrition

Food waste reduction has been a key focus for the Trust following analysis in 2025 which identified significant waste across acute sites, with the Trust recording 9.14 tonnes of food waste, generated from production, highlighting clear operational, financial and environmental impacts. Menu items with low patient uptake were removed, stock management improved and more appropriate choices introduced, balancing reduced waste with maintaining nutritional intake for recovery.

Adaptation

The Trust continues to strengthen its approach to climate adaptation and resilience, in line with national reporting requirements through the Estates Return Information Collection (ERIC). Key measures include monitoring and assessment of environmental risks across the estate, including:

- Overheating incidents triggering formal risk assessments in line with the Trust's Heatwave Plan, ensuring patient and staff safety during extreme temperatures
- Flood incidents requiring risk assessment and response measures, supporting ongoing estate resilience planning
- These metrics support a proactive approach to managing climate-related risks, ensuring that the Trust's estate remains safe, resilient and capable of delivering high-quality care under changing environmental conditions.

Energy and Carbon Performance

The ongoing implementation of the Carbon Management Programme continues to make a significant impact on the carbon footprint. Against a trend of increasing activity, the Trust has made carbon reduction savings of more than 35% since 2010 in support of the government's 2050 targets. The Trust's Green Plan has developed a range of measures to reduce our carbon footprint, challenge behaviours, and define aspirations for North Tees and Hartlepool NHS Foundation Trust to work towards becoming net-zero by 2040.

The carbon impact of electricity and steam, combined with water, waste, oil and business miles show that the Trust carbon footprint for FY2025/26 currently sits at 10,302 TonnesCO2. This is a decrease of 2.8% on the previous year.

Greenhouse Gas Emissions - - - - -

Area							
		2023/24	2024/25	2025/26	2023/24	2024/25	2025/26
Finite Resources	Electricity	3695 Mwh	3725 MWh	3944 MWh	£1,038,416	£1,197,209	£1,219,617
		757 tCO2	771 tCO2	690 tCO2			
	Gas	51,032 MWh	51,699 MWh	50,390 MWh	£2,152,298	£1,894,838	£2,094,915
		9310 tCO2	9435 tCO2	9201 tCO2			
	Oil	33,832 kWh	142,827 kWh	91,751 kWh	£0	£0	£39,541
		8.6 tCO2	36.2 tCO2	23.3 tCO2			
Waste	Total Waste	1330 t	1360 t	1532 t	£370,798	£294,515	£347,055
Hazardous Waste	Clinical waste to alternative treatment of incineration	251 t	171 t	155.4t			
		56.7 tCO2	1.1 tCO2	tCO2			
Non-hazardous Waste	Landfill	0 t	0 t	0 t			
		0 tCO2	0 tCO2	0 tCO2			
	Re-used / Recycled	201 t	172 t	252.1 t			
	Incinerated with Energy Recovery	926 t	999.8 t	1113.1 t			
	Electrical Waste (WEEE)	14.1 t	17.2 t	11.4 t			
Travel	Commercial Vehicles Diesel	0	0	0	£0	£0	£0
		0 tCO2	0 tCO2	0 tCO2			
	Lease Vehicles Petrol	199,028 miles	175,359 miles	131,750 miles	£79,611	£70,143	£59,287
		40.2 tCO2	36.5 tCO2	34.4 tCO2			
	Lease Vehicles Diesel	9,296 miles	3,811 miles	191 miles	£3,720	£1,525	£86
		2.3 tCO2	1.0 tCO2	0.1 tCO2			
	Business Miles	1,230,670	1,112,747	1,305,905	£492,268	£445,099	£587,657
		296.1 tCO2	268.2 tCO2	311.9 tCO2			
Water	Water Consumption	121,048 m3	120428 m3	126143 m3	£406,944	£443,212	£560,659
		45.7 tCO2	40.8 tCO2	45.7 tCO2			

Acting together for population health equity

Background

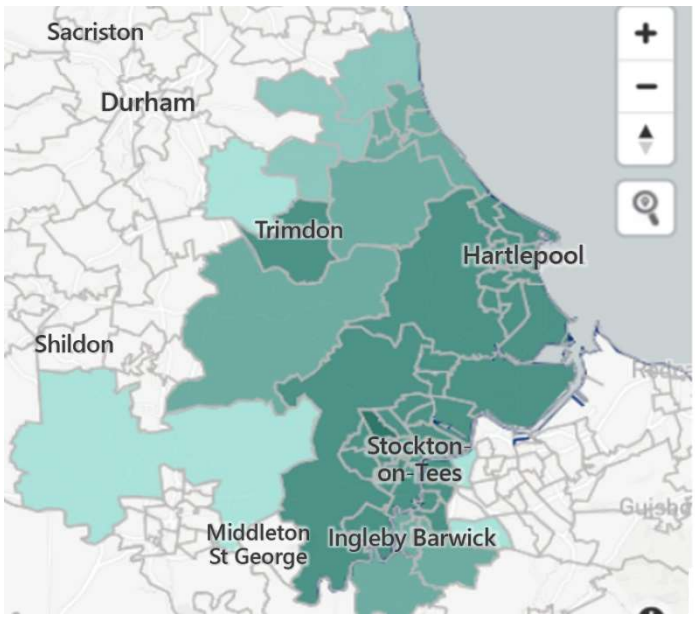
Legal requirements	NHS trusts must publish an annual report reflecting the requirements of NHS England's Health Inequalities Statement. This statement was updated in November 2025 with a suggested structure (see infographic below), Key Lines of Enquiry for trusts to consider and a Measurement Framework.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

New Health Inequalities Reporting Structure and summary of key findings	
Understanding health needs:	• Our population is the 14th most deprived in England and this affects health through poorer access to good housing/community/environment/food/education/work/services • 1/5 private-rented homes locally are “non-decent” • People live 10 years less in some areas and are more likely to be disabled
Understanding healthcare access, experience and outcomes:	• Many people face travel/communication/digital barriers to accessing healthcare • People from our most deprived communities are more likely to miss appointments, have procedures cancelled and to die if they have cancer • Mothers aged 35+, or from “Black” or “other” ethnic groups are less likely to have their first antenatal appointment in the first 10 weeks of pregnancy
Improving data quality, collection and analysis	• We analyse our data by age, sex, ethnicity & deprivation, and compare with other data to ensure everyone can access our services • We are acting to better record patient’s ethnicity and disability/housing status to ensure there are good outcomes of our all our population - Ethnicity is recorded in 100% of maternity records and recording is improving in other departments
Using information on healthcare inequalities:	• We developed our “Improving Population Health and Reducing Health Inequalities Strategy” and are collaborating via the Anchor Institute Network, Health & Wellbeing Boards, Place/other Partnerships to reduce inequalities • We have reduced cancelled procedures, increased clinic attendance, reduced tobacco/alcohol/substance harms, increased readability of documents/signs, increased digital devices/access, and are reducing inequalities via Emergency Medicine at the Deep End, personalised care, Making Every Contact Count, screening and workforce/veteran/inclusion health work
Publishing information:	• The Trust produce bi-annual Health Inequalities Implementation Reports and Population Health and Health Inequalities Annual Reports • The monthly Board Performance Report includes inequality analysis, with action led by the multi-agency Healthcare Inequalities Oversight Group, reports to the Quality Assurance Committee and up-to-date data via our Health Inequalities Dashboard

1. Understanding healthcare needs of our population

Key line of enquiry 1.1:
What steps have been taken to understand health needs and inequalities experienced by local 'Core20' and 'PLUS' population groups, for example, ethnic minority communities, people with a learning disability, autistic people, groups that share protected characteristics, inclusion health groups and coastal or rural communities, across a range of clinical domains?

To understand the health needs of our population and inequalities faced locally we use publicly available data, national and trust dashboards, as well as bespoke data analysis. North Tees and Hartlepool NHS Foundation Trust covers around 400,000 people and serves the whole of Stockton-On-Tees and Hartlepool Councils' populations, approximately 70% of East Durham population and parts of Darlington and Sedgefield locality areas. The map below from the NHS trust catchment populations tool shows, for each area, the proportion of patients admitted to any hospital in 2020, who were admitted to North Tees and Hartlepool NHS Foundation Trust. Darker colours indicate a greater percentage of admissions to our trust, compared to other trusts.

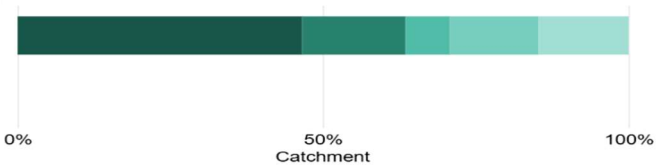


Percentage of people admitted to any hospital, who were admitted to North Tees & Hartlepool NHS Foundation Trust:

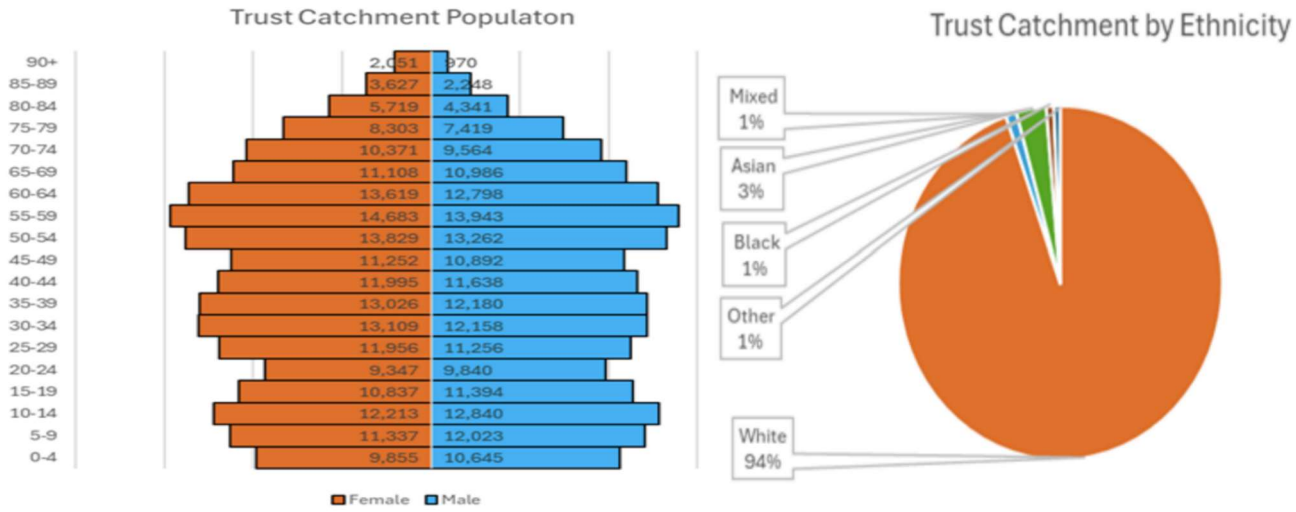
1 - 05% - 19%
2 - 20% - 39%
3 - 40% - 59%
4 - 60% - 79%
5 - 80% or more

Our trust's population is the second most deprived in the North East and North Cumbria and the 14th most deprived in England. Almost half of our population live in the 20% most deprived communities nationally (the "Core20" of the Core20PLUS5 and darkest section of the bar below).

47% of population in Core20 most deprived

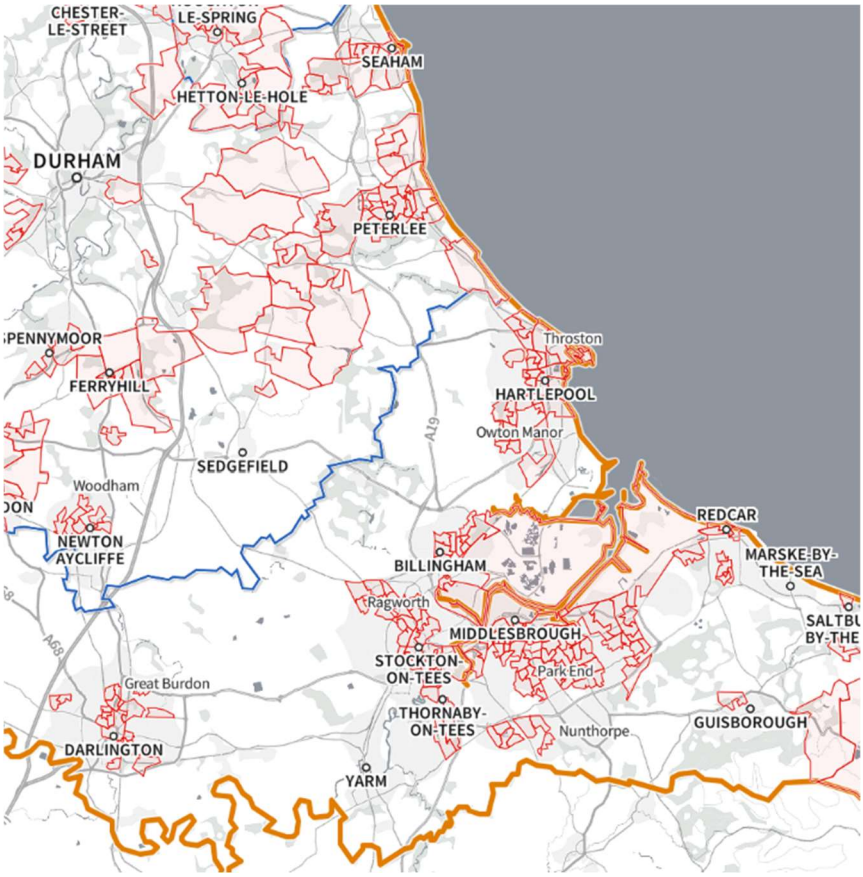


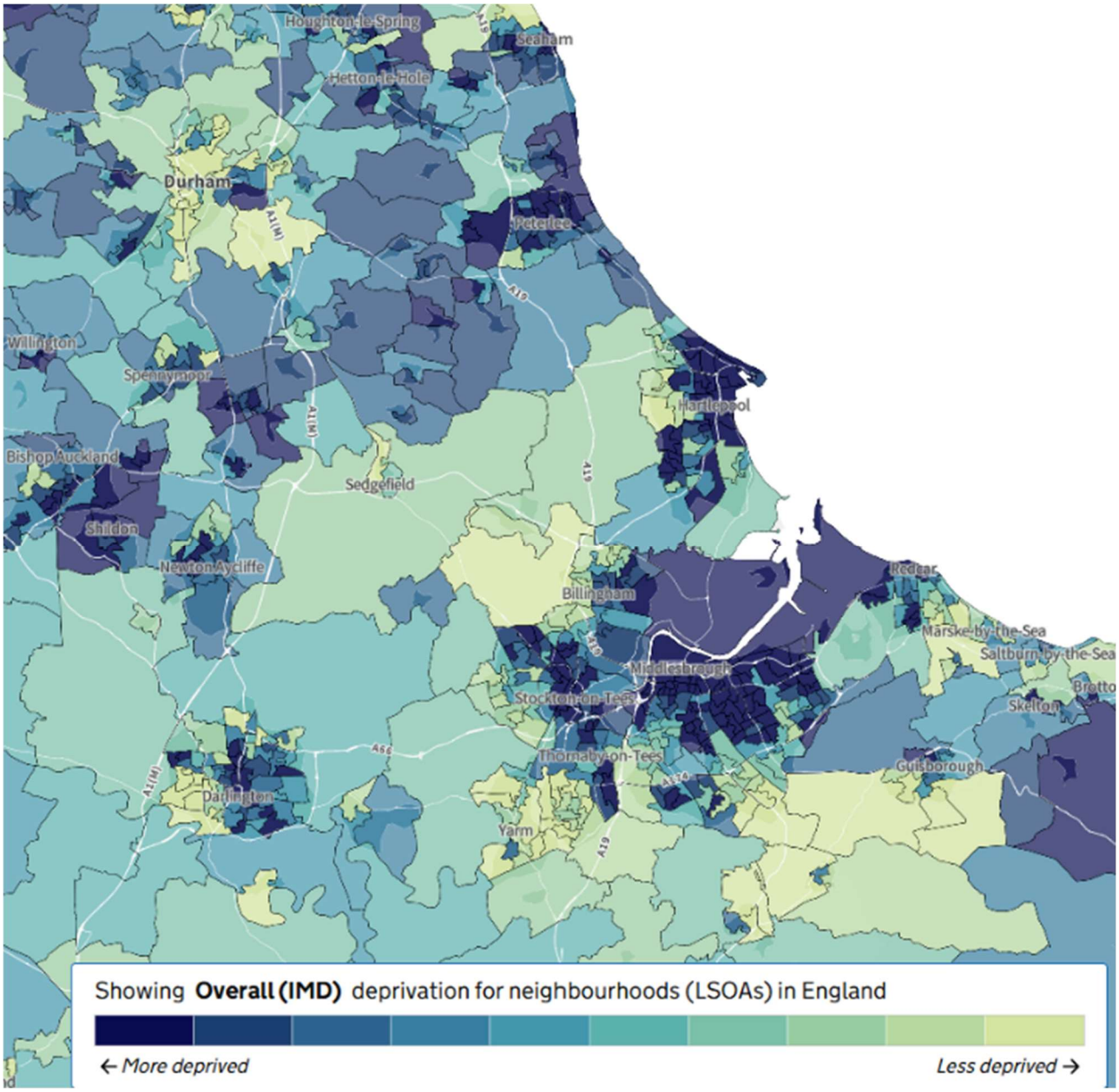
The images below show the age, sex and ethnicity of people within the trust catchment. One in five people are aged over 65. Ethnic groups within our population include “White” (94%), “Asian” (3%), “Black” (1%), “Mixed” (1%) and “Other” ethnic groups (1%).



Core20 communities (the 20% most deprived neighbourhoods nationally)

The Strata map (below) shows our Core20 most deprived areas in pale red. Our Core20 communities include many densely populated areas and some more rural areas. The Local Deprivation Explorer map (next page) shows more deprived areas (darker blue) and some less deprived areas (lighter green) across the trust catchment.



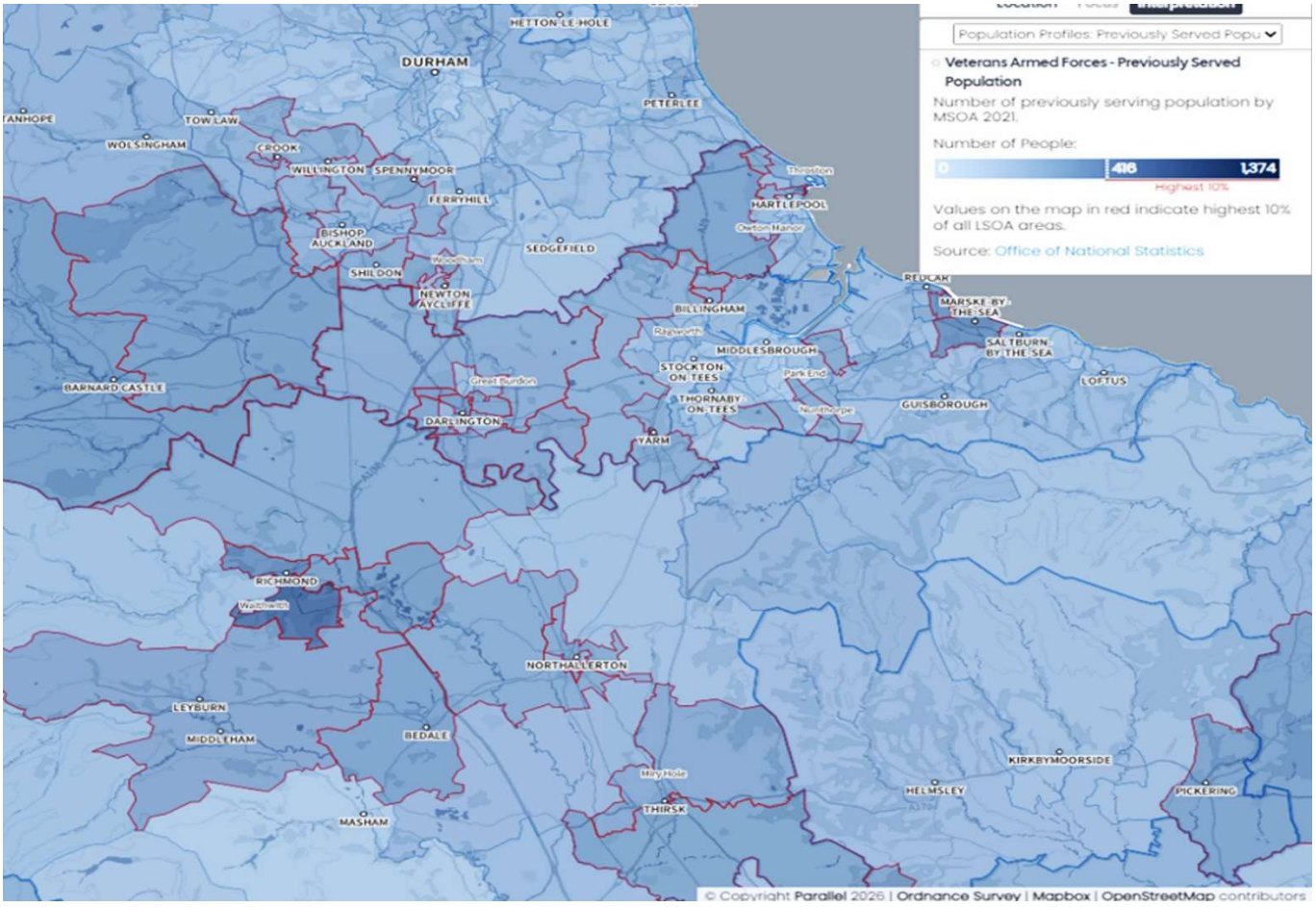

Houghton-le-Spring
Seaham
Hetton-le-Hole
Durham
Peterlee
Willington
Spennymoor
Hartlepool
Bishop Auckland
Sedgefield
Shildon
Newton Aycliffe
Billingham
Redcar
Marske-by-the-Sea
Saltburn-by-the-Sea
Middlesbrough
Stockton-on-Tees
Skelton
Thornaby-on-Tees
Guisborough
Darlington
Yarm
A19
A1(M)
A66
A174
Showing Overall (IMD) deprivation for neighbourhoods (LSOAs) in England
← More deprived
Less deprived →

PLUS groups

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

Publicly available local-level data is limited on many inclusion health groups. However, there is some data regarding **homelessness**. The number of households owed a duty under the Homelessness Reduction Act varies across the trust catchment from 1.4% to 2.4%.

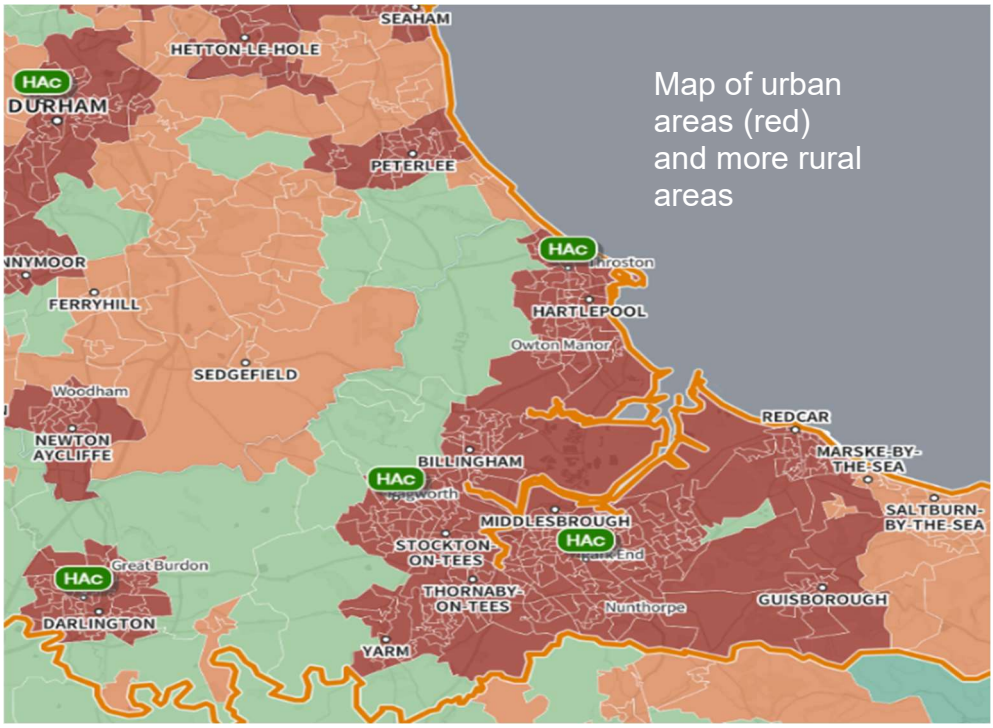
The map (below) shows areas with a greater percentage of **people with disability** (darker blue). Several areas in the trust catchment are in the highest 10% nationally for people recorded as disabled in the 2021 census (areas with a red outline).

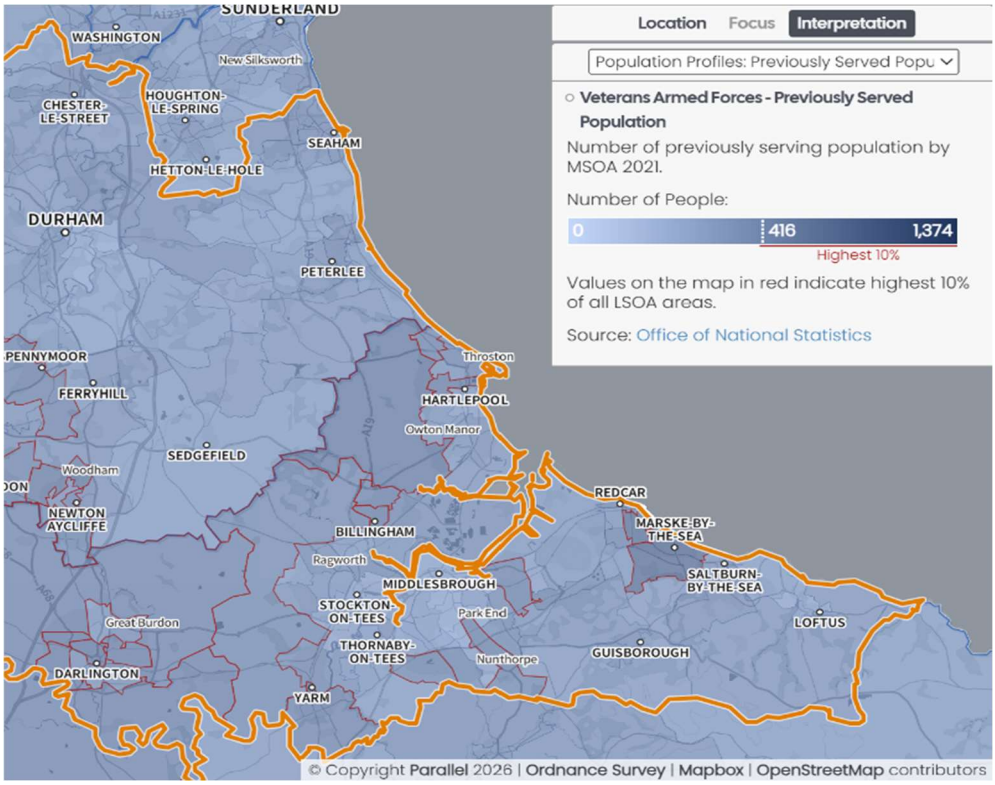


Regarding learning disability, across the trust catchment, 0.6-0.8% of people are recorded on GP practice register as having a learning disability. However, around 2% of people in the catchment area report having a learning disability.

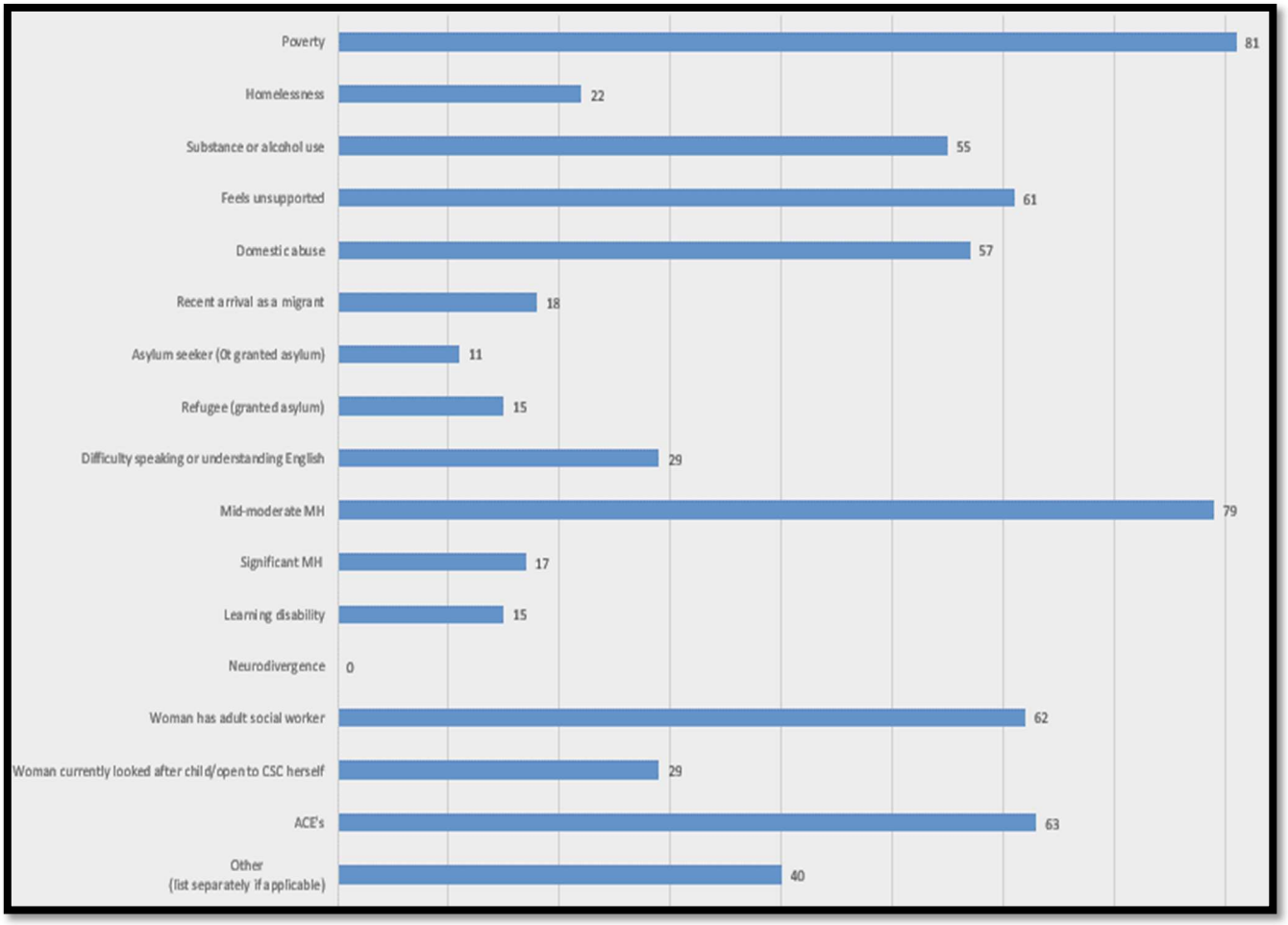
Our trust catchment **covers costal, urban and rural communities**. The first map below shows more urban areas (red) and more rural areas (greener).

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





Information regarding PLUS or inclusion health groups can also come through trust interventions to reduce health inequalities. For example, we piloted a pregnancy anticipatory care (PAC) model with an embedded social prescribing link worker and strengthened personalised care provision for socioeconomic vulnerabilities. The figure below shows the types and frequency of social factors reported as being experienced by patients within this intervention. Poverty and mental health were the commonest factors identified.



Health and life expectancy

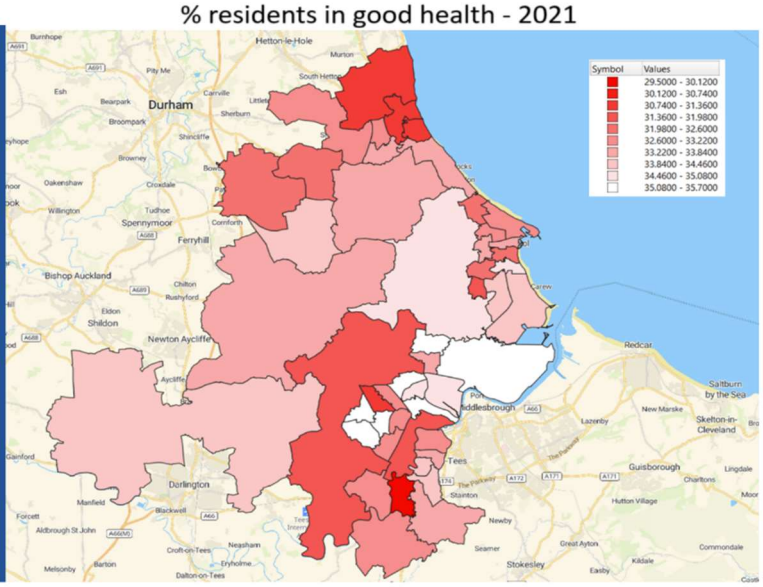
Data analyst support has enabled mapping of self-reported health and inequalities in life expectancy across areas served by North Tees and Hartlepool NHS Foundation Trust (NTandHFT).

There is more than 10 years difference in life expectancy across the trust catchment, with shorter lives and poorer health associated with more deprived areas.

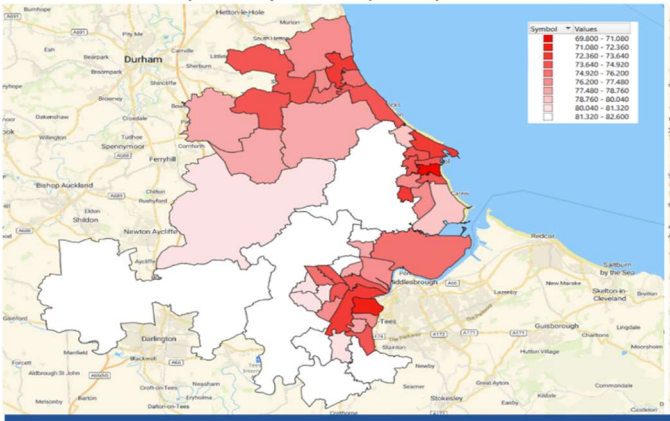
In some more deprived areas of the trust catchment the average male can expect to live to around 69.8 years old. This has implications for services aimed at older adults or with age specific criteria.

Within NT&HFT the area with the largest proportion of residents in good health is **Fair-field in Stockton with 35.7%**, whilst the smallest is **Ingleby Barwick West with 29.5%**. This is a **difference of 6.2 percentage points** within the foundation trust.

% residents in good health - 2021

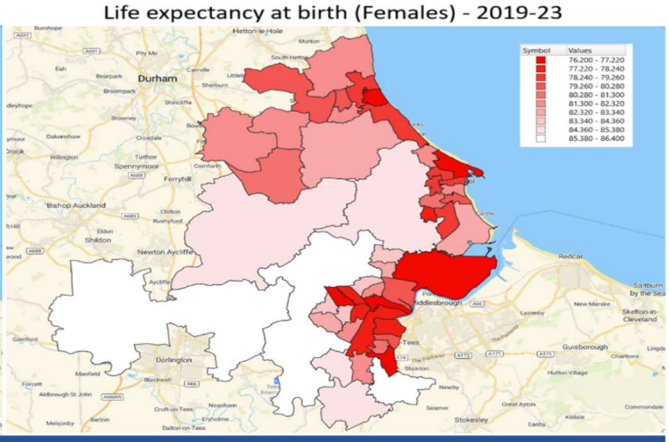


Life expectancy at birth (Males) - 2019-23



Male life expectancy at birth in NT&HFT ranges from **69.8 years in the Burn Valley** area of Hartlepool, to **82.6 years in the Rural West** area of Hartlepool. This is a **difference of 12.8 years** of life expectancy within the foundation trust.

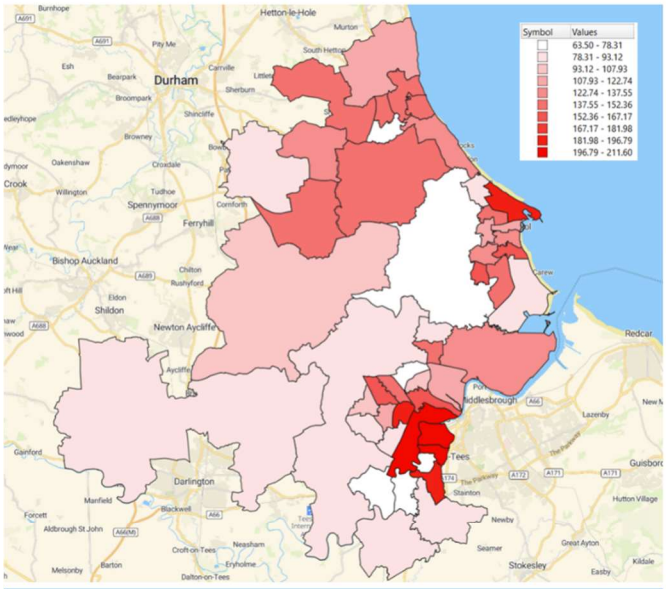
Life expectancy at birth (Females) - 2019-23



Female life expectancy at birth in NT&HFT ranges from **76.2 years in Horden** in Durham, to **86.4 years in the Northern Parishes** area of Stockton. This is a **difference of 10.2 years** of life expectancy within the foundation trust.

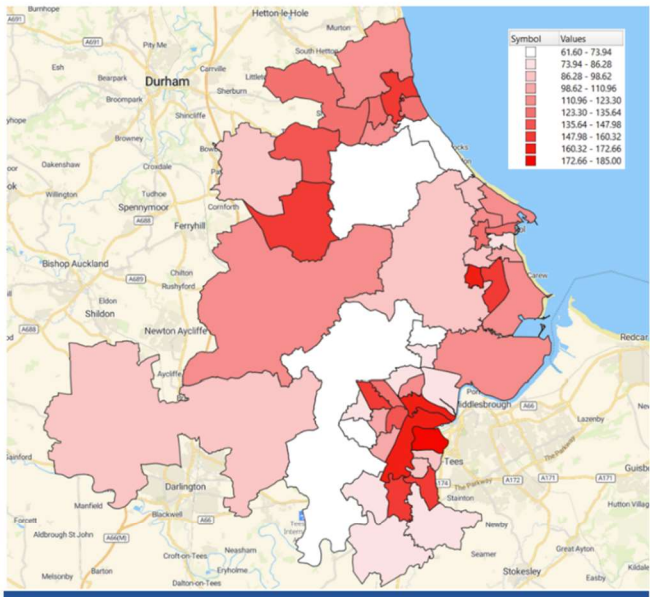
Some common causes of death are coronary heart disease (CHD), stroke, respiratory (lung) disease and cancer. The maps below show areas where deaths from these causes are more common than might be expected (darker red) given the age and sex of people living there. A Standard Mortality Ratio (SMR) above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

Deaths from CHD (SMR) - 2019-23



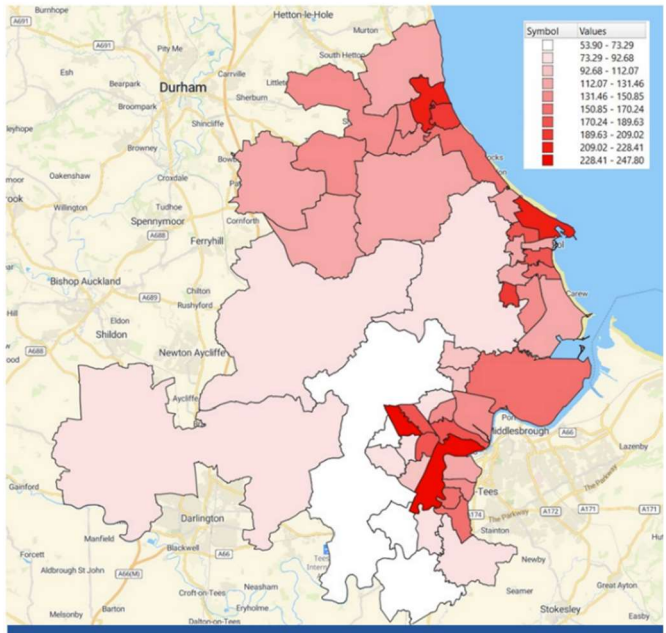
Within NT&HFT the area with the highest level of death from CHD is **Mandale & Victoria** in Stockton, with an **SMR of 211.6**, whilst the smallest level is **Passfield** in Durham, with an **SMR of 63.5**. The **range of SMR in the trust is 148.1**.

Deaths from Stroke (SMR) - 2019-23



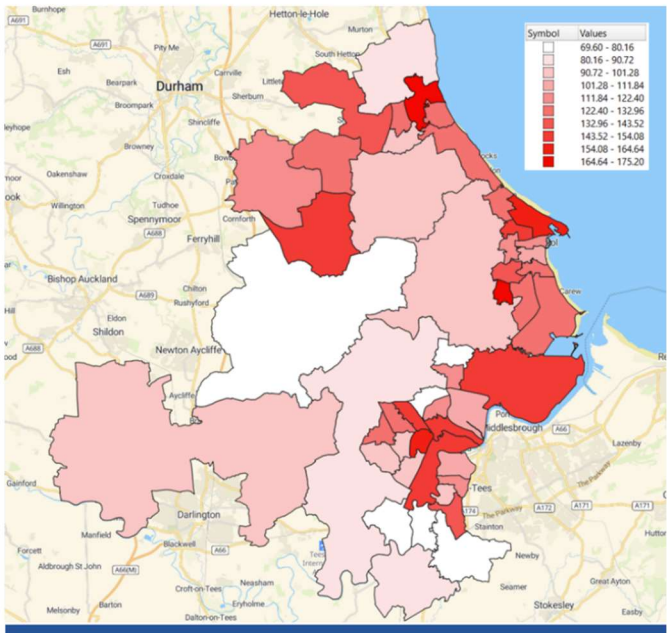
Within NT&HFT the area with the highest level of death from Stroke is **Mandale & Victoria** in Stockton, with an **SMR of 185**, whilst the smallest level is **Northern Parishes** in Stockton, with an **SMR of 61.6**. The **range of SMR in the trust is 123.4**.

Deaths from Respiratory diseases (SMR) - 2019-23



Within NT&HFT the area with the highest level of death from Respiratory diseases is **Central Stockton**, with an **SMR of 247.8**, whilst the smallest level is **Yarm** in Stockton, with an **SMR of 53.9**. The **range of SMR in the trust is 193.9**.

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



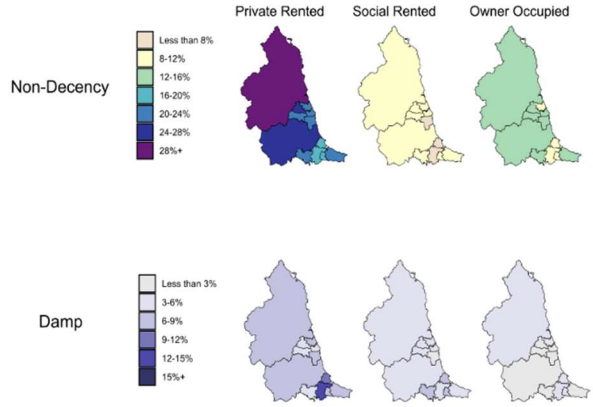
Within NT&HFT the area with the highest level of death from Cancer is **Peterlee East**, with an **SMR of 175.2**, whilst the smallest level is **Billingham Central**, with an **SMR of 69.6**. The **range of SMR in the trust is 105.6.**

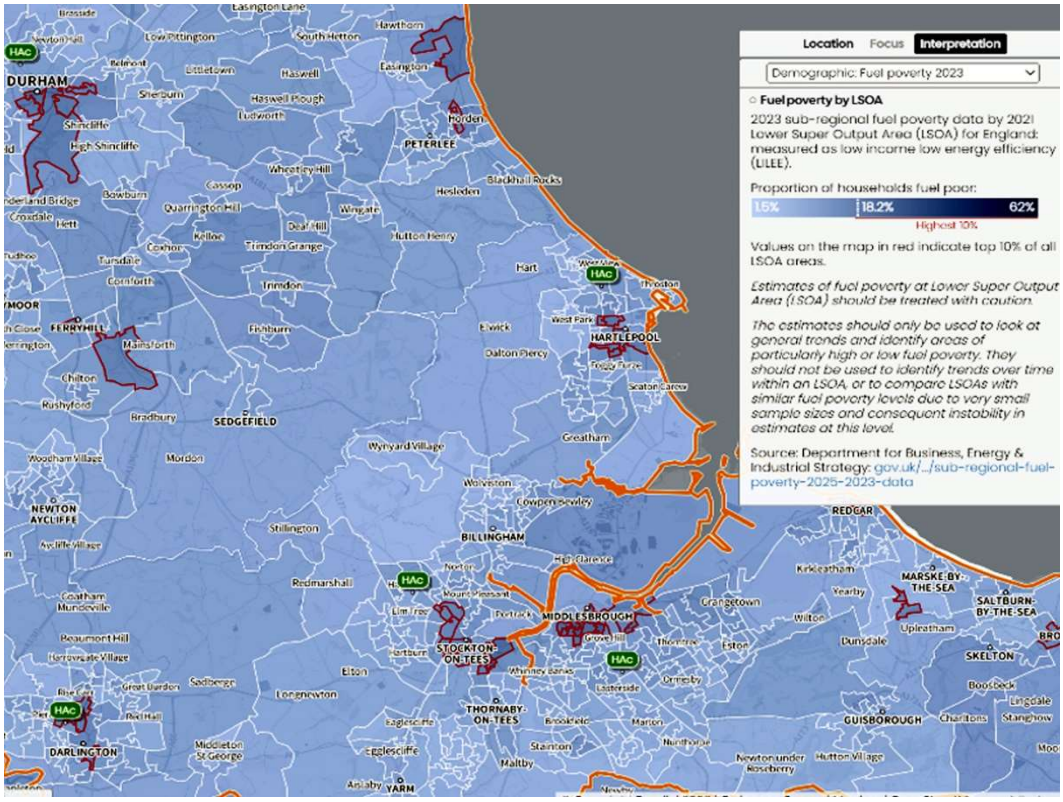
Health Needs: Key building blocks of good health

Good health depends on having access to a good home, food, transport/communication, services (including healthcare), education/work, community and living environment. There are significant disparities across the trust's catchment for many of these factors. This has implications for providing holistic, personalised care, in order to achieve equitable outcomes for all our communities. NHS England also notes that trusts can influence these factors in their role as anchor institutions. Joint Strategic Needs Assessments for Stockton and Hartlepool provide more information on local health profiles in these areas.

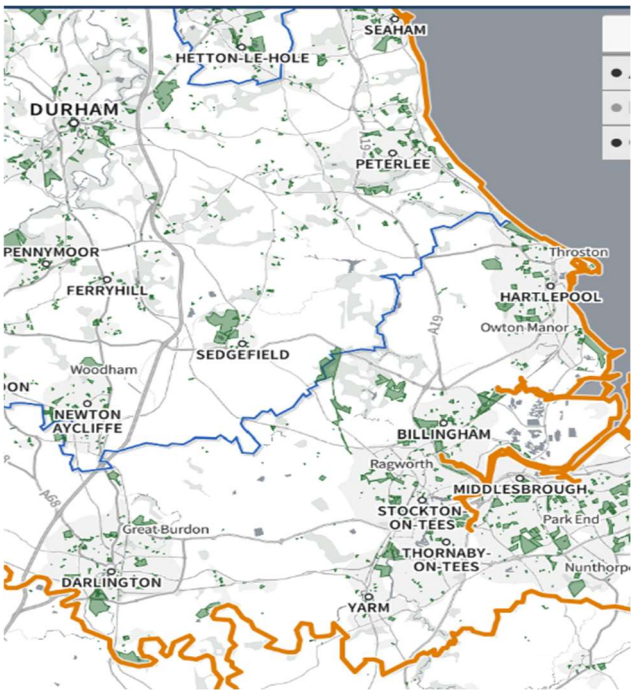
Homes, food and living environment

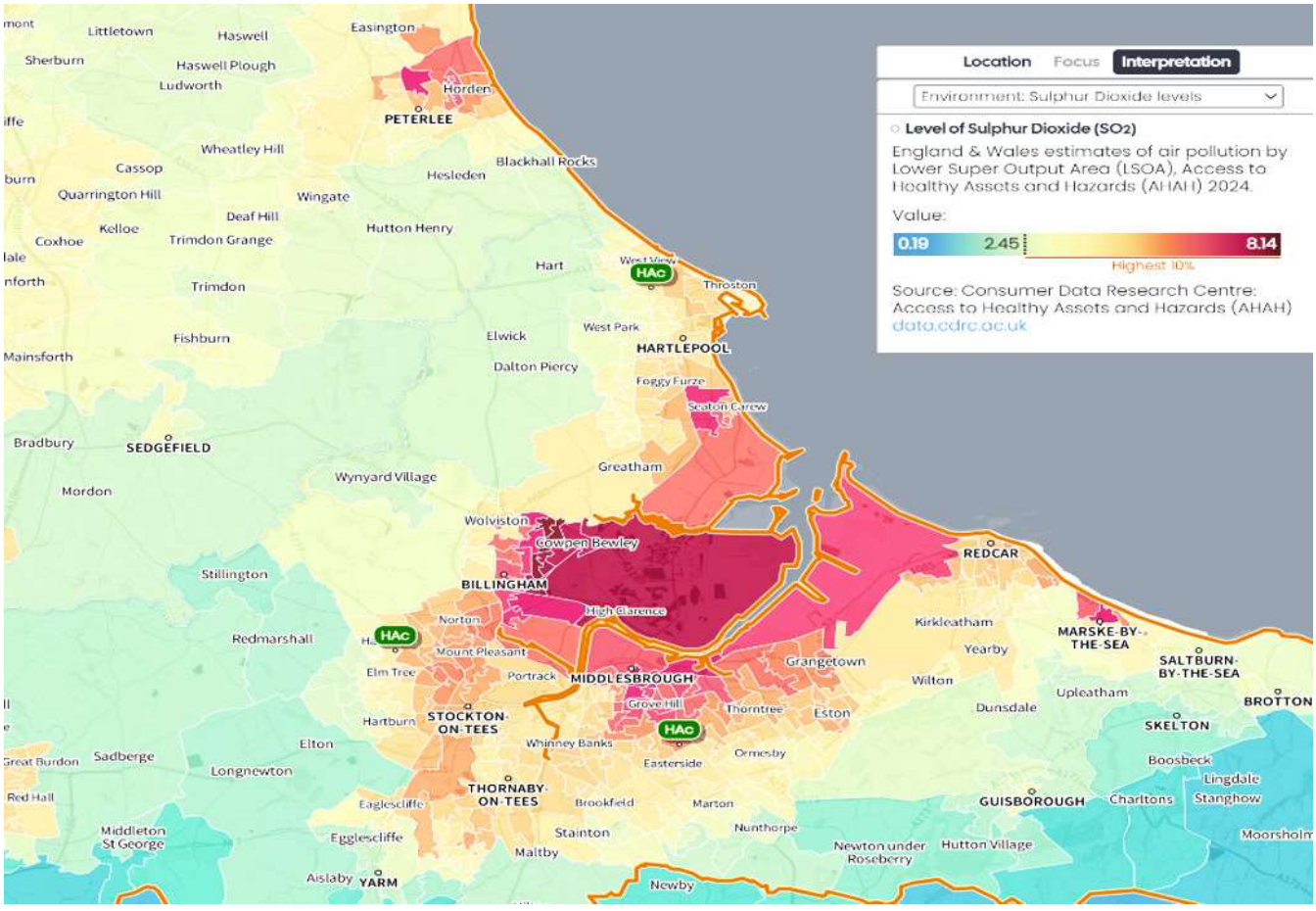
In some areas of the trust catchment, more than one in five private rented homes are classed as non-decent and around one in ten have damp. In the blue map below, areas outlined in red are in the highest 10% nationally for proportion households affected by fuel poverty.





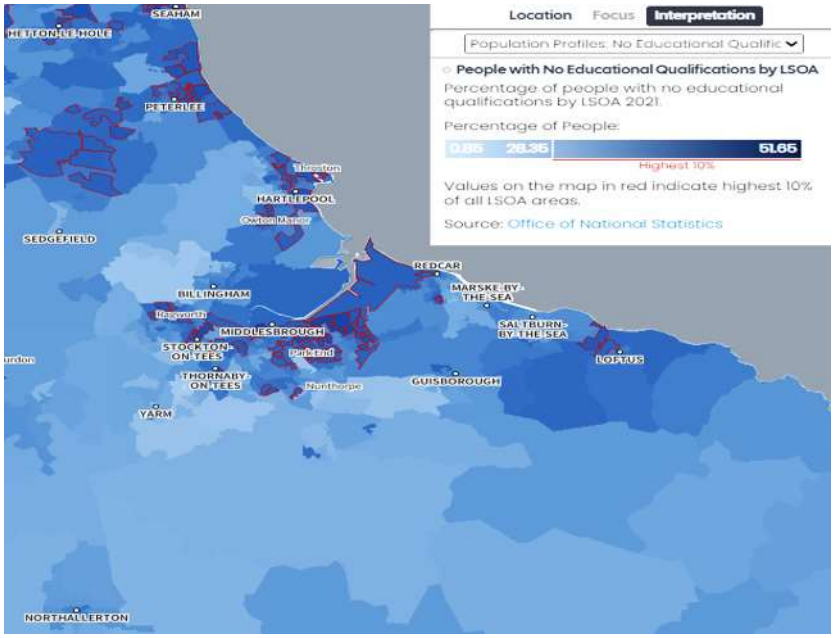
Maps below show open green space and levels of different types of pollution experienced in different areas. several areas in the trust catchment are in the highest 10% nationally for the lev





Education

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



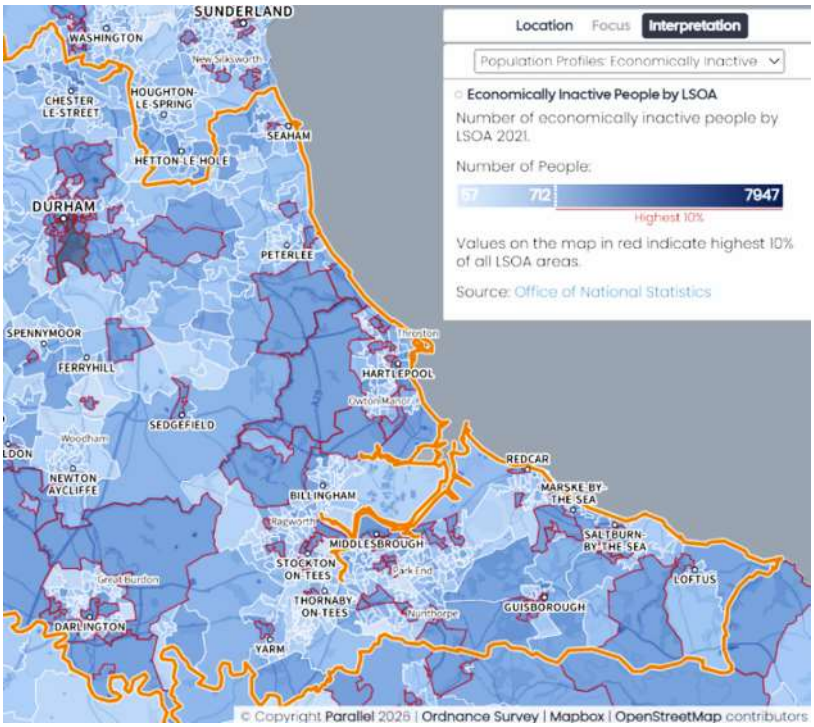
[School Readiness statistics] suggest less than seven in ten children in our trust catchment are achieving a good level or development at the end of reception, and for children eligible for free school meals this figure falls to around 5 in 10. Pupil absence in our catchment is higher than national average and attainment in secondary school varies across our catchment. As with national figures attainment tends to be lower for children eligible for free school meals and children in care.

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

Economic activity and occupation

Fingertips Data suggests, across the trust catchment, economic inactivity varies from 22% to 31% and the percentage of people in employment varies from 65% to 75%. The map (right) shows areas of higher economic inactivity (darker blue), recorded in the 2021 Census. Many areas in the trust are in the highest 10% nationally for economically inactivity (red outline).

Historic manufacturing and mining occupations have implications for population health through industrial disease and economic challenges where these services have declined.



Intersectionality

Key line of enquiry 1.2:
How is intersectionality between these groups explored, for example, inequalities that may exist for people with a learning disability from different ethnic backgrounds, or children and young people from deprived areas?

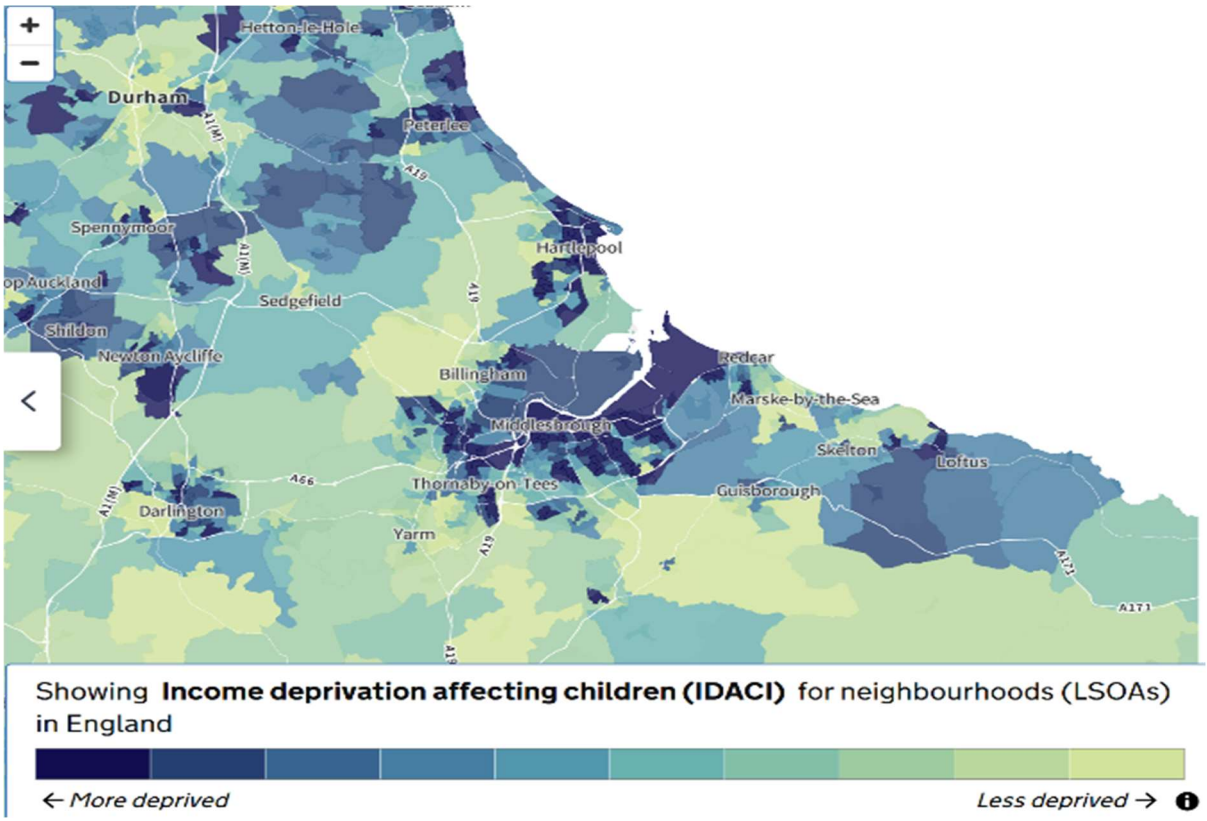
NHS England notes that disadvantage can be compounded when different factors, intersect or occur together. It is important to understand such intersectionality to effectively reduce health inequalities. We are able to explore intersectionality which affects large groups of people using public/internal dashboards or bespoke collection (e.g., as part of interventions to reduce health inequalities). For smaller cohorts, exploring intersectionality and reporting on it, whilst keeping data non-identifiable, is more challenging.

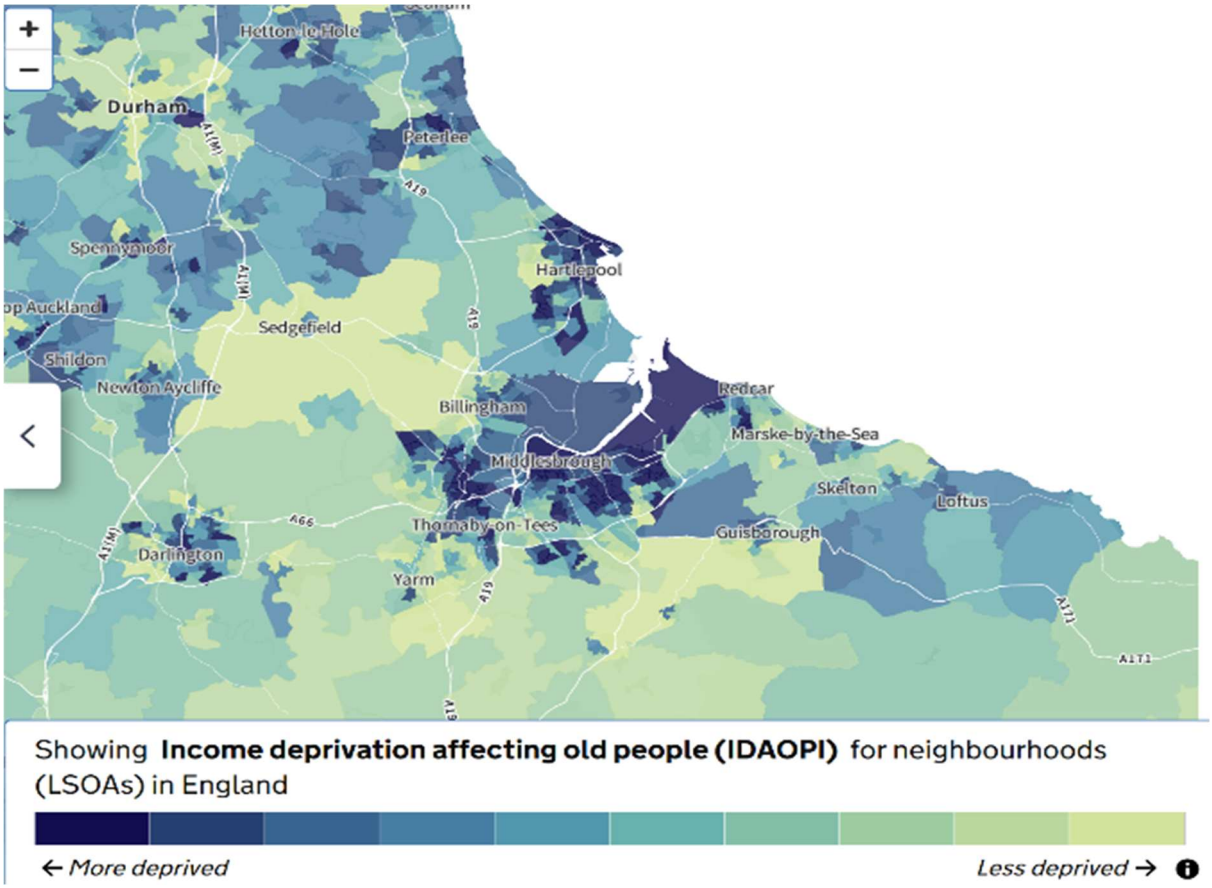
Ethnicity and deprivation

Due to small numbers, in-depth bespoke ethnicity analysis of internal data is undertaken to ascertain any disparities to be addressed. Approximately half of our patients who are Asian, and 70% of our patients who are black, live in our core20 most deprived communities.

Age and deprivation and geographical factors

A significant proportion of children in our catchment are from low-income families and this can affect children's health and families' ability to attend hospital appointments. Deprivation can also impact on older people's ability to stay warm or travel to appointments. The Local Deprivation Explorer 2025 maps show income deprivation affecting children, and income deprivation affecting older people, are generally concentrated in similar areas.

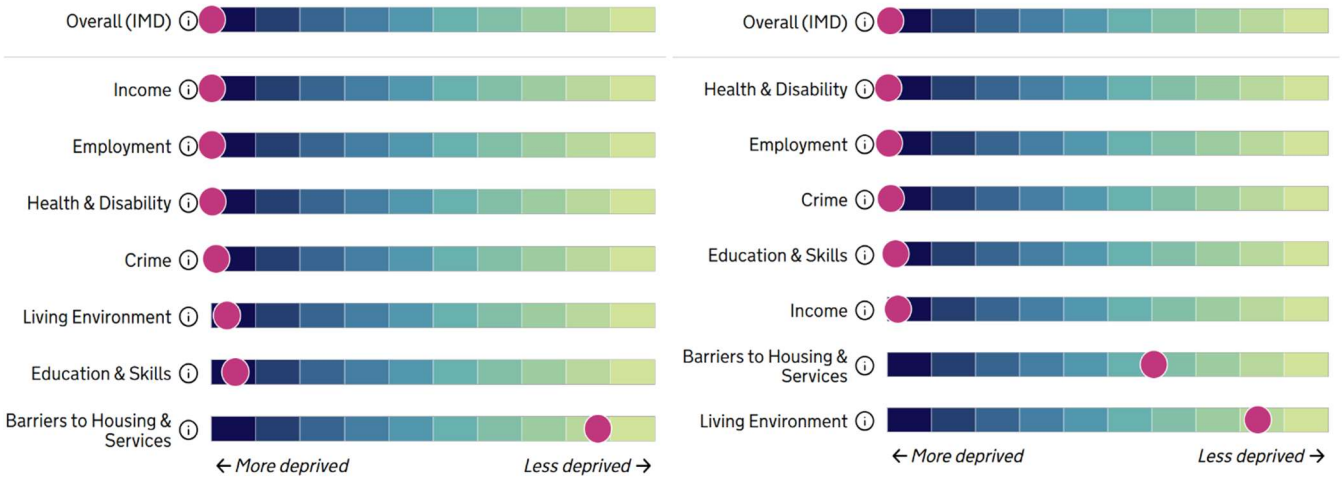




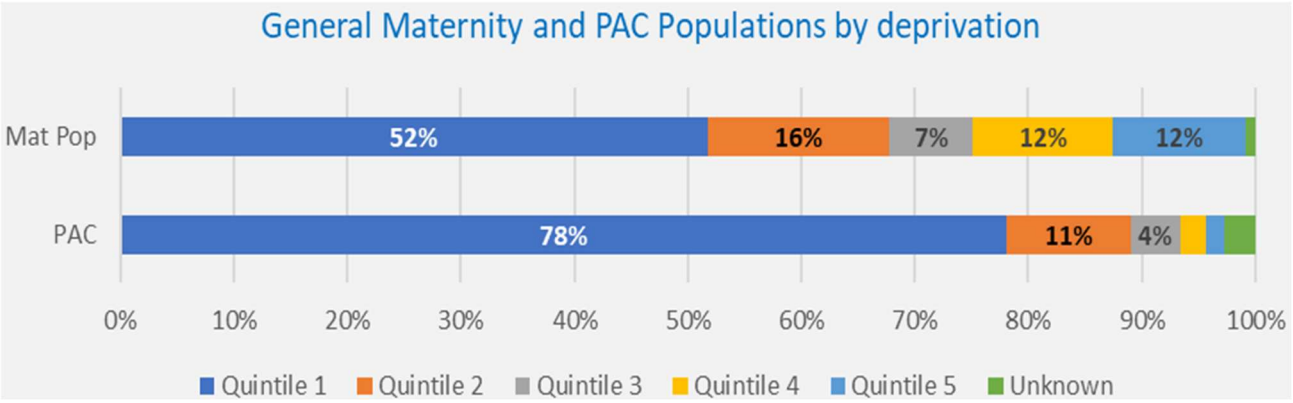
However, there are some differences on a very local scale. In some areas income deprivation affecting older people is around the average of all neighbourhoods in England but, for children, the same area is more deprived than 90% of neighbourhoods. In other areas, deprivation affecting older people is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

Intersectionality of key health determinants

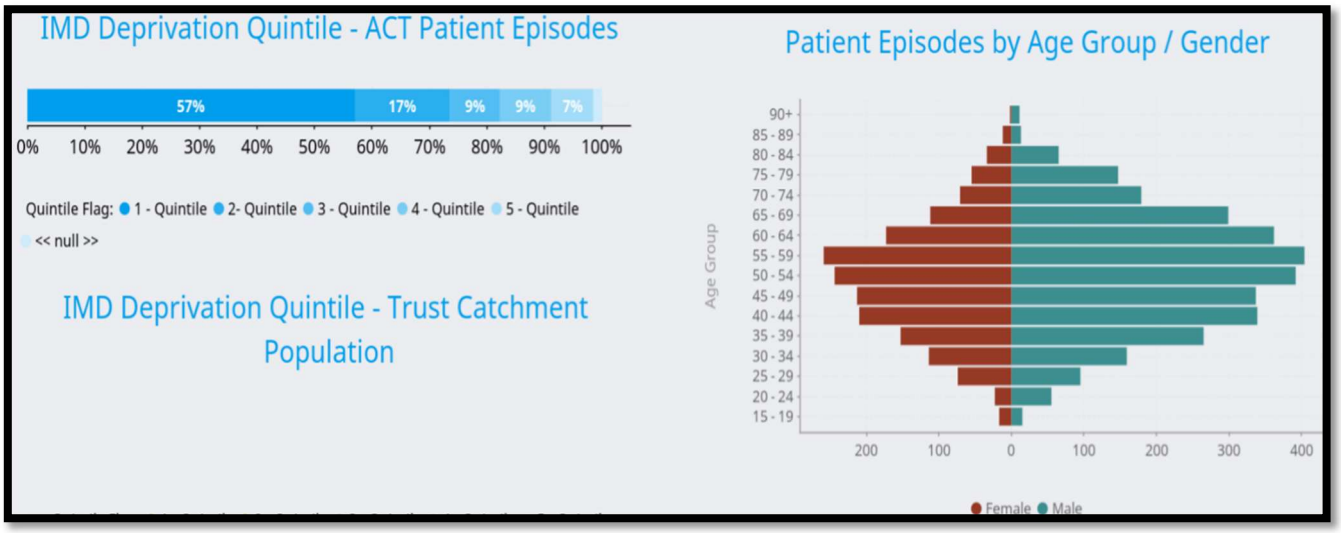
Some areas within the trust catchment are more deprived than 99% of all neighbourhoods in England. Many low-income areas have reduced access to good homes, education/employment, and services. However, as the example profiles below show, even the most deprived 1% of areas can have significant strengths that can be built on to improve health using an asset-based approach, collaborating with communities and other statutory/voluntary organisations.



During the Pregnancy Anticipatory Care (PAC) pilot, it was noted that 78% of patients with complex social factors (such as homelessness, mental ill-health, Adverse Childhood Experiences, alcohol/substance use or experience of domestic abuse), live in our Core20 communities. In general, 52% of pregnant people served by the trust live in Core 20 communities (Quintile 1).



Figures from substance use work within the trust, suggest that 72% of substance use attendances involve people living in our Core20 communities. Although substance use attendances mainly involve people aged between 30–54 years old, the full age range for all attendances is from under 16 to over 80 years old.



57% of people seen by the alcohol care team live in our Core20 populations. These patients were more likely to be male and around 55-59 years old (range under 19 to 90+ years)

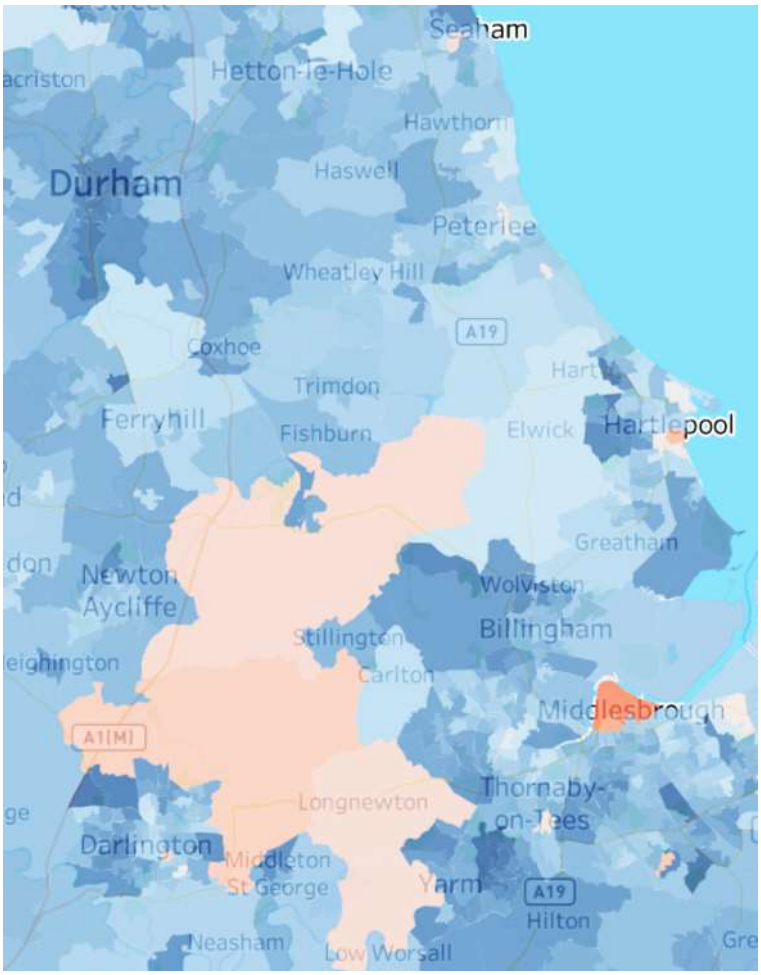
Barriers to healthcare

Key line of enquiry 1.3:
What steps have been taken to understand the prevalence and distribution across your geography of risk factors for healthcare inequalities, for example, digital exclusion, geographical access barriers such as transport, health literacy, language barriers? How has this insight informed targeted planning, commissioning and delivery of services?

Digital exclusion

Digital inclusion is increasingly important for healthcare and is a key part of the NHS 10-year Plan. The Digital Exclusion Risk Index suggests that some of the trust catchment are at higher risk of digital exclusion (red in map). These areas include rural communities to the west and north of the catchment (with worse scores for broadband) and some areas of Hartlepool (with scores reflecting deprivation and age/disability).

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

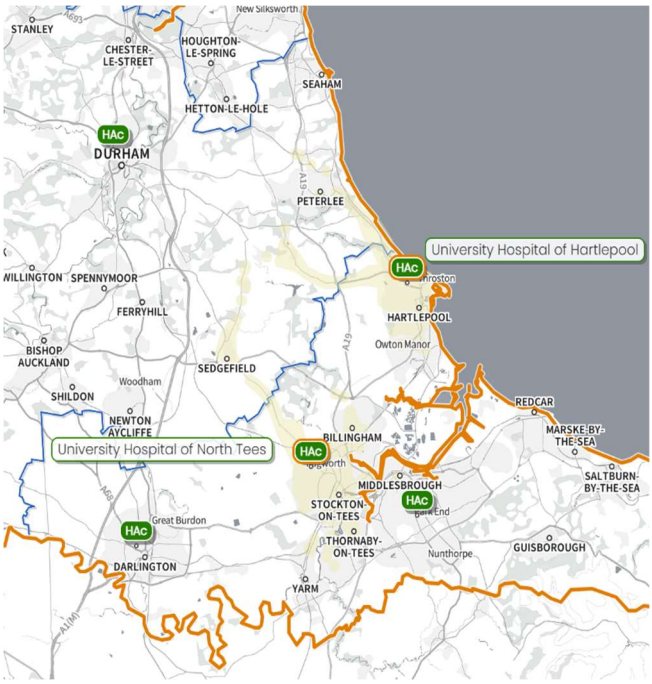


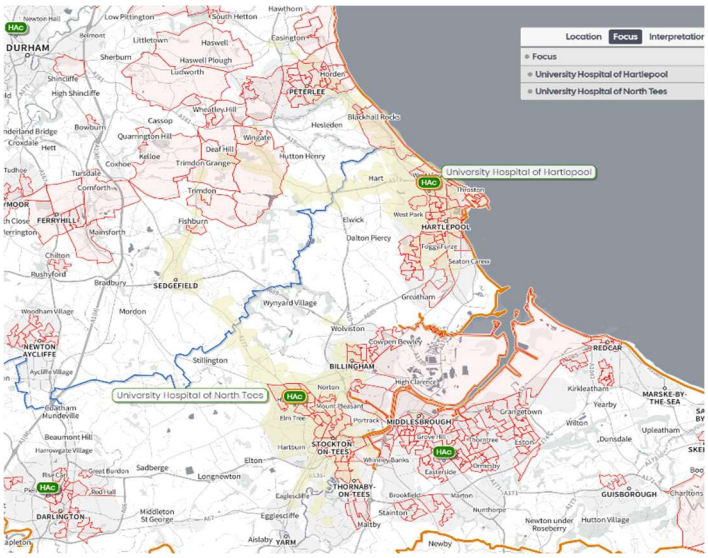
Geographic or transport barriers to healthcare

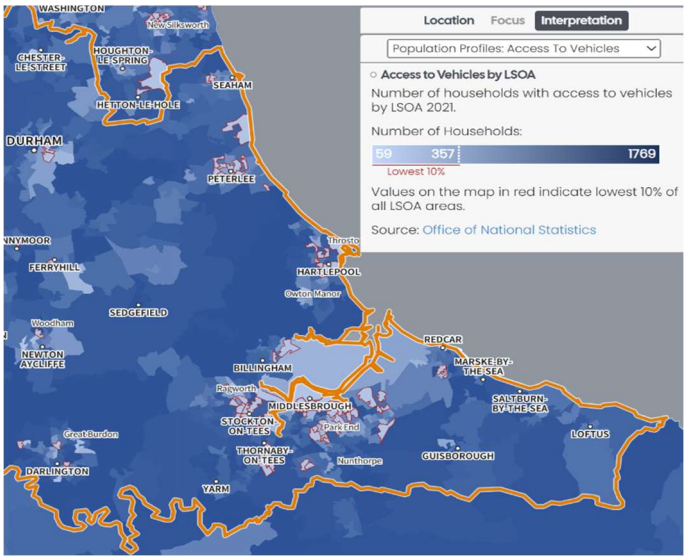
Strata maps can also suggest areas of the trust catchment experiencing transport barriers to healthcare access. The trust operates through several locations but key sites include the University Hospital of North Tees and the University Hospital of Hartlepool. The pale green areas on the map below are estimated to be within 30 minutes of these Hospitals by public transport.

This suggests a significant proportion of the trust's catchment would require more than 30 minutes to reach these sites using public transport. It is also important to consider that these sites offer different services, so patients may need to travel to a site which is not the nearest hospital to them, for some emergency or elective care. If some services, offered as University Hospitals Tees, were only provided on the largest South Tees site (James Cook University Hospital) than any patients from the North Tees and Hartlepool NHS Trust catchment area using public transport would likely require more than 30 minutes travel time.

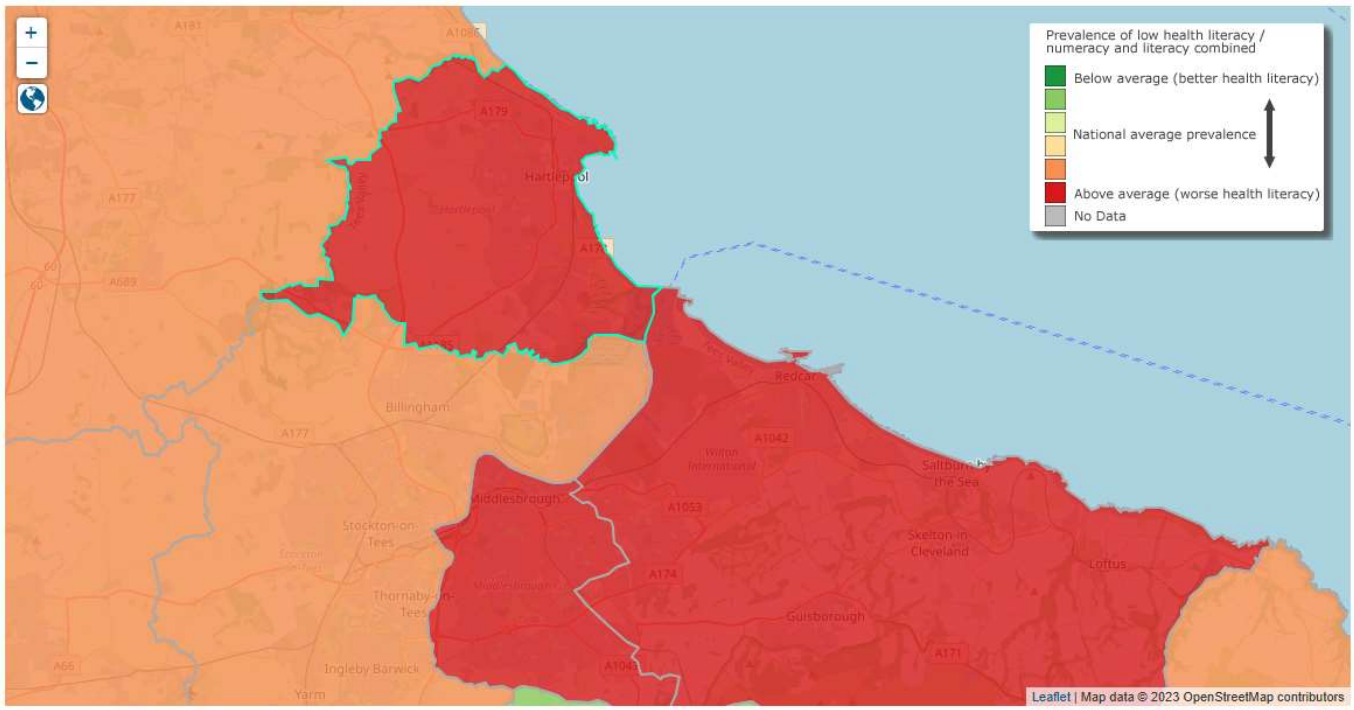
Communities where car ownership may be lower (e.g. deprived neighbourhoods or older people) may face particular barriers to attending hospital-based appointments. Strata mapping shows many of the 20% most deprived neighbourhoods lie outside of the estimated 30 min travel time by public transport (left map below). Some areas of the trust catchment are in the lowest 10% nationally for the percentage of households with access to vehicles (right map below). Ensuring our services are accessible to people without access to a vehicle and people from deprived communities is vital to reducing health inequalities. Planning services in line with the NHS 10 Year Plan's shift from hospital to community is an opportunity to develop greater equity of access and health.







Health literacy

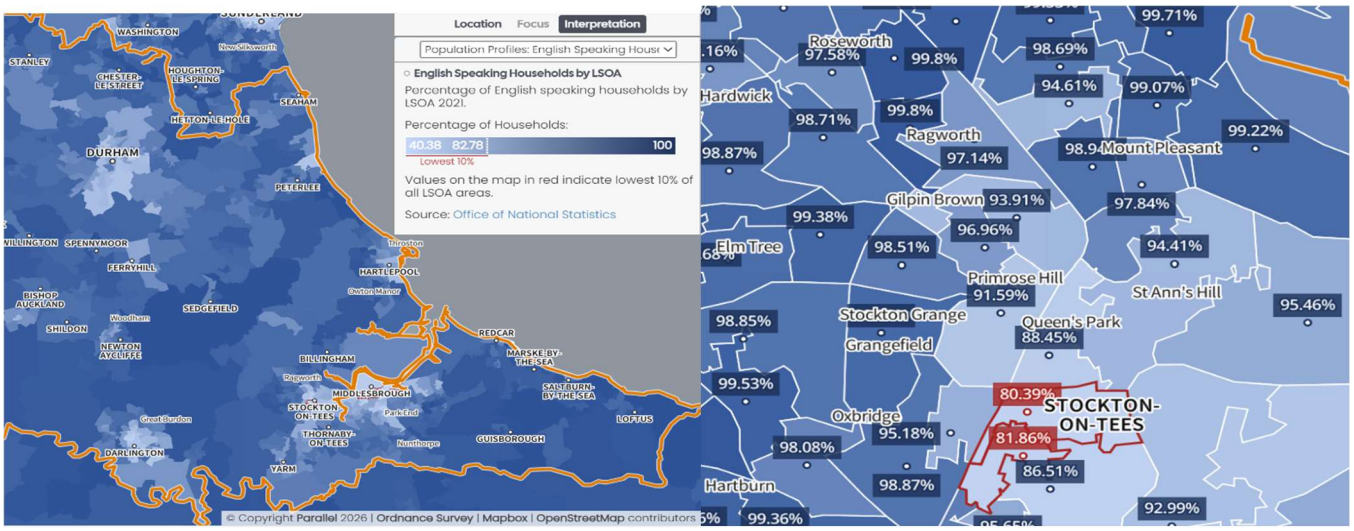


Health literacy is about people being able to understand health information. The North East and North Cumbria Health Literacy page notes that people with low health literacy are more likely to die younger, have long-term conditions, miss appointments more often, find it hard to take medication correctly, feel worried and angry or struggle to look after their own health effectively.

Nationally, around half of adults find it hard to understand health information and that the average reading age of adults is 9-11 years old. However, the trust's catchment population has worse than average health literacy (red/orange areas on the map). It is, therefore, vital to ensure we make health information easy to understand. Health literacy training can help us all to speak and write in ways that are clear and help our patients make informed choices about their health.

Language barriers

Difficulty speaking or understanding English was one of the top 10 complex social factors noted in our Pregnancy Anticipatory Care Pilot. Across the trust catchment, there is some variation in the percentage of households recorded as having English as the main language in the 2021 Census (maps below). In some areas English was recorded as the main language in 100% of households (darkest blue) and some areas the percentage was 80% (lightest blue). These figures may change over time but the 2021 Census data is one of the most robust data sources available regarding main language. In the second map (below right) the two areas in Stockton outlined in red were in the lowest 10% nationally for the percentage of households with English as the main language. This suggests that one in five people in these areas may face some degree of language barrier in accessing trust services, and other services that support wellbeing.



How understanding health inequality risk factors has informed service planning and delivery

Understanding risk factors for healthcare inequalities has informed service planning and delivery in many ways. For example, the Personalised Care service support core20plus patients attending appointments with many barriers to healthcare access. The Personalised Care Directory of Services is used to support patients with issues such as transport and MECC training is being rolled out across all departments. Reimbursement of travel expenses has been made easier by enabling forms to be dropped in at additional key sites.

The Device Access Pathway for supplying digital device and sim/data to eligible patients is established and is being promoted with staff to improve distribution to patients. The staff campaign for device donation has also been relaunched.

To address health literacy related barriers, training is being provided for all staff and we have been reviewing outpatient letters, trust leaflets, hospital signage and clinical pathways from a health literacy perspective.

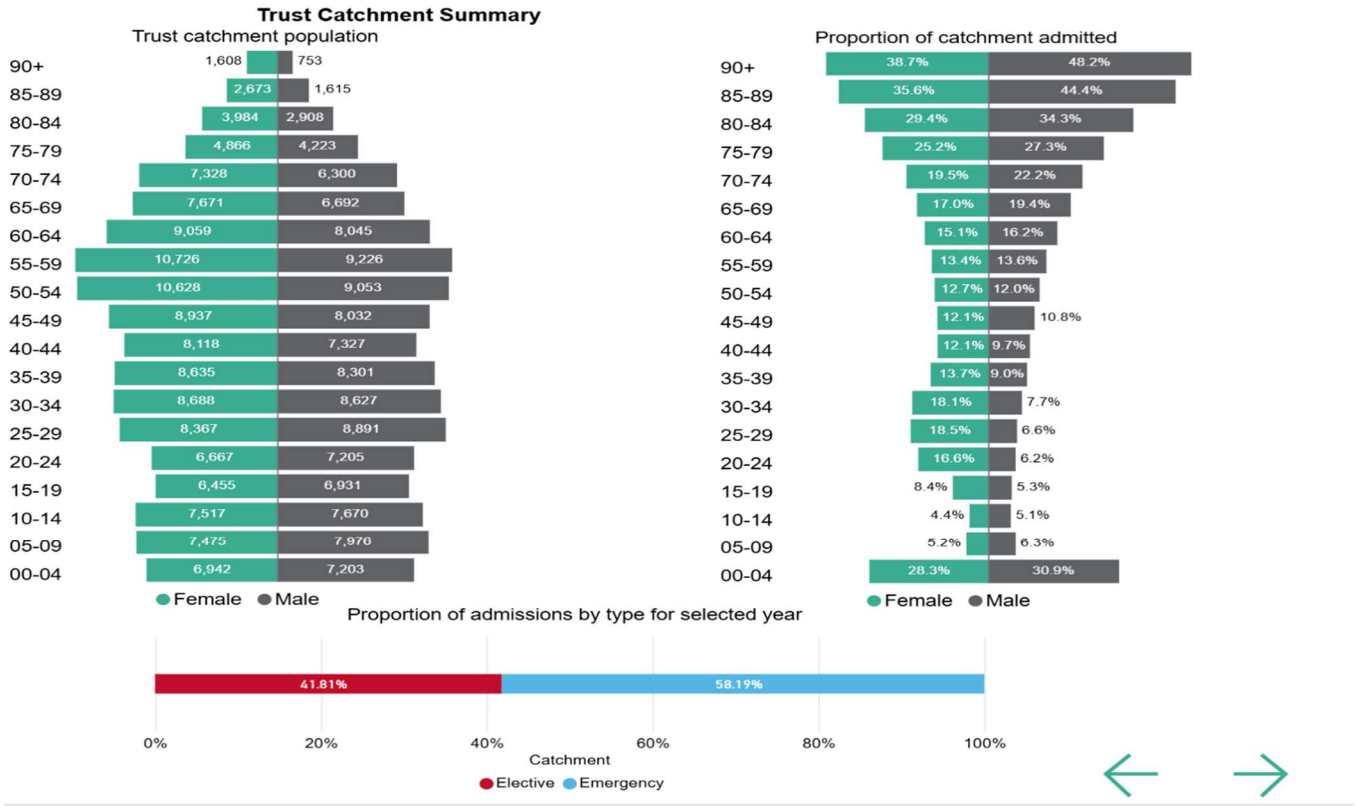
2. Understanding healthcare access, experience and outcomes

Key line of enquiry 2.1:
To what extent have health inequalities across a range of population groups and clinical domains been identified as a driver of trends in performance, productivity and resource utilisation?

Health inequalities have been identified as a driver of trends in performance, productivity and resource utilisation across a range of population groups (Core 20, inclusion health, age/sex/ethnicity) and clinical domains (e.g. cancer and surgery). For example, it was noted that people from our Core20 communities were more likely to die in the first five years following a cancer diagnosis. People from Core20 communities were also less likely to attend screening or outpatient appointments and more likely to have procedures cancelled. These issues led to projects to increase uptake of screening, increase clinic attendance and reduce cancellation of procedures (e.g. Waiting Well) for our Core20 population.

Admissions to the trust vary by age, with a greater proportion of under-5-year-olds and over-75-year-olds in the catchment (over 25%) being admitted annually. Between the ages of 15-49, females appear more likely to be admitted than males. However, above age 65 (or under-5 years old), a greater proportion of males are admitted (source: OHID, NHS Acute Trust's catchment populations 2022). People in the oldest and youngest age bands are more likely to be admitted as an emergency rather than electively.

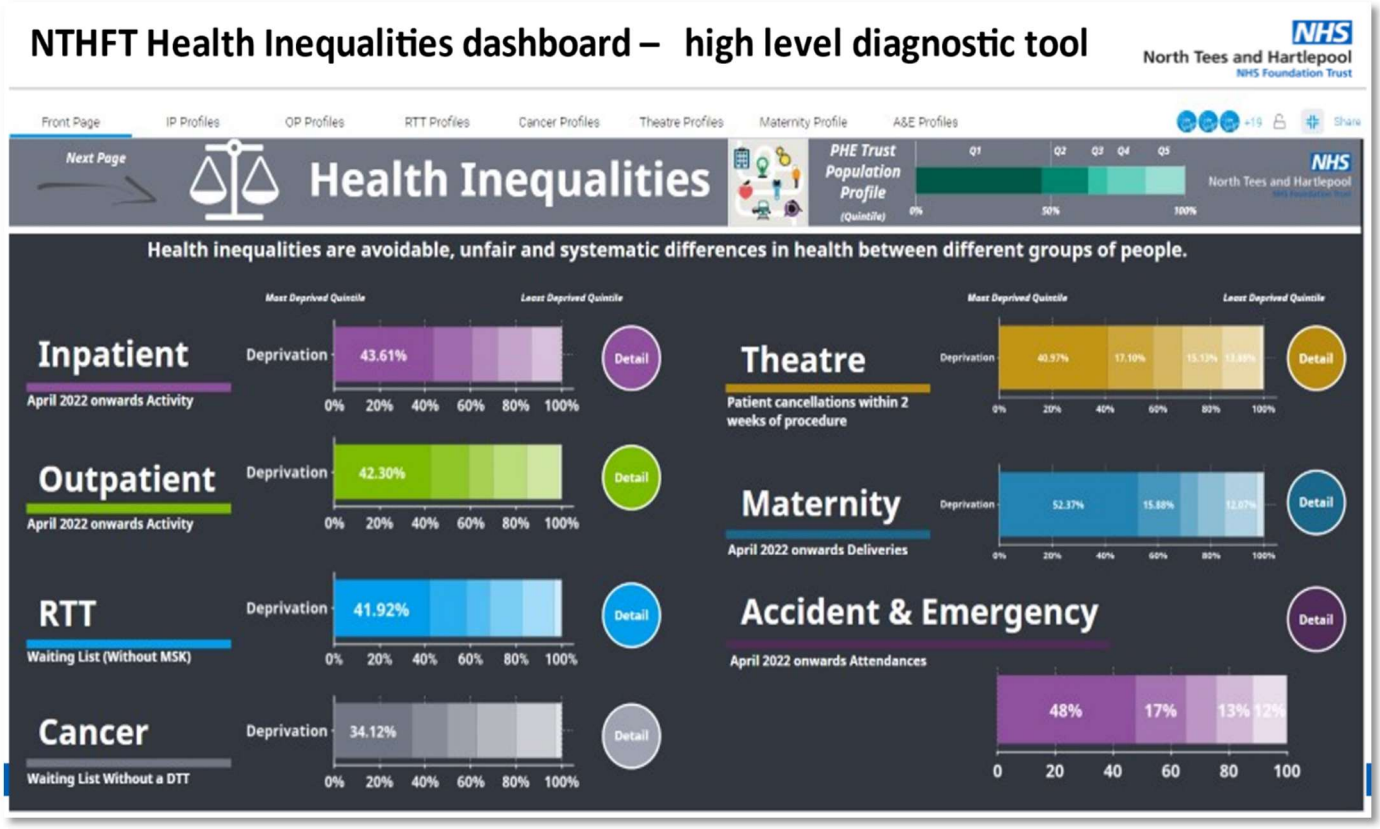
People in an ethic minority make up around 6% of the catchment population and a similar proportion of admissions.



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

Key line of enquiry 2.2:
How is routine performance data – including elective and urgent and emergency care data – analysed and broken down by deprivation, ethnicity, age and sex, to better understand areas of inequality, and how have other triangulated sources of insight supported an understanding of the drivers of these including barriers to access or inequalities in patient experience?

Through our trust high level Health Inequalities Dashboard, we have disaggregated key acute datasets to help us understand disparities in access, experience and outcomes across the areas of trust activity. All the datasets are analysed by gender, ethnicity and deprivation as a minimum.

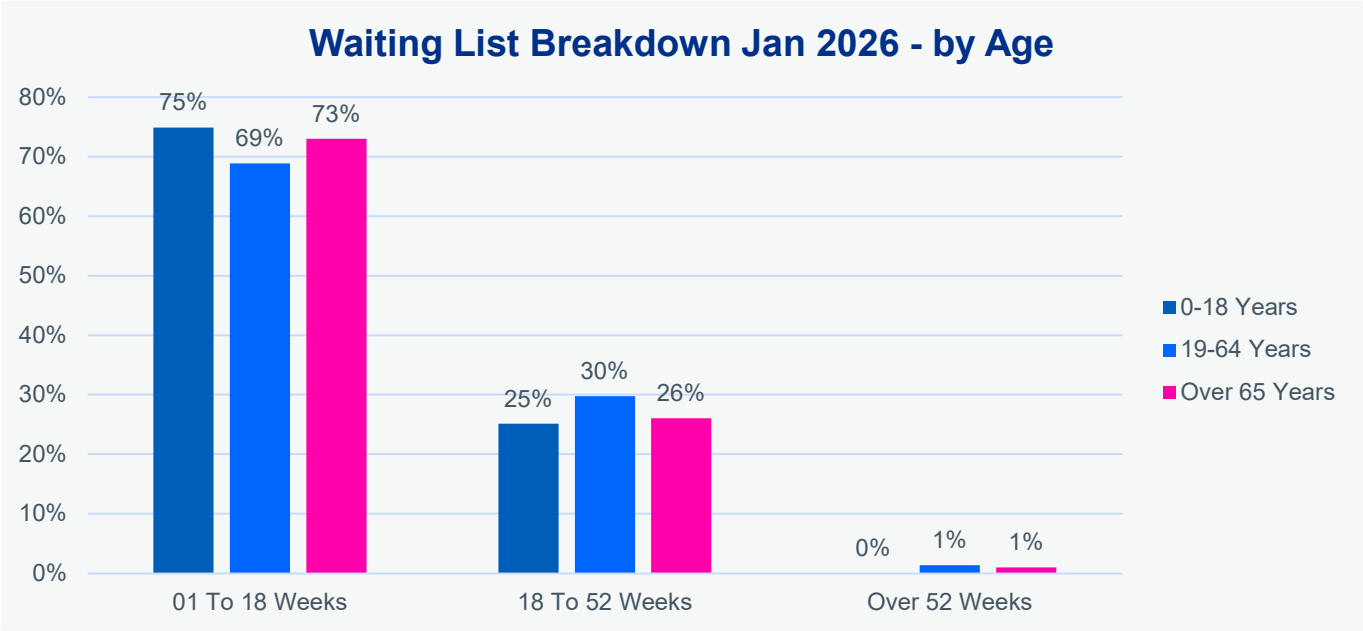


Due to small numbers, in-depth bespoke analysis of our BAME population is undertaken to ascertain any disparities that might need to be addressed. We have also undertaken bespoke analysis to ascertain any disparities for our patients who are flagged as having a learning disability. We are implementing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

Elective care waiting time

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

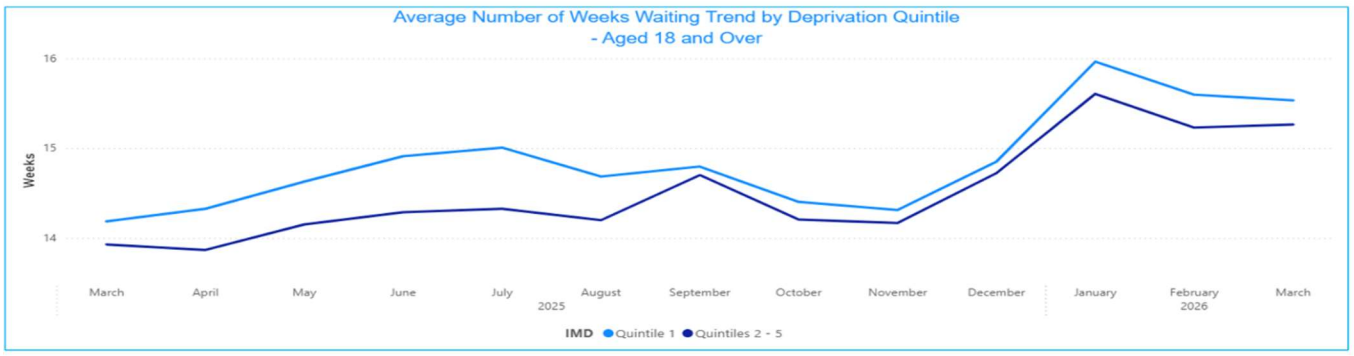
The latest data from the Waiting List Minimum Dataset (January 2026), show 21,920 people are on the North Tees and Hartlepool NHS Foundation Trust waiting list for elective treatment. Of the 21,920 people on the North Tees and Hartlepool NHS Foundation Trust waiting list, 71% of people have been waiting 18 weeks or less for elective treatment. There is statistically significant variation by age (but not gender), with a larger percentage of working age people recorded as waiting longer than 18 weeks. Of people aged 19-64 years, 69% had been waiting 18 weeks or less. This compares to 75% of people aged 0-18 years, and 73% of people aged over 65.

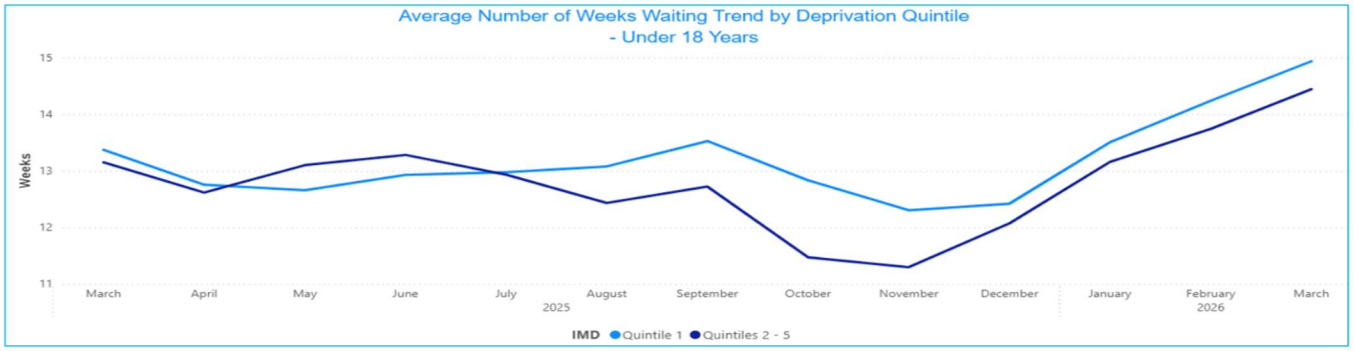


Where ethnicity was recorded as “not stated”, people were more likely to have been waiting 18 weeks or less. Where ethnicity was stated, there was no statistically significant difference in between ethnic groups.

Although the percentage of people waiting 18 weeks or less varied from 70% to 73% between the most and least deprived communities, variation across deprivation groups was not statistically significant. 70% of people living in our Core20 communities (20% most deprived neighbourhoods in England) waited 18 weeks or less compared to 71% of people living in non-Core20 communities. Around 1% of people have been waiting more than 52 weeks for elective treatment and there is no statistically significant difference in this by age, gender, ethnicity or deprivation.

As well as the Waiting List Minimum Dataset, the trust also had local data available. This data does not include musculoskeletal referrals (due to the IT systems used for these referrals) but the data can provide detail on how the average waiting time has changed over recent months. The graphs below show that, over the last year, the average waiting time has increased from around 14 weeks to 15.5 weeks for people aged 18+ years. People aged under 18 tend to wait slightly shorter times.



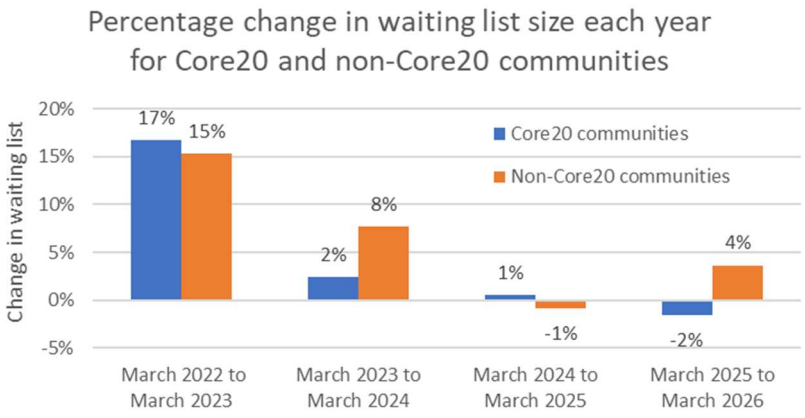


Waiting list size (number of people waiting for elective care)

Local data suggests, the trust's waiting list size (excluding musculoskeletal referrals) has increased from 14,304 people waiting in March 2022 to 17,625 people in March 2026, with the majority of the increase between 2022 and 2024. Compared with last year, there was a 1% increase in the number of people waiting.

Waiting list size for Core20 communities.

44% of people on the trust's waiting list live in our Core20 most deprived communities. Compared with March 2025, the waiting list size for our Core20 communities reduced by 2%, to 7697 people in March 2026. In contrast, the waiting list for non-Core20 communities increased by 4%. The graph shows how the waiting list for both groups has changed each year.



Waiting list size by ethnicity

The table below shows people on the waiting list by recorded ethnicity, in March 2025 and March 2026. Prior to March 2025, changes in waiting list size for some ethnic groups involved less than 10 people. These figures are not shown to protect the anonymity of these patients.

Recorded Ethnicity	Number of people on waiting list in March 2025	Number of people on waiting list in March 2026
Asian or Asian British	199	224
Black or Black British	54	89
Mixed	68	82
White	13902	13755
Other Ethnic Groups	90	111
Not Stated / Known	3084	3364
Grand Total	**17397**	**17625**

Waiting list size by age

In March 2026, 57% of people on the waiting list were aged 18-64 years, 10% were under 18 years and 32% were over 65 years of age. The table below shows people on the waiting list by age, for 2024, 2025 and 2026. In 2026, the number of under 18-year-olds waiting rose by 17% after a fall of 26% the year before. In the years before 2024, changes in waiting list size for some age groups involved less than 10 people.

Age (years)	Number of people on waiting list in March 2024	Number of people on waiting list in March 2025	Number of people on waiting list in March 2026
Under 18	2077	1537	1802
18-64	9897	10250	10111
65 and over	5505	5610	5712
Grand Total	**17479**	**17397**	**17625**

Waiting list size by gender

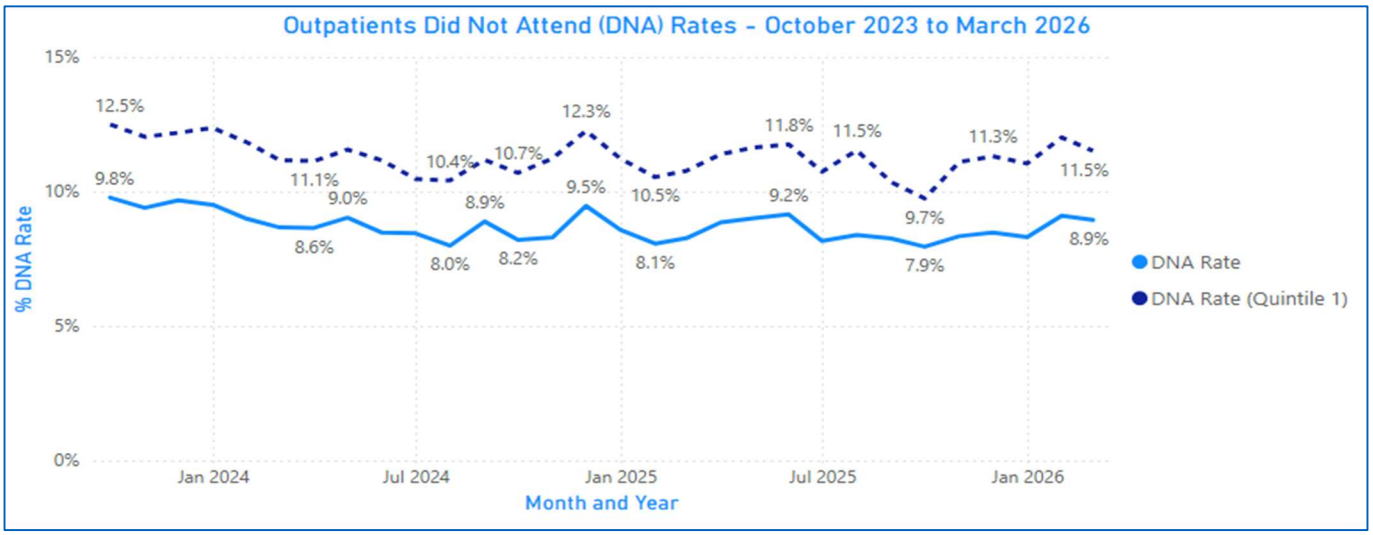
In March 2026, 39% of people on the waiting list were recorded as male, 61% recorded as female and less than 1% recorded as another gender or unknown. Rounded to the neared 10 to preserve patient anonymity, these represent 6,850 males, 10,770 females and <10 people of another/unknown gender. From 2025 to 2026, the number of males waiting rose 1% and number of females rose 2%.

Community Care

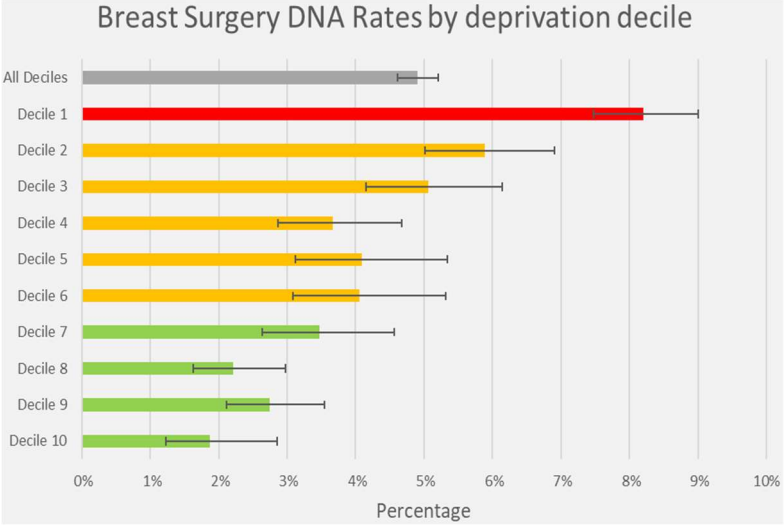
The average waiting time for community services is 10.8 days. The average wait for males and females is similar. The average wait for people recorded as being from a “British” ethnic group was 9.7 days. People from our Core20 communities waited an average of 11.6 and a greater proportion were aged 18-64 years (a greater proportion of non-Core20 people were aged 65+).

Outpatient and screening attendance

The proportion of people who “Did Not attend” (DNA) their outpatient appointment at the trust is lower than the national standard, and showing a declining trend, however disparities between the core20 and other patients persist as shown by the figure below. The DNA pilot is being expanded to help address this.



This year, a detailed local analysis of Breast Screening attendance has also been carried out. Attendance was highest (80%) for people aged <50 years (not in the main screening cohort but may be seen due to concerns), followed by 70+ years (65% attended, 15% were deceased, 20% did not attend). Attendance was lowest around 60-64 years (61% attended, 16% were deceased, 23% did not attend). Geographic variation was noted that may reflect distance to screening sites.

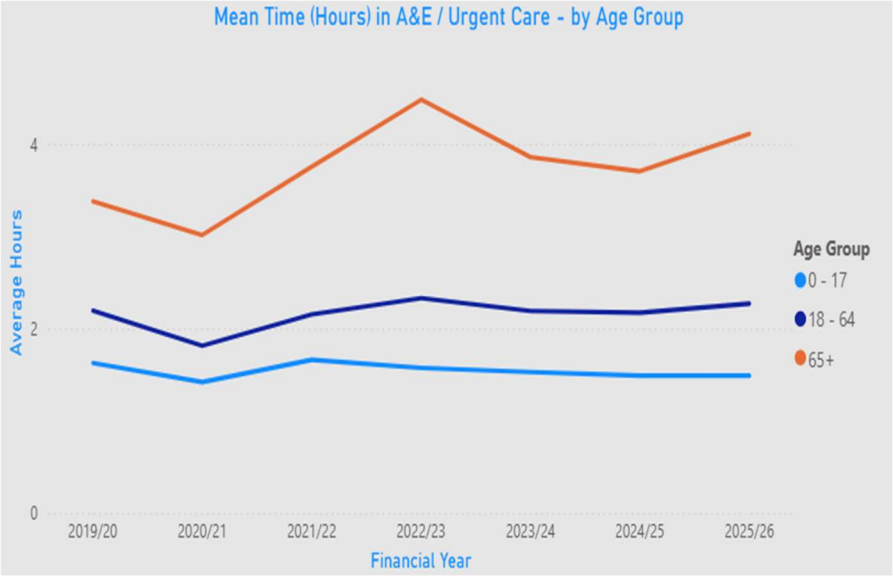


Analysis of Breast Surgery Outpatient appointment attendance suggested DNA rates were significantly higher in the 10% most deprived communities (Decile 1 and red bar in graph).

People aged 20-34 were less likely to attend and people aged 60-74 most likely to attend. People from minority ethnic groups account for 1.62% of all breast surgery outpatient appointments but only 1.13% of total DNAs

Urgent and Emergency care

In 2025/26, the average time patients spent in A&E or urgent care was 2.37 hours. People aged 65+ were likely to spend longer in A&E or urgent care than other ages, and the graph on the right suggests the gap has been widening over time. People aged 65+ spent an average of 4.11 hours in A&E or urgent care in 2025/26, compared to 1.49 hours for people aged 0-17 years and 2.27 hours for people aged 18-64 years.

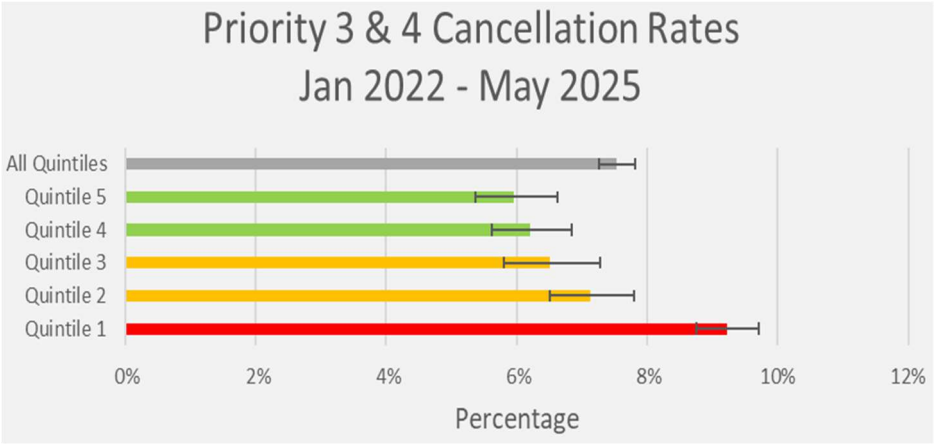


The average time in A&E for people from our Core20 communities was 2.40 hours (compared to 2.31 hours for people from our non-Core20 communities). The table below shows the average time by ethnic group.

Financial Year	1. Asian or Asian British	2. Black or Black British	3. Mixed	4. White	5. Other Ethnic Groups	6. Not Stated / Known
2019/20	1.97	2.38	1.71	2.30	1.79	2.04
2020/21	1.73	1.63	1.66	1.99	1.57	1.77
2021/22	1.91	1.71	1.76	2.30	1.79	2.21
2022/23	2.01	1.82	1.75	2.48	1.78	2.34
2023/24	1.91	1.73	1.73	2.32	1.67	2.12
2024/25	1.76	1.70	1.73	2.30	1.80	2.08
2025/26	1.81	1.67	1.67	2.46	1.82	2.23

Procedure cancellation rates in our Core20 population

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



Timing of first antenatal appointment in pregnancy ("booking")

NICE recommends that a first "booking" antenatal appointment occurs within the first 10 weeks of pregnancy. The percentage of pregnancies "booked" within 10 weeks of the pregnancy starting has increased from 48% in 2023/24 to 70% in 2025/26. In our Core20 communities 66% of pregnancies were booked within 10 weeks (compared to 74% of pregnancies in our non-Core20 communities).

Booking by 10 weeks was statistically less likely for mothers aged 35+ (61% booked by 10 weeks) and people recorded as being from "Black" (49%) or "other" ethnic groups (55%). The table below shows the percentage of bookings by 10 weeks has increased over time for each ethnic group.

Ethnic group	2023-24	2024-25	2025-26
Asian	32%	56%	62%
Black	16%	47%	49%
Mixed	28%	48%	58%
White	53%	67%	72%
Other	26%	47%	55%
Not known	39%	60%	56%
Total	**48%**	**64%**	**70%**

Preterm birth and post-partum haemorrhage (PPH)

There was no statistically significant variation in preterm birth or postpartum haemorrhage (either >500ml or >1500ml blood loss) by age, deprivation or ethnicity.

Smoking in pregnancy and at Time of Delivery (SATOD)

In 2025/26, 8% of people giving birth were recorded as being a current smoker (compared to 11% in 2023-24). Smoking around the time of birth is significantly more common for mothers living in our Core20 communities (13% vs 3%).

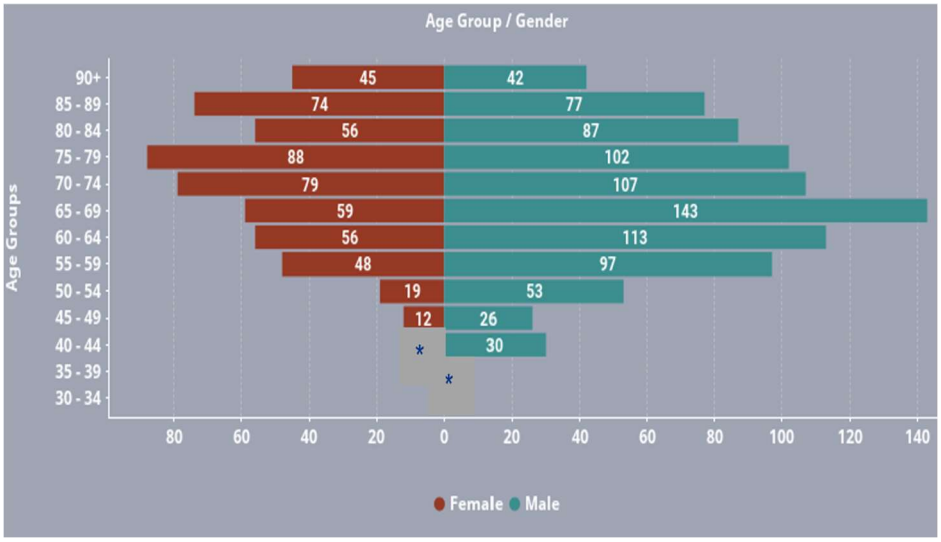
The percentage of people aged under 35 who are smoking around the time of delivery has fallen over the last 2 years and the percentage of people over 35 smoking at delivery appears to have increased slightly (though is not statistically significantly different to other ages). Less than 10 people from minority ethnic groups were recorded as smoking in 2025/26.

In 2025/26, there were around 200 pregnant people who were smoking at the time they had their first antenatal appointment. Around 16% of these people were recorded as having stopped smoking at 36 weeks. There was no statistically significant difference in people stopping smoking at 36 weeks by deprivation or age (though numbers may be too small to detect a difference).

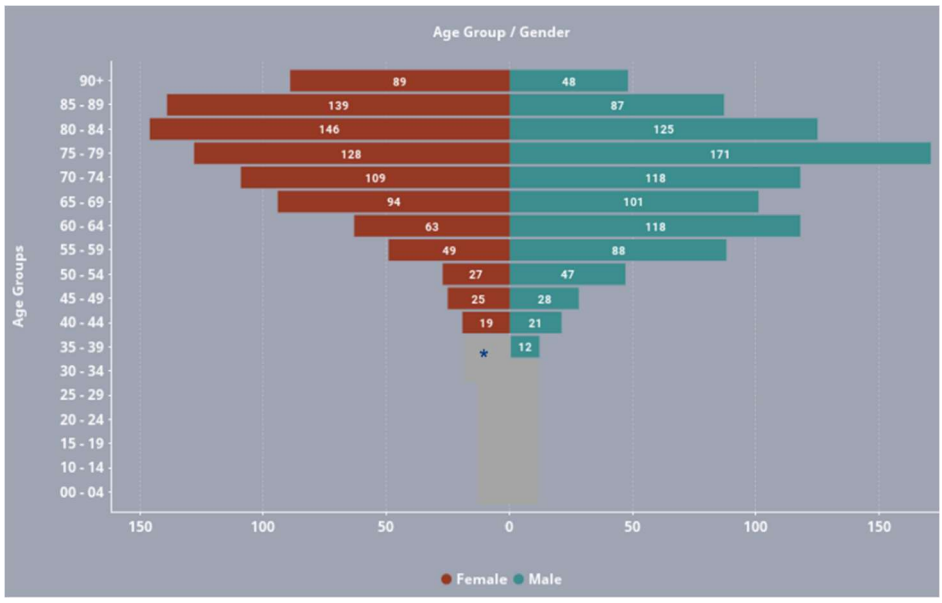
Cardiovascular disease

In 2025/26 we conducted bespoke analysis of cardiovascular disease including myocardial infarction (“heart attack”) and stroke. This local analysis noted that between April 2022 and March 2025 there were 1436 admissions for myocardial infarction. Of these admissions for myocardial infarction, 62% involved male patients, 38% female patients and <10 admissions were recorded as another gender. The graph shows the age and gender of people admitted with myocardial infarction (* denotes values <10). Myocardial infarction admissions for males peaked at 65-69 years and were higher than females for all age ranges except 90+years. Myocardial infarction admissions for females peaked at 75-79 years.

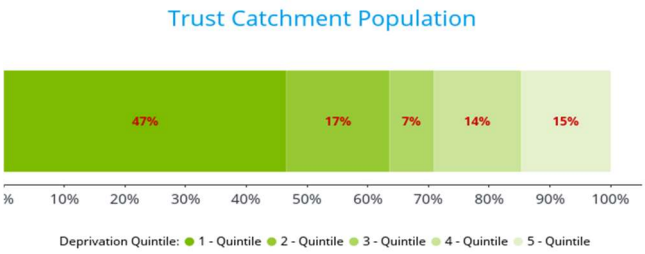
Myocardial infarction admission in our Core20 population peaked at an earlier age (60-65 for male and female) than less deprived communities. 6.3% of myocardial infarction admissions involved people aged under 50 years old.

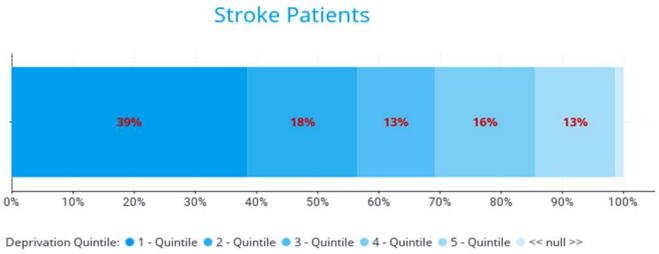


For stroke, there were 1885 admissions from March 2022 to April 2025 (52% male and 48% female). The peak age for admissions for stroke was 75-79 years for males and 80-84 years for females. The number of admissions for stroke under 80 years old was higher for males but females make up a larger proportion of 80+ admissions. 7.3% of stroke admissions involved people aged under 50 years old.



Given that 47% of the trust catchment lives in a Core20 community, significant numbers of admissions for myocardial infarction and stroke involve people from our Core20 most deprived communities. However, the percentage of admissions from our Core20 communities is lower than the trust catchment may suggest. 40% of myocardial admissions and 39% of stroke admissions are from Core20 communities. In contrast, the proportion of myocardial infarction and stroke admissions involving people in deprivation quintile 3 (the middle 20%) were slightly higher than the proportion of the catchment that they represent.

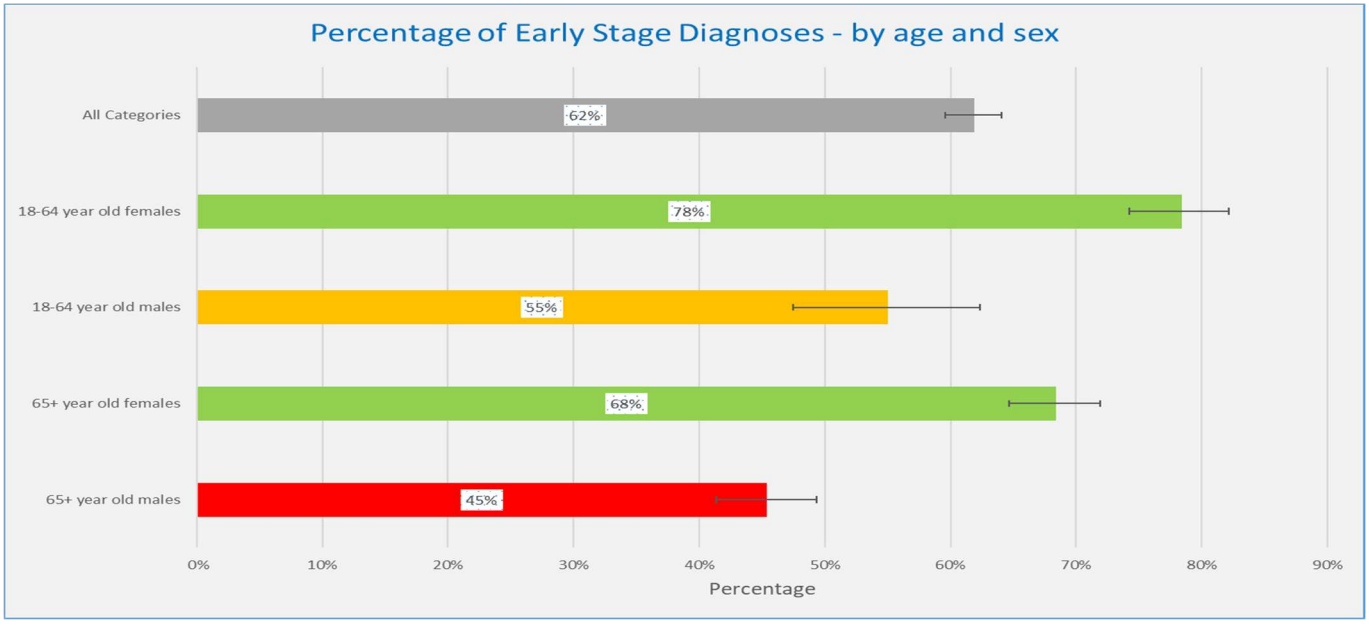




Cancer stage at diagnosis and 5-year survival

If cancer is diagnosed at an earlier stage this can improve survival. Determining the stage of cancer may require different investigations for different cancers and it may not be possible to accurately determine the stage for all patients. Of people diagnosed with cancer within the trust, 39% are from our Core20 communities (just under half of the trust catchment live in Core20 communities). Of cancers in our Core20 communities, 65% have a known stage. This is statistically similar to the proportion with a known stage in our non-Core20 communities (67%).

Females were more likely to be diagnosed at an earlier stage (especially females aged 18-64 years). The graph below shows that, where staging is known, 78% of females aged 18-64 years were diagnosed at an early stage compared with 45% of males aged 65+ years. There was no statistically significant difference in the percentage of cancers diagnosed at an early stage by deprivation or ethnic group.



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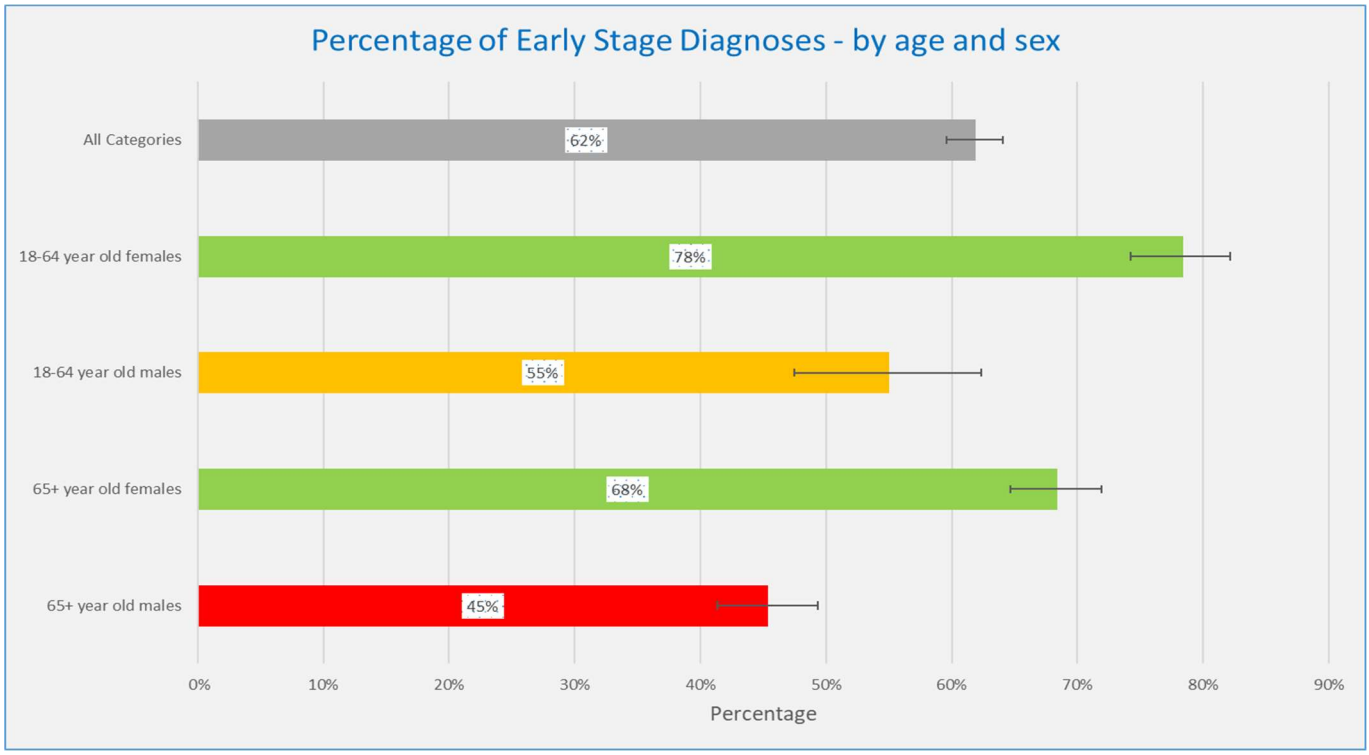
Females were more likely to be diagnosed at an earlier stage (especially females aged 18-64 years). The graph below shows that, where staging is known, 78% of females aged 18-64 years were diagnosed at an early stage compared with 45% of males aged 65+ years. There was no statistically significant difference in the percentage of cancers diagnosed at an early stage by deprivation or ethnic group.



As well as stage of diagnosis, many factors can affect the chances of a patient surviving 5+ years (e.g. cancer type/site, patient age/health and suitable effective treatment). Five-year survival appears lower for our Core20 communities and for people aged 65+ years. Survival also varies by sex and cancer type. Local analysis is underway to investigate this further.

Frequent A&E attendance

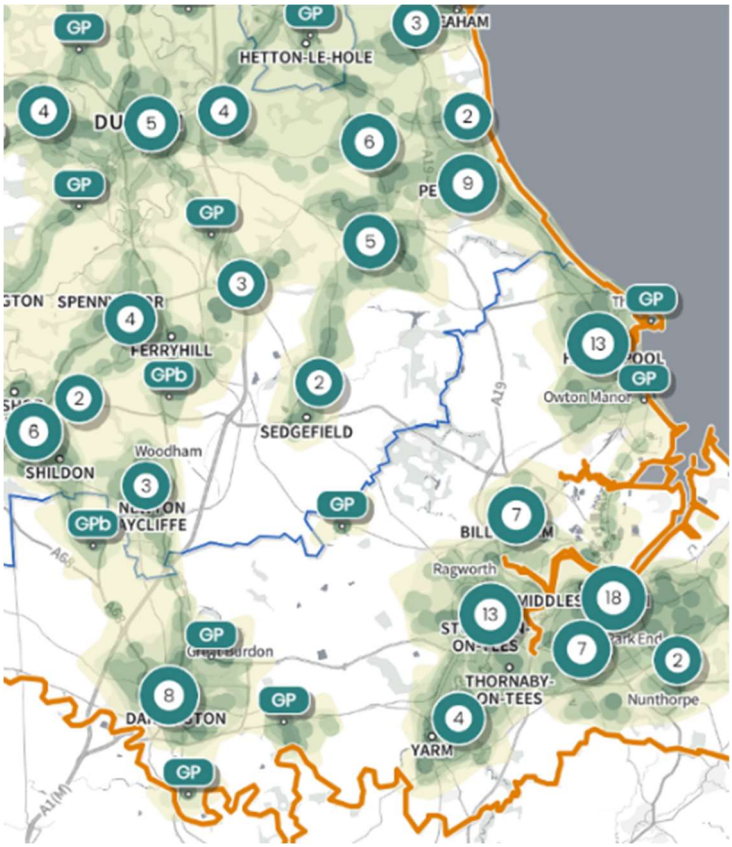
Key line of enquiry 2.3:
How is analysis being undertaken to identify those who frequently attend A&E, and understand the health inequalities they face, to inform proactive targeted support?

We have expanded our partnership response to help improve access to community-based interventions for people who frequently attend A&E. A population health management approach is utilised to identify and navigate individuals to wider psychosocial support (e.g. housing, substance/alcohol or mental health support). We are also working in partnership with our Deep End GP practices to scope and implement an offer to reduce A&E high intensity use. The NENC Deep End network has approved a grant to help us with implementation of our project. Future work includes identifying patients who leave the department before treatment since there may be overlap with people who frequently attend A&E and this could be considered in the management plan for individual patients.

Primary care access

Key line of enquiry 2.4:
How has local data been analysed to better understand areas of inequality in access to primary care, and how have other triangulated sources of insight supported an understanding of the drivers of these?

Strata mapping suggests that significant areas of the trust Catchment live in areas where they would have to travel more than 30 min by public transport to reach a GP Practice (uncoloured areas in map. Challenges arranging primary care appointments were also identified by patients in the Poverty Proofing Audit in A&E.



Patient reported measures

Key line of enquiry 2.5:
How has qualitative information, such as patient reported outcomes measures (PROMs) and patient reported experience measures (PREMs) been collected and analysed to address healthcare inequalities?

Patient reported experience and outcome measures are collected, analysed and reported for individual evaluation of services (e.g. Waiting Well Programme) and through Friends and Family surveys (with a weekly dashboard). Our patient experience and involvement report gives an overview of what the trust is doing to capture patient feedback. The NHS Oversight Dashboard also reports on patient experience measures, comparing the trust with other providers

3. Improving data quality, collection and analysis

Key line of enquiry 3.1:
What actions have been taken to identify and improve the completeness and accuracy of coding and recording practices, including for ethnicity, other protected characteristics and socioeconomic factors such as housing status?

Local analysis has identified the completeness of ethnicity recording for:

- **Community Services:** 77% complete, 23% “default” code
- **Emergency and urgent care:** 84% complete 5% “not stated”, 11% “not known”
- **Outpatients:** 85% complete, 15% “not stated”
- **Inpatients:** 86% complete, 14% “not stated”
- **Maternity:** 100% of mothers’ ethnicity recorded (to nearest percentage, with less than 10 “default” codes) and 99% of babies’ ethnicity recorded (with 40 “default” codes and 50 “missing” codes)

Ethnicity recording has improved over time for outpatients (from 81% in 2022-23 to 85% in 2025-26). From local analysis, ethnicity recording completeness does not appear to vary by age, sex or deprivation. Some variation in ethnicity coding between departments has been identified and interventions to improve completeness and accuracy of coding and recording practices are underway. Optimising recording of housing status and other inclusion health issues are key priorities being addressed with experts from the multiagency Inclusion Health Group. The trust has implemented the reasonable adjustments digital flag information standard. There is a flag on clinical systems for veterans, learning disability, serious mental illness and alcohol/substance use.

Processing and linking data:

Key line of enquiry 3.2:
How is data processed and, where relevant, linked to identify population groups who are underrepresented in the NHS data sets and to understand pathways across services and patterns of access and demand among groups experiencing inequalities?

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

As recommended by NHS England, performance, quality and patient outcomes within the trust are analysed by age, sex, ethnicity and deprivation. Where appropriate, data may be analysed by other characteristics (such as disability status, sexual orientation, employment or housing status). We also compare data regarding access/demand for specific groups with available figures regarding our trust catchment profile to identify groups that may be under-represented in our data.

Addressing data gaps

Key line of enquiry 3.3:
Where gaps in data quality affect the ability to carry out healthcare inequalities analysis, how is assurance undertaken on steps to address these?

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

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

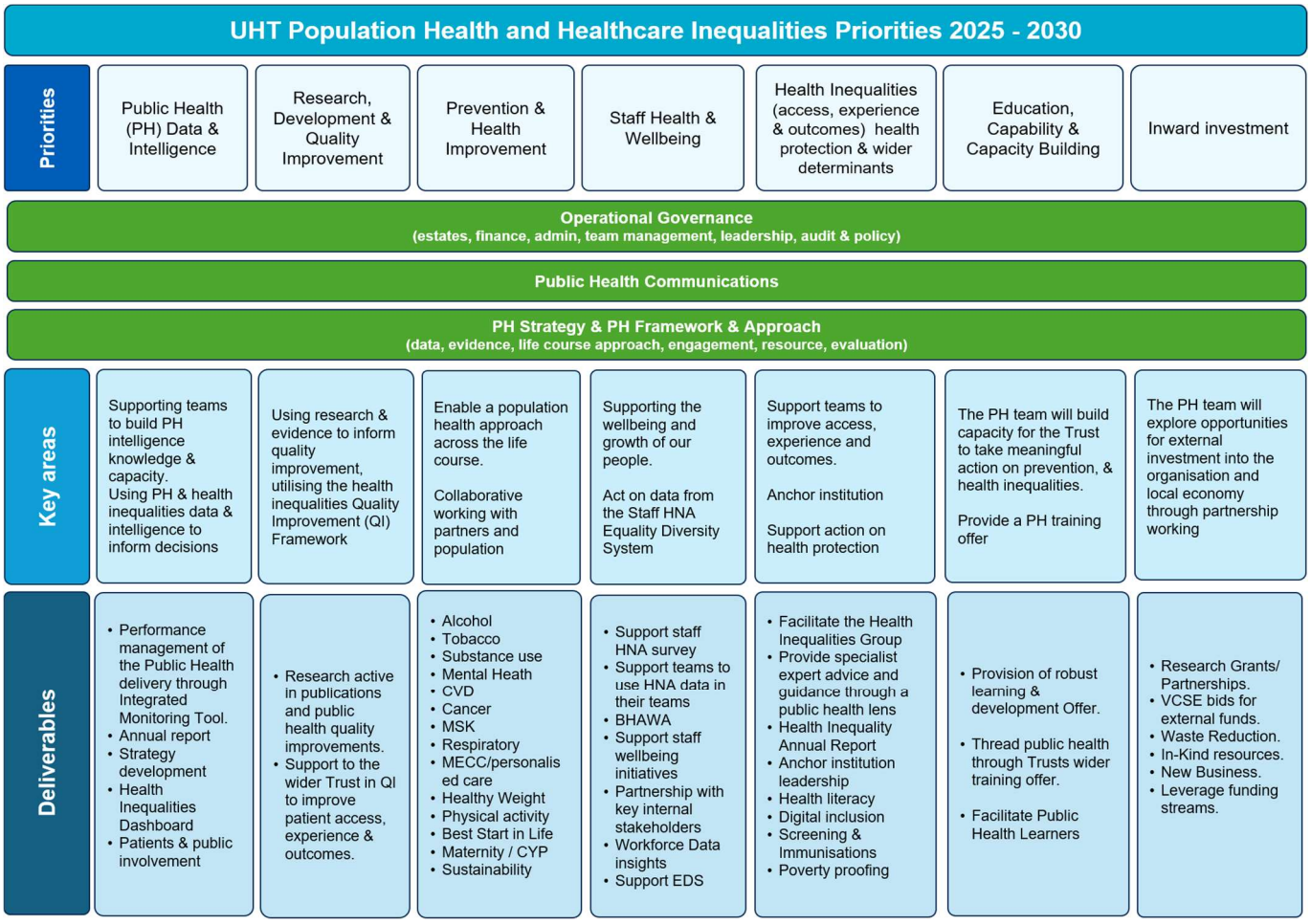
Key line of enquiry 4.1:
How has information on health inequalities informed strategic commissioning decisions, pathway redesign or long-term strategies?

Key line of enquiry 4.2:
How has information on health inequalities informed quality improvement approaches in service delivery, including in neighbourhood health models?

Key line of enquiry 4.3:
To what extent have inequalities in population health outcomes been used to inform decision making? Where trends exist, what ambitions have been set to target improvements?

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

Information on health inequalities has informed the draft University Hospitals Tees (UHT) strategy for 'improving population health and reducing healthcare inequalities. The infographics below show the priorities within the strategy with deliverables reflecting local heath inequalities and evidence-based opportunities for action.



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

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

Reducing healthcare inequalities				
Priorities	**How we will achieve this**	**Phase 1 2025 to 2026**	**Phase 2 2026 to 2030**	**Phase 3 From 2030 onwards**
Improve equity in access, diagnosis and management	• Improve case finding of long-term health problems in core20plus population • Improve access, uptake and optimisation of behavioural interventions for Core20Plus population • Provide inclusive healthcare for people with low incomes • Improve health and digital literacy	• Develop UHT health inequalities dashboard • Develop UHT MECC & personalised care plan • Develop a UHT pre - habilitation offer (cancer & non-cancer) • Stocktake current poverty proofing models by CSUs • Stocktake UHT health and digital literacy offer • Complete UHT baseline analysis against the patient safety health inequalities framework • Stocktake UHT screening services for health inequalities plans • Test modules from the access and attendance model	• Pilot UHT prehab model with potential to embed as routine practice • Test population health management model to implement the personalised care plan and quality improvements • Start rolling out poverty proofing training and models for CSUs • Implement UHT offer for health literacy and digital inclusion • Start rolling out health inequalities models for all our screening programmes • Roll our shared decision making training across CSUs • Start rolling out access and attendance model across UHT	• Embed poverty proofing models as routine practice • Embed health inequalities quality improvement to all our screening pathways • Establish a UHT prehab model for cancer and non-cancer patients • Embed the UHT access and attendance model
Empower patients, communities and organisation for equity	• Embed patient, public and people with lived experience engagement model • Reduce inequalities in social determinants of health • Empower staff to address inequalities • Leverage quality improvement to address health care inequalities	• Confirm PPLE standards for UHT with patient experience and involvement leads • Establish routes of participation with place based partnerships for neighbourhood health development. • Implement trauma informed training for staff	• Develop health inequalities ambassadors model for clinicians CSUs • Agree health inequalities transformation/CIP quality improvement projects with priority CSUs • Stocktake UHT inclusion health offer and develop support pathways e.g high intensity users	• Embed inclusion health pathways into routine practice • Embed health inequalities and prevention offer in all transformation/CIP quality improvement projects with CSUs
Financing for equity	• Implement funding models to address heath care inequalities • Agree payment mechanism to improve prevention spending by UHT	• Develop baseline of all public health funding work streams per Trust	• Agree UHT budget arrangements for Population health and health inequalities delivery • Identify CSUs with highest care expenditure as priority	• Embed a health economic equity lens in all UHT business case decisions for transformation projects

Information on health inequalities has informed specific health inequalities programmes, service improvements and decision making across a wide range of areas (including, but not limited to, Public Health and Prevention Provider Services outlined below).

North Tees and Hartlepool FT Public health and prevention provider services	
• Tobacco dependency treatment service – staff, acute in-patient and maternity • Specialist stop smoking service – Hartlepool and Stockton • Alcohol care team, recovery navigator and community fibro scan • Alcohol detox bed • Substance use practitioners • Waiting well • Cancer prehab • Bowel screening • Breast screening • Cervical screening – colposcopy	• Diabetic eye screening • Oral health promotion team • Speech and language • Sexual health • Maternity vaccination • Maternity social prescribing link workers • Access and attendance – health inequalities support officer • BBV and Syphilis testing in Emergency Department • Lung health checks

Anchor institute and collaboration with partners

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

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

Workforce health

Action to improve staff wellbeing is important for reducing health inequalities since staff are part of our local communities and may be facing health inequalities themselves, a healthier workforce is able to provide better care for patients and there can be additional health benefits for staff member's families and friends. Following the findings from the staff health needs assessment, we have established staff weight loss programmes, improved staff engagement with health and wellbeing and identified new health and wellbeing champions. We are accredited for the Better Health at Work Award scheme and were awarded 'Ambassador' status once again in 2025.

The Tobacco Dependency Service has also been offering onsite smoking cessation support to staff. This has had a high success rate, benefiting both staff and patients.

Actions to support staff nutrition include identifying local support for weight management, developing 'Motivate UHT' an in-house staff weight management and healthy lifestyle programme and a digital weight management staff pathway, collaborating with NTH Solutions/catering team/oral health promotion team/national awareness weeks and developing trust 'Nutribites' to promote awareness of healthy eating and improved nutrition. We have also established the eco shop and are holding discussions with NTH Solutions and vending machines provider to improve our premises to make them less obesogenic. The physical activity offer has been aligned through our iMSK and occupational health services and includes signposting, raising awareness, removing barriers, team walking challenges throughout the year, exercise classes and the Couch to 5k App.

The work around "Flippin Pain in the Workforce" aims to support staff experiencing chronic pain. Working jointly with Teesside University and the occupational health teams at UHT, we have been awarded the developmental grant of £120k by NIHR for a research project to embed a public health approach to re-imagining chronic pain with the aim to reduce work absence and promote the health benefits of work. The project has commenced with staff recruited as part of engagement to inform the co-production process. We have also been recommended to make a submission for the full bid via the NHIR work and health call for £2m to support embedding the interventional research over a five-year timeframe.

Making Every Contact Count, shared decision making, personalised care and clinic attendance

Our data on barriers to healthcare and Core20 outpatient attendance rates suggests that many patients facing health inequalities could benefit from support through Making Every Contact Count (MECC), shared decision making (SDM), personalised care and other support with accessing outpatient care. Currently, MECC Training is being rolled out across all departments and we have completed SDM baseline assessment against NICE guidance in maternity and iMSK. Train the trainer sessions for SDM are being rolled out across departments and a draft decision tool has been developed to help facilitate patient – clinician conversations.

This year analysis of the original DNA Pilot (and subsequent project) within three departments showed significant improvement in DNA rates (average improvement factor 25%) with estimated cost savings of £55,118 per year. Following this successful DNA work, we have launched the multi-agency access and attendance collaborative to embed a multi-faceted equity model as a cost improvement project across all outpatients' departments. The model will be implemented at NTHFT first and rolled out across UHT. In partnership with Teesside University, we have recruited a PhD student who will be embedded within practice and develop a full evaluation of the model across UHT.

Maternity

We have used information on health inequalities to pilot an enhanced maternity offer using a pregnancy anticipatory care (PAC) model. The model includes embedding a social prescribing link worker offer and strengthening our personalised care provision for socioeconomic vulnerabilities during antenatal and postpartum. The types and frequency of social factors being experienced by the PAC patients (such as poverty, mental ill-health, Adverse Childhood Experiences, alcohol/substance use, experience of domestic abuse difficulty understanding/speaking English and homelessness) were analysed to inform the types of personalised care offer that will be provided going forward.

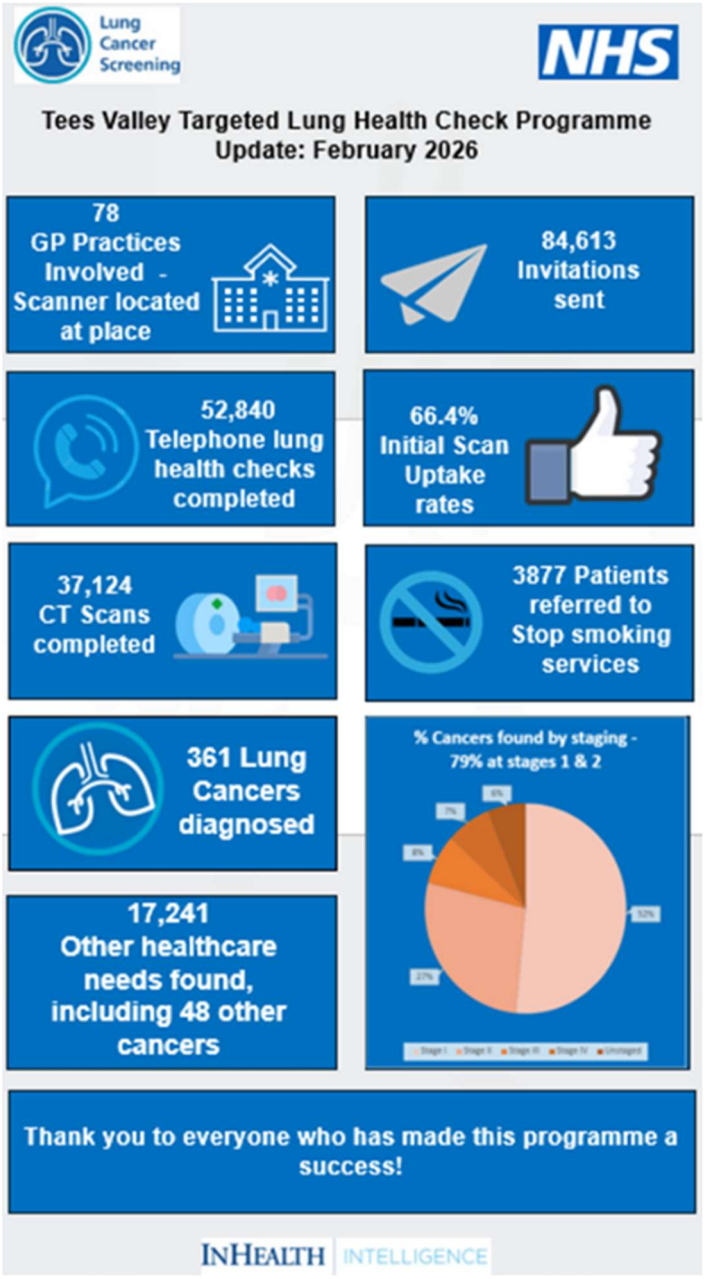
In addition, our Public Health Prevention in Maternity Best Start in Life programme seeks to: support physical activity during pregnancy, improve perinatal mental health support for those who do not meet specialist criteria during pregnancy, optimise the service vaccination model, address tobacco dependency throughout pregnancy and become fully accredited with UNICEF baby friendly initiative BFI standards. To support physical activity, aqua natal exercise classes are provided by the trust and embedded in East Durham and being spread to Stockton and Hartlepool. A midwifery referral pathway into citizens advisory bureau to address family poverty is being piloted. A vaccine nurse has been in post since January 2025 which will increase the offer of vaccines to all pregnant women in a mixed setting of community and hospital offer. This is in addition to the universal community midwives' vaccination offer. Smoking brief intervention training is part of maternity mandatory training and midwifery assistants in community offer smoking cessation classes to all women and families.

Lung Health screening

Lung Screening Programme continues to demonstrate strong outcomes in the early detection of lung cancer, as well as the identification of a significant number of incidental cancers and other conditions. To date, the programme has detected at least 361 lung cancers, with 79% identified at curative stages 1 and 2.

The service operates through mobile CT scanners located in accessible community settings, such as supermarket car parks, enabling patients to attend with a relative or carer if required and to park easily. The team makes reasonable adjustments wherever possible, and in exceptional circumstances can arrange taxi transport. In 2025, the scanner was deployed to Holme House Prison to ensure eligible individuals who would otherwise be unable to attend were offered screening.

A promotional video of the service, including British Sign Language (BSL), is being rolled out across GP practices. In addition, the team is planning a dedicated screening day for deaf patients, supported by enhanced communication resources. The Lung Screening Programme remains a key component of the national 10-year plan and represents a significant success in improving cancer survival through earlier diagnosis.



CVD prevention

In collaboration with Hartlepool and Stockton Councils, as part of our shift from 'treatment to prevention' we have completed small area analysis of non-elective admissions for stroke and myocardial infarction to help implement targeted intervention to improve uptake of the NHS health checks for early identification and support provided through primary care and community lifestyle interventions. The local authorities have commissioned community health screens for early identification of cardiovascular disease risk.

We have also received approval for trust charitable funds to purchase a health pod that will be hosted at the community diagnostic centre (CDC). This will support screening for high blood pressure, atrial fibrillation and obesity for staff, patients and carers. We are now exploring additional funding opportunities to cover the maintenance costs for the health pod.

We know around a third of adults in our catchment area are not as active as is recommended for good health. Physical activity tends to be even less for people who are disabled, from some ethnic minority groups or living in more deprived communities. We are an active hospital and are embedding the movement is medicine model into relevant support pathways. We are also in working in partnership with Sport England and local authority colleagues to provide opportunities to embed physical activity into long-term conditions pathways.

Specialist Community Stop Smoking Service

The trust is the provider for the Stockton specialist stop smoking service and Hartlepool specialist stop smoking service. Stockton Community Stop Smoking Service has been running for many years but one gap in reducing health inequalities had previously been the lack of a stop smoking services for Hartlepool. However, Hartlepool Specialist Stop Smoking Service was initiated in January 2025, and so far, 600 clients set a quit date with the service.

To increase accessibility for people who may face health inequalities, the Stop Smoking Service offer a range of support services and tailor the programme to client's needs. The service can offer face to face clinics, telephone clinics and home visits for housebound patients (or a mixture of these). The service regularly arranges translators for clients facing language barriers and hold pop up clinics at homeless shelters. Out of the 600 Hartlepool clients setting a quit date, 147 have experienced mental illness and 295 had a diagnosed long term health condition such as COPD, Diabetes, CVD, CHD or Asthma.

The service offers a 12-week programme of support and offer medications such as Nicotine replacement therapies, e-cigarettes or a combination of these. A full assessment will be completed with the client at their initial appointment. The service is open to anyone over the age of 18 years old who lives or works across Hartlepool.

On average 45% of the clients who join the programme go on to hit their 4-week quit. Then an average of 74% of those quit at 4 weeks will then go on to successfully complete the 12-week programme.

In addition to the 12-week programme, staff in the service offer training for professionals across the community on 'very brief advice' which is a session showing how to broach the subject of smoking with their own clients and how to refer on. A case study of a local couple who have

been through the service and successfully quit has also been developed and is being promoted through trust communications for National No Smoking Day.

We have developed pathways to facilitate opt-out referral process from cancer clinics. We will explore further roll out of this model to all outpatient clinics.

Inpatient Tobacco Dependency Treatment Service

Inpatient tobacco dependency services are discussed separately from stop smoking services as the focus is not just on stopping smoking but supporting people who are inpatients and may experience withdrawal symptoms that affect their other hospital care. Inpatients are a key population for tackling health inequalities and treating tobacco dependence, since smoking is more common among inpatients. Also, as noted on Fingertips Smoking Profile, tobacco is associated with poor health and many indicators of disadvantage (such as deprivation and routine/manual occupations). People from deprived communities are often more heavily addicted and face greater barriers to quitting, such coping with multiple risk factors and greater stress produced by poverty.

Treating inpatient tobacco dependency can reduce symptoms of nicotine withdrawal, aid temporary abstinence and may lead to an attempt to quit smoking with further benefits to health. Nicotine replacement also means people are more able to remain in the ward to receive their treatment plan, aiding faster recovery and discharge.

The impact on health and Return on Investment from quit attempts facilitated by the tobacco dependency team is significant, with an estimated 32 lives saved in the last year. The infographic below also notes reductions in readmissions, A&E attendances and increases in bed spaces.

The Return on Investment from quit attempts facilitated by the tobacco dependency team (Jan – Dec 2025):

Individual patient stories also demonstrate the impact the service has:

Since the inception of the Tobacco Dependency Treatment Service (July 2022) to Dec 2025:

- 8939 identified smokers were offered a personalised tobacco prevention plan from the team
- 3382 identified smokers accepted support to remain smoke free
- 1365 opted to continue quit smoking and were referred to community provision
- 442 of these achieved a 4-week quit smoking status

The service is also continually improving and innovating with regular audits and updates to the Health Inequalities Oversight Group. The latest audit findings note that within the trust:

- 100% of smokers were identified (compared to 24% nationally) and all received a visit from the specialist team within 24 hours
- 4 week quit smoking rates were 44% (compared to 21% nationally)

Since the previous audit, improvements were noted in documentation for people who opt-out of support and in advice provided in relapse to smoking cases post-discharge. The most recent audit also identified actions for strengthening provision of Nicotine Replacement Therapy (NRT) within discharge medications (regular comms reminders and training) and improvement in documentation of tobacco type and comorbidities considered in treatment plans (with a change request submitted to external digital contractor). Most recently, Tobacco Dependency Specialist Support has been piloted within A&E, and has shown numerous benefits as outlined in the infographic below.

Tobacco Dependency Team Support (TDTS) in A&E – January 2026 Pilot

Results

- **24** smokers identified
- **10** smokers accepted treatment

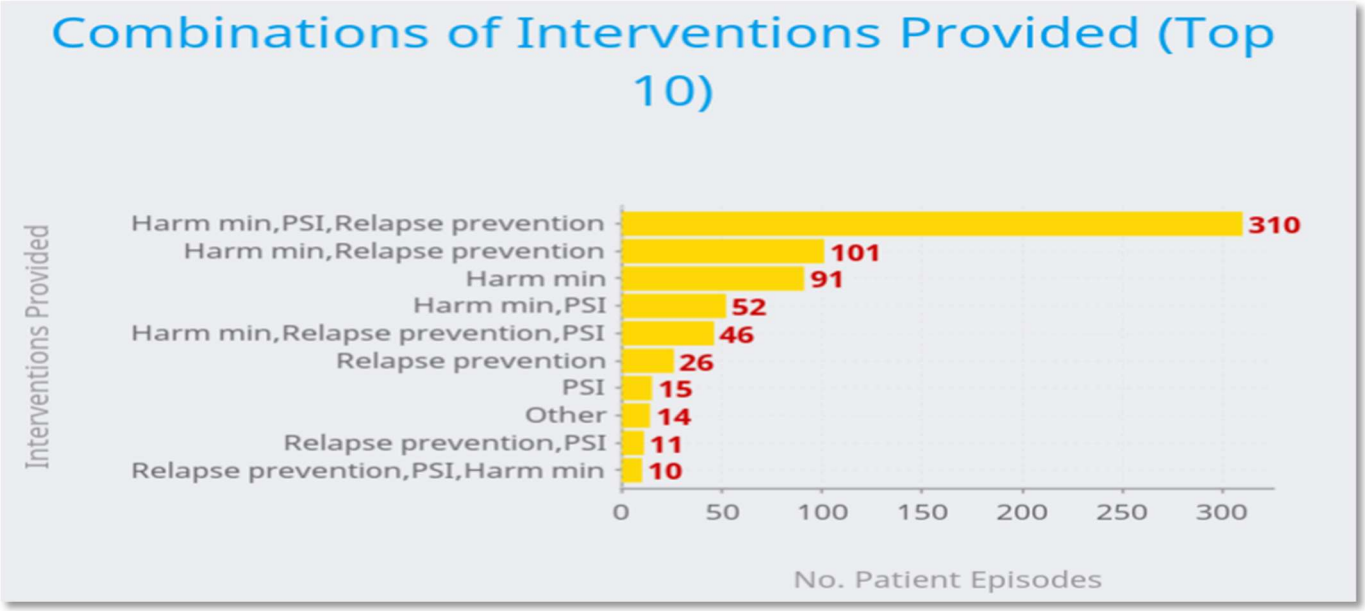
42% uptake – showing an increase in accepting support when compared to the uptake on inpatient wards.

Additional Benefits

- Patient satisfaction, very positive service-user feedback.
- A & E staff noted to be prescribing NRT prior to TDTS visits on more occasions.
- TDTS utilised the visits as a training opportunity to increase A & E staff awareness regarding VBA and offering NRT.
- An increase in patients receiving prompt supply of NRT within 2 hours of admission.

Alcohol and substance use

The Substance Use Service was initiated in October 2024 and since then the trust has implemented a pathway to initiate opiate substitution therapy and a naloxone kit distribution. We recently trained our A&E clinicians to support the naloxone kit distribution and have also agreed to support our community services team to also distribute naloxone kits. As shown below, Substance Use Service support generally includes harm minimisation with onward referrals to community services for further social and mental health support.



In March 2025, we piloted 24/7 presence of the Alcohol/Substance Use team within A&E that led to a three-fold increase in referrals with increased numbers of admissions prevented. The numbers in referrals have since reduced, as the capacity of the current service is not able to support that level of demand. We are therefore exploring options for additional funding to help maintain a 24/7 presence in A&E.

Accessibility of support is key for people already facing health inequalities. There are alcohol anonymous (AA) meetings every Tuesday and the SMART meetings every Friday. The fibro scan clinics (for early detection of liver disease) have been moved from North Tees Hospital to the community diagnostic centre (CDC) in Stockton town centre which seems to be more accessible for people to get to. Recent funding enabled purchase of a new fibro scan machine and employment of a band 5 alcohol care team nurse on a temporary contract.

Currently the team is liaising closely with midwifery, and the vulnerability midwives, to be a part of their monthly multidisciplinary team (MDT) meetings, provide further support to women and ensure they have the right support when discharged as well as supporting community nurses and midwives to distribute Naloxone. The team is also working with Hartlepool Recovery Connections on a pathway to have lived experience workers aligned to the team.

Early bowel and breast cancer early diagnosis

We used data to determine the top 5 cancers where there was opportunity to impact on early diagnosis. Subsequently, we implemented a health inequalities project in bowel screening that has led to transformational changes in our offer that supports uptake of bowel screening home FIT testing and attendance for specialist nurse screening and colonoscopy appointments. In addition, we have now launched a multi-agency breast health inequalities project to help improve uptake for screening and reduce DNAs for symptomatic clinics.

Waiting well

Identifying inequalities in procedure cancellation rates for our Core20 population led to the development of the Waiting Well service. The service aims to provide equitable support to access health and surgical services to improve surgical outcomes and improve general health and wellbeing and is currently funded until March 2027. The case study illustrates examples of support offered by the Waiting Well Programme.

This year detailed analysis was carried out to understand the impact of Waiting Well on cancellation rates and patient wellbeing. Rates of same day cancellation in the complex/targeted waiting well group were 6% compared to 13% in the non-waiting well core20 group. Cancellation rates were lower for people who participated in the Waiting Well Programme, regardless of whether they were aged under 65 or 65+.

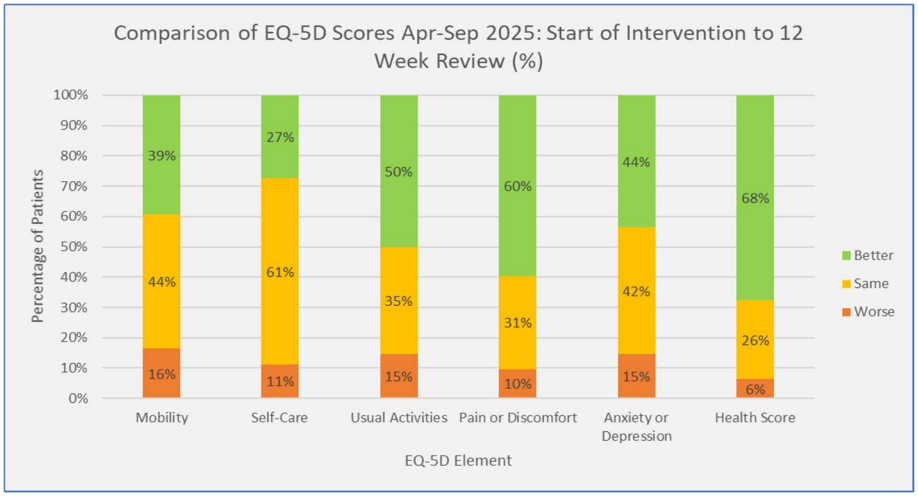
Finger Joint Replacement Metacarpal Phalangeal joint

Support identified- Weight management, Financial, Pain management, Bereavement & Self-care.

Support and outcome; Referred to Surgery Hero 12 wk. weight management programme, successfully losing weight. Nutritional advice. Leisure activities in local area. Web links he could utilise at home i.e. Moving medicine & NHS Better health to maintain weight loss and increased activity. Financial advice via CAB resulted in patient and partner receiving Personal independence payments/ carers allowance. Pain clinic referral – successful pain management.

Patient stated, ‘you must be so proud of your work colleague C, she has been absolutely fantastic in her job. From first hearing from C it was like I've known her for years, the support and advice she has given me has been brilliant. Thank you’

There was also an improvement in patient wellbeing. The wellbeing of Waiting Well Patients is measured at three time points (start of intervention, completion of intervention and 12 weeks post completion). Patients are asked to score themselves regarding mobility, ability to self-care, ability to undertake usual activities, pain/discomfort, anxiety/depression (the 5 elements from EQ-5D, a measure health-related quality of life in adults). Patients also gave a health score between 0-100). Analysis of outcomes from April to Sep 2025 showed for each element of the EQ-5D, average score improved from the start of intervention to completion of intervention. The average score for each EQ-5D element continued to improve, or was maintained (Anxiety/Depression), between completion of the intervention and 12-week review.



Feedback on the Waiting Well Programme has been positive. Texts were sent to patients in September via the new digital patient feedback platform of FormFinity. Subsequent feedback (October to December) suggests people generally feel listened to and better prepared for surgery. Free text comments suggest that pain is an ongoing issue for some people (note some patients have had procedures and some are still waiting).

In addition to the support above, Surgery Hero is a new digital offer of support with some remote contact with a coach and with group work. The last available report noted that throughput is increasing steadily with more than double the number of patients accepting the service in September than in previous months. The service is being extended to new areas, including the cancer rehabilitation team. Self-rated health scores increased after the using Surgery Hero and there have been good results in reducing weight and BMI. Patient feedback is excellent.

Current work of the Waiting Well team includes collaborating with Hartlepool Borough Council to secure funds for a pilot to subsidise patients access to wellbeing and activity facilities. The Waiting Well team are also exploring a pilot with another agency to enable referral of patients into a programme of weight loss and wellbeing and collaborating with the Cancer Prehabilitation team and Work Well programme. The Waiting Well Programme has recently been expanded from Core20 communities to our 40% most deprived communities so equity will continue to be monitored closely.

Emergency Medicine at the Deep end

We are implementing a project for A&E at the Deep End with the aim to apply the principles for the GP at the Deep End to emergency medicine. This model addresses workforce capability to respond to the additional pressures on emergency departments who serve populations with high deprivation levels.

As part of this project we have completed a poverty audit; implemented the 'socks for health' initiative; blood borne viruses (BBV) screening; piloted Flu vaccination in A&E as part of our winter planning plans; trained our clinicians to support expansion of Naloxone kit distribution; and are extending our A&E coverage for addictions support – alcohol, substance use and tobacco dependence as well as hosting food parcels and bags with essentials to be given out to patients who need them. We are also working in partnership with our Deep End GP practices to scope and implement an offer to reduce A&E high intensity users. The NENC Deep End network has approved a grant of £38k to help us with implementation of our project.

Inclusion health

The multi-agency inclusion health group focuses on reducing health inequalities in access and experience with an initial focus on migrant and refugees, sex workers, veterans, drug and alcohol users, people in contact with the criminal and justice system, people with severe mental illness, people with a disability and the homeless populations. A trauma informed practice module designed with the involvement of people with lived experience has been approved by the group and is now available for all staff on ESR. Also, infrastructure is now in place for us to continuously run campaigns to promote trauma informed practice within the organisation. We are currently exploring feasibility to align the peer navigator pathway provided by recovery connections to the A&E at the Deep End model.

Armed forces

The hospitals which make up University Hospitals Tees have separately held veteran aware accreditation for many years. With the introduction of the group structure, we have been able to work at an increased scale with partners from Help for Heroes (H4H) and the Armed Forces National Training and Education Programme (NTEP) to take even more meaningful steps forward in demonstrating our commitment to our Armed Forces Community (AFC) service users. The AFC can face many healthcare inequalities, and it is important to us to reduce these where possible.

People from the Armed Forces Community often find it difficult to navigate the NHS health system. Our aim is to help them overcome any barriers they may face. Over the last year, our Help for Heroes' nurse has been highly visible on the 'shop floor' actively identifying members of the AFC. Once identified, an assessment of need is carried out, and we then actively support them by referring them to other health and social care avenues to ensure personalised care. We also offer our help to give them advocacy at appointments.

A snapshot audit carried out over Remembrance last year showed us that for every known member of the AFC, who was an inpatient ('flagged' on their healthcare records), there is likely to be another six AFC inpatients in the trust at that same time. This shows the importance in training our staff in identifying patients who are a part of the AFC. We are working closely with the NTEP to train our staff on identifying members of the AFC and importantly what it clinically means. Since the launch of NTEP in November 2025, 161 of our staff have formally undertaken

module 1 awareness training. Our executive team were the first executive team in the country to conduct the ‘executive level’ and 85 patient facing staff members have conducted module 3, which is aimed at training frontline staff in how they can support members of the AFC. This increased training means that more staff are aware of the importance of flagging members of the AFC appropriately on our healthcare systems and importantly referring them to our H4H for personalised care. We now have several examples of how we have truly made a difference to a patient’s experience.

Regarding our commitment to holding gold standard ‘employment recognition scheme’ status, we are working closely with our nearby military communities offering them insight days into the NHS and attending career fayres. Recent feedback from an event held earlier this year said, “The Application and Interview tips were great to hear from an employer and know that I need to align my values with NHS if applying for a role” and “Great to see there is a Veterans Aware networks within the trust”. We hold several events promoting our commitment to the AFC. These include regular coffee mornings aimed at connecting to staff and patients who are a part of the AFC and recognition events over Armed Forces Week and Remembrance.

Over the next year we are extending our focus now into how we can make the healthcare journey for our AFC members more seamless. Specifically working on how a member of the AFC is flagged to secondary care at the point of referral. We will be working with both GP and ICB partners to progress this worthwhile piece of work. In terms of our AFC employees, we will be reviewing our policies to ensure we are committed to supporting the wider AFC at times when their spouse or partners deploy on operations.

Inpatient safety inequalities

The NHSE Patient Safety and Healthcare Inequalities Reduction (PSHIR) framework sets out five principles to reduce patient safety healthcare inequalities across the NHS, and outlines opportunities for implementation that NHS local trust teams could take up which all aligns with the NHSE Patient safety strategy.

Following publication of this framework, we conducted a gap analysis of our current Patient Safety and Healthcare Inequalities Reduction practice at North Tees and Hartlepool NHS Foundation Trust. We established gaps that need to be addressed in North Tees and Hartlepool NHS Foundation Trust to foster a culture of inclusive and safe care. Our next steps include the development of an improvement plan to address the gaps identified.

Quality Improvement

There are various QI projects completed in 2025 and ongoing for 2026 e.g. reducing admin in Cow’s milk protein pathway, updating our video for gestational diabetes patients for faster access via Badgernet, training as DAFNE educators to allow us to offer online T1 diabetes education, creating electronic coeliac packs, updating referral forms to improve triage, working with waiting well team to support weight management.

5. Publishing information on health inequalities

Board reporting

Key line of enquiry 5.1:
How is health inequalities data incorporated into performance reporting at board level, and what has been the impact of this on reducing inequalities?

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

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

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

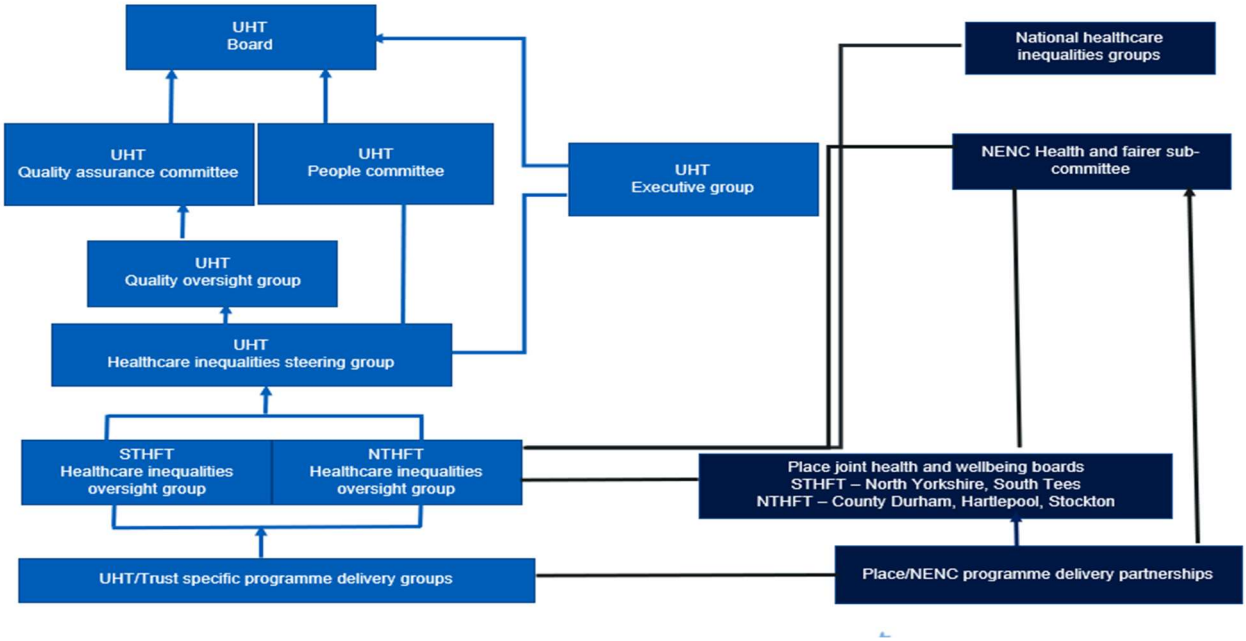
Action plan development and monitoring

Key line of enquiry 5.2:
How have action plans to reduce inequalities in access and quality of care been developed and monitored across services and pathways?

At trust level, a bi-annual implementation report to the North East and North Cumbria (NENC) Integrated Care Board (ICB) commissioners is provided in fulfilment of the provider contractual obligations for the health inequalities activity plan. The trust also produces a population health and health inequalities annual report.

Following the formation of University Hospitals Tees, where North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust came together to operate under a group model with shared governance and leadership arrangements, some action plans are being developed and monitored at University Hospitals Tees Group level. To monitor implementation our University Hospitals Tees (UHT) strategy for ‘improving population health and reducing healthcare inequalities’ we will produce a bi-annual assurance report to the quality assurance committee on progress of implementation of the strategy.

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



The infographic shows relevant governance arrangements for monitoring delivery of health inequalities action plans and programmes.

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

Below is the minimum dataset that will be reported through our organisation's internal oversight arrangements. All indicators will be analysed to ascertain disparities for health inequalities indices – age, sex, ethnicity, deprivation – as appropriate. The data will be analysed to provide group level overview and per provider trust. In-depth analysis will also be undertaken to ascertain disparities for inclusion health groups.

Domain	Indicator
Elective recovery	• Trend in elective activity vs pre-pandemic baseline levels for under 18s and over 18s – deprivation gap • % of patients treated within 18, 52 and 65 weeks
Urgent and emergency care	• Trend in emergency admissions for under 18s – deprivation gap
Cardiovascular disease	• Trend in stroke rate of non-elective admissions (per 100,000 age-sex standardised) – deprivation gap • Trend in myocardial infarction rate of non-elective admissions (per 100,000 age-sex standardised) – deprivation gap
Cancer	• Trend in % of cancers diagnosed at stage 1 or 2, case mix adjusted for cancer site, age at diagnosis, deprivation, ethnicity and sex
Oral Health	• Trend in tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under

Smoking	• % of eligible adult and maternity inpatients that are referred to the tobacco dependency treatment service • % of eligible adult acute inpatients offered support to quit smoking • % of eligible pregnant women who are offered support to quit smoking • Trend in % of maternity patients who smoke at time of delivery – deprivation gap
Maternity and neonatal	• Trend in preterm births under 37 weeks – deprivation and ethnicity gap
Prevention of ill health	• Trend in % of people waiting for over 6 weeks for a diagnostic procedure • % of patient facing staff to receive a flu vaccination • Trend in % of obese patients that are either supported in-house, referred or signposted for community or digital support
Reducing inequality	• Trend in % of over 65s attending emergency departments to be admitted • Trend in % of under 18s attending emergency department to be admitted • Trend in DNAs in outpatient and community services for all patients vs core20 population • % of alcohol addicted patients identified – maternity, inpatients, A&E and urgent care – that are supported and referred to community specialist services)

6. Our main challenges and constraints

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

7. Looking ahead – Our priorities for 2026-27

In 2026-27, our priorities are:

- Offer a board development session on health inequalities;

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

Capital Programme Summary 2025/26

The 2025/26 capital programme had significant focus on backlog maintenance repairs across the estate, particularly on the North Tees site. This included repairs to the aging heating and hot water systems, flooring and roofing repairs, fire precaution enhancement work, two ward refurbishment and the replacement of several end-of-life ventilation systems.

£2.85m National funding was secured to continue the RAAC (Reinforced Autoclaved Aerated Concrete) removal within the residential blocks on the University Hospital of North Tees site. RAAC removal is planned to be fully eradicated from the North Tees site by the end of FY26/27.

Large scale service developments included the completion of the reconfiguration of the Emergency Assessment Unit (£2.7m) to improve the layout of the department, reduce waiting times and improve the patient experience.

The final phase of the robotic theatre project (£2.3m) was also completed creating purpose-built estate with all the facilities required to fully enable the use of robotic surgery.

The Tees Valley Community Diagnostic Centre on Stockton High Street was also enhanced with the installation of a third MRI scanner and the addition of a DXA scanner to increase the range of services available on Stockton High Street (£4M).

The final element of a large decarbonisation project was also completed at the University Hospital of Hartlepool. The project included de-steaming the site, the installation of 1500 solar panels and a 2.5MW ground source heat pump to provide net zero carbon heating and hot water to the site for two thirds of the year, with the existing gas fired boilers only now needed during peak Winter conditions.

Quality

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

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

Quality Objectives

In 2025 the organisation agreed nine quality priorities

These were:

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

Progress against these priorities is monitored through the Quality Assurance Committee.

Further detail on how these have progressed over the year is outlined in our Quality Report.

Subsidiary undertakings

NTH Solutions LLP was formed in 2018 and commenced providing estates, facilities, supplies and procurement services to the trust. The LLP was owned by two members (95% owned by North Tees and Hartlepool NHS Foundation Trust and 5% owned by Northumbria Healthcare Management Limited, a subsidiary of Northumbria Healthcare NHS Foundation Trust. On 31 March 2026, Northumbria Healthcare NHS Foundation Trust transferred its membership interests in the LLP to South Tees Hospitals NHS Foundation Trust. The LLP has a formal structure and corporate documents that govern how the LLP operates and are held to account for delivery of services. The trust appoints a Chair of the LLP Management Board and also appoints two trust representatives on the board. The LLP produces an annual business plan, aligned to Trust strategic objectives, which is approved by the Management Board and performance is reviewed regularly throughout the year.

Optimus Health Limited is a wholly owned subsidiary company of the trust. It started trading in 2014 and continues to operate and deliver the outpatient and retail pharmacy service at University Hospital of North Tees. During the year, the performance driven service to the trust has strengthened and continue to widen its available services to better match the needs of patient demographics.

Through 2025-26, Panacea Pharmacy has been able to broaden its services within the trust group. It now provides services for a wide range of departments across the trust, enabling optimisation of medicine costs and supporting the flow of patients through the hospital group.

In 2022 the Trust also formed the Tees Valley Pathology Services LLP and the Tees Valley Laboratory Services LLP with South Tees Hospitals NHS Foundation Trust. The 2 LLP's all have a financial year end of 31 March in line with the Trusts, they were all dormant in 2025/26 and will not be consolidated as part of the Trust Group for the financial year to 31 March 2026.

The Tees Valley Pathology Services LLP and the Tees Valley Laboratory Services LLP are jointly controlled by the Trust and South Tees Hospitals NHS Foundation Trust.

2. Accountability report

Director's report

The Board of Directors – role and responsibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Board of Directors composition

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

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

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

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

Board of Directors meetings

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

Board of Directors' profiles

Professor Derek Bell OBE

Chair

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

- Appointed 1 September 2021
- Reappointed 1 September 2024

Ann Baxter

Vice Chair / Non-Executive Director

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

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

She is the Board Maternity Champion

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

Ali Wilson

Vice Chair / Non-Executive Director

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

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

She is the board Health and Wellbeing Champion

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

Ada Burns

Non-Executive Director / Senior Independent Director

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

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

Chris Macklin

Non-Executive Director / Senior Independent Director

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

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

David Redpath

Non-executive Director

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

He was chair of the Resources Committee until 31 January 2026

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

Miriam Davidson

Non-executive Director

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

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

She is the Board Maternity Champion.

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

Mark Dias

Non-executive Director

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

He is chair of People Committee

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

Fay Scullion

Non-Executive Director

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

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

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

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

Ken Readshaw

Non-Executive Director / Senior Independent Director

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

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

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

Alison Fellows

Non-Executive Director

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

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

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

Liz Barnes

Non-Executive Director

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

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

Professor Chris Day

Non-executive Director

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

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

He is chair of the Academic Committee.

- Appointed 1 July 2025

Celia Weldon

Non-executive Director

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

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

She is chair of Resources Committee.

- Appointed 1 February 2026

Stacey Hunter

Chief Executive Officer

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

- Appointed on 1 February 2024

Michael Stewart

Chief Medical Officer

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

- Appointed Group Chief Medical Officer 11 March 2024

Emma Nunez

Chief Nursing Officer

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

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

- Appointed Group Chief Nurse 1 April 2025

Neil Atkinson

Chief Delivery Officer

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

- Appointed Group Managing Director 5 April 2024

Rachael Metcalf

Chief People Officer

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

- Appointed Group Chief People Officer 5 April 2024

Chris Hand

Chief Finance Officer

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

- Appointed Group Chief Finance Officer 5 April 2024

Matt Neligan

Deputy Chief Executive / Chief Strategy Officer

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

- Appointed 14 October 2024

Attendance at Board meetings 2024/25

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

Declaration of Interests of the Board of Directors

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

Better Payment Practice Code

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

Non NHS	NHS
Target: 95%	Target: 95%
Result by number: 98.1%	Result by number: 99.5%
Result by value: 97.8%	Result by value: 100.0%

A detailed breakdown of the figures is shown below:

	2025/26		2024/25	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	70,057	174,075	71,378	186,519
Total non-NHS trade invoices paid within target	68,713	170,251	69,698	183,210
% of non-NHS trade invoices paid within target	98.1%	97.8%	97.6%	98.2%
Total NHS trade invoices paid in the year	734	32,511	703	28,733
Total NHS trade invoices paid within target	730	32,510	659	28,648
% of NHS trade invoices paid within target	99.5%	100.0%	93.7%	99.7%

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Income disclosures

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

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

Statutory statement required within the Directors' Report

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

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

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

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

Foundation trust membership

The trust's membership was established following our authorisation as a foundation trust on 1 December 2007. Since that time, we have continued to engage with our members and the wider public to ensure that the views of local people and those across the wider populations that we serve are represented and help us to shape our services for the future.

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

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

- Stockton
- Hartlepool
- Easington
- Sedgefield
- Out of Trust Area / Rest of England (this is any other area outside of the core constituent areas within England)

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

As at 31 March 2026, the Trust had 7,860 members, comprising 2,084 public members and 5,776 staff members. During the Autumn round of elections, we undertook a data cleansing exercise to invite members to confirm how they wished to be communicated with going forward to reduce postal costs where possible and ensure the membership remained engaged and active.

The tables below provide details of the NTHFT's membership

Constituency	Number of members	Members as at 31 March 2026
Stockton	637	2,146
Hartlepool	418	1,396
Easington	692	712
Sedgefield	67	394
Rest of England/Out of Area	270	275
Total:	**2,084**	**4,923**

Further information about the trust membership can be found on our website: About our membership - North Tees and Hartlepool NHS Foundation Trust or by emailing: Nth-tr.membership@nhs.net.

Council of Governors

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

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

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

The Council of Governors comprises 39 governors who represent the trusts' public and staff constituencies and those stakeholder organisations who nominate individuals to become appointed governors. The table below provides details of the trust's Council of Governors.

11 Public Governors from Stockton	**6** Public Governors from Hartlepool
2 Public Governor from Sedgefield	**2** Public Governors from Easington
1 Non-Core Public Governor from other areas	**11** Appointed Governors
6 Staff Governors	

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

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

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

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

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

Governor	Constituency	Term of office	Number of terms	Term due to end/ended	Council of Governor meeting Attendance
Public elected governors					
Anne Johnston	Stockton	3	2	30 Nov 2026	2/4 50%
Elliott Kennedy	Stockton	3	1	30 Nov 2026	2/4 50%
Patrick Kimmitt	Stockton	3	1	30 Nov 2026	3/4 75%
Allan Fletcher	Stockton	3	1	Stood down 14 October 2025	0/2 0%
Melanie Fordham	Stockton	3	1	30 Nov 2026	3/4 75%
Lynda White	Stockton	3	2	30 Nov 2027	4/4 100%
Clive Collier	Stockton	3	1	30 Nov 2027	3/4 75%
Anthony Taylor	Stockton	3	1	30 Nov 2027	3/4 75%
Andrew Tingle	Stockton	3	1	30 Nov 2027	3/4 75%

Barbara Murphy	Stockton	3	1	30 Nov 2028	0/1 0%
Bill Green	Stockton	3	1	30 Nov 2028	1/1 100%
Colin Overton	Stockton	3	1	30 Nov 2028	0/1 0%
Mike Scanlon	Hartlepool	3	2	30 Nov 2028	2/4 50%
Misra Bano-Mahroo	Hartlepool	3	1	30 Nov 2026	3/4 75%
Allan Kellehear	Hartlepool	3	1	30 Nov 2026	2/4 50%
Anne Holt	Hartlepool	3	1	30 Nov 2026	2/4 50%
Pam Shurmer	Hartlepool	3	1	Stood down 16 September 2025	1/2 50%
Terrence Hegarty	Hartlepool	3	1	30 Nov 2027	3/4 75%
Jessica Ingham	Hartlepool	3	1	30 Nov 2028	1/1 100%
Allison Usher	Sedgefield	3	2	30 Nov 2028	4/4 100%
Paul Frame	Sedgefield	3	1	Resigned 3 July 2025	0/1 0%
June Black	Easington	3	1	Resigned 19 September 2025	0/2 0%
Sarah Moule	Easington	3	1	30 Nov 2026	3/4 75%
Angela Warnes	Rest of England	3	2	Stood down 22 January 2026	3/3 100%
Staff elected governors					
Steven Yull		3	2	30 Nov 2025 was not re-elected	2/2 100%
Natalie Wintersgill		3	1	30 Nov 2026	4/4 100%
Jennifer Jones		3	1	30 Nov 2026	4/4 100%
Ashwini Gaur		3	1	30 Nov 2027	3/4 75%
David Russon		3	3	30 Nov 2027	4/4 100%
Deepak Dwarakanath		3	1	30 Nov 2028	1/1 100%
Emma Francis		3	1	30 Nov 2028	1/1 100%

Appointed/Partnership Governors

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

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

Council of Governor meetings

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

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

Council of Governor committees

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

Governor development and engagement

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

meeting. The sessions during 2025/26 have all been held jointly with South Tees Council of Governors.

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

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

Telephone: 01642 624506

Email: nth-tr.membership@nhs.net

Write to your Governor at:

Membership Office

4th floor, North Wing

University Hospital of North Tees

Hardwick

Stockton on Tees

TS19 8PE

The Board of Directors' relationship with the Council of Governors

The Board of Directors and Council of Governors continue to work together in order to fulfil their respective duties. To ensure governors are kept informed of key matters of business and topical issues in a timely manner, the lead governors and vice chairs of both trusts have worked closely with the Chair and Company Secretary regarding the planning of the Council of Governors meeting agendas and topics for development sessions. The role of the Non-executive Directors in providing assurance to the Council of Governors regarding the work of the board and wider organisation is now well established. They attend all meetings and share the work of the committees including highlighting the challenge and oversight on key areas of performance through the committees' chairs logs. In addition, the Chief Executive supported by other members of the executive team, attend the meetings as required, to provide valuable updates about the work of the trust and UHT to ensure governors are fully appraised regarding delivery of the strategy and organisational development.

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

Declaration of Interests of the Council of Governors

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

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

Nominations Committee

The Nominations Committee is a statutory committee responsible for the recruitment, remuneration, terms and conditions, appointment/re-appointment or removal of the Chair and Non-executive Directors. In addition, the committee has oversight of the annual appraisal process for the Chair and Non-executive Directors and supports succession-planning proposals for the board. The Committee has a membership representative of public and staff elected governors and appointed governors, it is chaired by the Chair, except when matters relating to their appointment or remuneration are being discussed. The Senior Independent Director and vice chairs are invited to the committee as required to provide support and advice along with the Company Secretary.

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

- Chair and Non-executive Director appraisal process and outcome
- Board Succession Plan updates
- Non-executive Director recruitment
- Non-executive Director appointments and re-appointments
- Reviewed remuneration and terms of service for Non-executive Directors
- Received assurance on compliance with Fit and Proper Persons;

Attendance information for the Nominations Committee meetings is below.

Members		Total number attended	% attendance
Professor Derek Bell	Chair	2/4	50%
Ada Burns	Non-Executive Director / Senior Independent Director	2/2*	N/A
Ann Baxter	Non-Executive Director/Vice Chair	2/4*	N/A

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

* attendance is by invitation and not mandatory

NHS England's Well Led Framework

The trust was inspected by the Care Quality Commission during 2022, which included a Well Led inspection. The report concluded that the ratings had changed from 'good' to 'requires improvement' with 13 trust wide 'must do' actions identified. During 2025/26, the trust undertook a Provider Capability Assessment, where the trust achieved amber / green rating demonstrating developing and established scores across the well led domains, highlighting areas of strength and opportunities for further improvement. Actions arising are being taken forward through a clear improvement plan with Board oversight. Building on this work, the trust is preparing for a developmental well led inspection planned for autumn 2026.

Annual Remuneration Report

Annual Statement on Remuneration

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

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

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

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

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

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

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

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

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

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

The Remuneration Committee considers the key business objectives as set out in the trust Strategy allocated to each director through the appraisal process. Performance is closely monitored and discussed through both an annual and on-going appraisal process. The Chief

Executive takes a lead on the evaluation of directors, and the Chair takes the lead on the Chief Executive's performance.

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

Major decisions on remuneration in 2025/26:

- No North Tees and Hartlepool NHS Trust specific decisions were made.

Major Decisions on Remuneration in 2025/26 made in common with South Tees Hospitals NHS Trust:

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

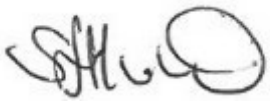
The Committee met on three occasions during the period of 1 April 2025 to 31 March 2026 in common with the Remuneration Committee of South Tees.

		Total number attended	% attendance
Professor Derek Bell	Chair	2/3	66
Ali Wilson	Non-Executive Director /Vice Chair	3/3	100
Ann Baxter	Non-Executive Director /Vice Chair	3/3	100
Ada Burns	Non-Executive Director / Senior Independent Director	2/2	100
Professor Chris Day	Non-Executive Director	0/2	0
David Redpath	Non-Executive Director	2/3	66
Miriam Davidson	Non-Executive Director	3/3	100
Mark Dias	Non-Executive Director	2/3	66
Fay Scullion	Non-Executive Director	2/3	66
Ken Readshaw	Non-Executive Director / Senior Independent Director	2/3	66

Alison Fellows	Non-Executive Director	2/3	66
Elizabeth Barnes	Non-Executive Director	1/1	100
Celia Weldon	Non-Executive Director	1/1	100

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

Signed:



Stacey Hunter

Chief Executive and Accounting Officer

Signed:

Professor Derek Bell OBE

Chair

Senior manager remuneration and benefits

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

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

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

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

Details of directors' remuneration and pension entitlements for the year ending 31 March 2025 are published in this Remuneration Report and the Annual Accounts section.

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

Pension arrangements for the chief executive and executive directors are in accordance with reference to NHS Pension Scheme, the accounting policies for pensions and relevant benefits are set out in the following tables:

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

Service contract obligations

Director and executive director service contracts do not include obligations on the Foundation Trust which could give rise to or impact on remuneration payments or payments for loss of

office. Trust does not make payments for loss of office outside the standard contract terms included in the employment contracts of senior managers.

Policy on payment for loss of office

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

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

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

Element	Link to strategy	Operation	Maximum	Changes
Base salary	To set a level of reward for performing the core role. To provide a competitive salary relative to comparable healthcare organisations in terms of size and complexity.	The aim is to offer benchmarked salary which the committee consider appropriate for experience and performance	There is no prescribed maximum annual increase. When reviewing salaries, the committee take account of personal and organisational performance and any national award offered to the wider employee population	No
Taxable benefits	The current remuneration policy of the trust does not make provision for taxable benefits or performance related bonuses unless specifically agreed by the Remuneration Committee on a case-by-case basis.			
Annual performance related bonuses				
Pension related benefits	To provide pensions in line with NHS Policy	Directors are automatically enrolled in the NHS pension scheme on the same basis as all other colleagues with the NHS	Pension arrangements for the Chief Executive and Executive Directors and Directors are in accordance with the NHS pension scheme. The accounting policies for pensions and other relevant benefits are set out in the note 1.6 to the accounts	No

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

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

Name and Title	Salary & fees (£000)	Taxable benefits (£)	Performance-related bonuses (£000)	Long-term performance bonuses (£000)	Pension-related benefits (£000)	Total (£000)
Ms Stacey Hunter Chief Executive	135-140	0	0	0	0	47.5-50
Mr Neil Atkinson Chief Delivery Officer	100-105	2,200	0	0	0	17.5-20
Mr Chris Hand Chief Finance Officer	95-100	1,000	0	0	0	32.5-35
Dr Mike Stewart Chief Medical Officer	125-130	0	0	0	0	0
Ms Emma Nunez Chief Nurse Officer from 01.04.25	90-95	500	0	0	0	90-92.5
Mrs Rachael Metcalf Chief People Officer	80-85	700	0	0	0	25-27.5
Mr Matthew Neligan Chief Strategy Officer	95-100	0	0	0	0	122.5-125
Prof Derek Bell Chair	40-45	600	0	0	0	0
Ms Ann Baxter Vice Chair	10-15	0	0	0	0	0
Mr Christopher Macklin Non-executive Director left 30.04.25	0-5	0	0	0	0	0
Mrs Alison Fellows (Care) Non-executive Director	5-10	0	0	0	0	0
Prof Elizabeth Barnes Non-executive Director left 30.06.25	0-5	0	0	0	0	0
Mrs Fay Scullion Non-executive Director	5-10	0	0	0	0	0
Ms Ali Wilson Vice Chair	10-15	0	0	0	0	0
Ms Ada Burns Non-executive Director left 30.09.25	0-5	0	0	0	0	0
Ms Miriam Davidson Non-executive Director	5-10	0	0	0	0	0
Mr David Redpath Non-executive Director	5-10	0	0	0	0	0
Mr Ken Readshaw Non-executive Director	5-10	0	0	0	0	0
Mr Mark Dias Non-executive Director	5-10	0	0	0	0	0
Professor Chris Day Non-executive Director from 01.07.25	5-10	0	0	0	0	0
Ms Celia Weldon Non-executive Director from 01.02.26	0-5	0	0	0	0	0
Mr Ian Simpson Subsidiaries Chair for North Tees and Hartlepool Solutions LLP and Optimus Health Ltd.	15-20	0	0	0	0	0

Notes:

1. Ms Stacey Hunter, Chief Executive of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Ms Hunter's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
2. Mr Neil Atkinson, Chief Delivery Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mr Atkinson's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
3. Mr Chris Hand, Chief Finance Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Mr Hand's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
4. Dr Mike Stewart, Chief Medical Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Dr Stewart's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
5. Ms Emma Nunez, Chief Nurse Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 01.04.25. South Tees Hospitals NHS Foundation Trust pay Ms Nunez' salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
6. Mrs Rachael Metcalf, Chief People Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Mrs Metcalf's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
7. Mr Matt Neligan, Chief Strategy Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mr Nelligan's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
8. Prof Derek Bell, Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Prof Bell's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. OBJ
9. Ms Ann Baxter, Vice Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Ms Baxter's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust. OBJ
10. Ms Ali Wilson, Vice Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Ms Wilson's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
11. Mr Christopher Macklin, Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust to 30.04.25. North

Tees and Hartlepool NHS Foundation Trust pay Mr Macklin's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.

12. Mrs Alison Fellows (Care), Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mrs Fellows' salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
13. Prof Elizabeth Barnes, Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust to 30.06.25. North Tees and Hartlepool NHS Foundation Trust pay Prof Barnes' salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
14. Mrs Fay Scullion, Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mrs Scullion's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
15. Ms Ada Burns, Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust to 30.09.25. South Tees Hospitals NHS Foundation Trust pay Ms Burns' salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
16. Ms Miriam Davidson, Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Ms Davidson's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
17. Mr David Redpath, Non-executive Director and Subsidiaries Chair for North Tees and Hartlepool Solutions LLP and Optimus Health Ltd from 01.10.25. of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Mr Redpath's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
18. Mr Ken Readshaw, Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Mr Readshaw's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
19. Mr Mark Dias, Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Mr Dias' salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
20. Professor Chris Day, Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 01.07.25. North Tees and Hartlepool NHS Foundation Trust pay Mr Day's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
21. Ms Celia Weldon, Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 01.02.26. North Tees and Hartlepool NHS Foundation Trust pay Ms Weldon's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.

22. Mr Ian Simpson, Subsidiaries Chair for North Tees and Hartlepool Solutions LLP and Optimus Health Ltd to 30.09.25. Non-executive Director for North Tees and Hartlepool Solutions LLP and Optimus Health Ltd from 01.10.25.

23. 2024/25 remuneration report included non-voting Directors. They are not included in the 2025/26 report.

Directors' costs table 2024/25

Name and Title	Salary & fees (£000)	Taxable benefits (£)	Performance-related bonuses (£000)	Long-term performance bonuses (£000)	Pension-related benefits (£000)	Total (£000)
Dr Susannah Cook Group Chief People Officer moved to Group role 05.04.24 and left 31.08.24. Include as voting member from 01.04.24 - 04.04.24.	25-30	0	0	0	0	0-2.5
Mr Steve Taylor Group Director of Estates from 01.07.24	45-50	300	0	0	0	87.5-90
Mr Ken Anderson Group Chief Information Technology Officer from 01.05.24 but was site CITO from 01.04.24 - 30.04.24.	70-75	0	0-5	0	0	15-17.5
Mr Stuart Irvine Group Director of Risk, Assurance and Compliance	60-65	1,300	0	0	0	47.5-50
Mrs Jackie White Group Head of Governance/Company Secretary	60-65	0	0	0	0	7.5-10
Mrs Ruth Dalton Group Director of Communications	55-60	3,100	0	0	0	12.5-15
Mr Matthew Neligan Group Chief Strategy Officer from 14.10.24	40-45	0	0	0	0	25-27.5
Dr Anandapuram Dwarakanath Site Medical Director from 01.07.24	205-210	800	0	0	0	35-37.5
Dr Elaine Gouk Interim Site Medical Director to 30.06.24	45-50	0	0	0	0	2.5-5
Mrs Rowena Dean Site Chief Operating Officer	130-135	0	0	0	0	77.5-80
Ms Beth Swanson Site Director of Nursing from 30.09.24	60-65	0	0	0	0	92.5-95
Mrs Linda Hunter Director of Planning and Performance left 26.05.24	150-155	0	25-30	0	0	0
Mr Michael Houghton Director of Transformation to 21.07.24 and Interim Managing Director, NTH Solutions LLP from 22.07.24	130-135	800	0	0	0	222.5-225
Mr Michael Worden Managing Director NTH Solutions left 4th March 2025	135-140	3,000	5-10	0	0	0
Prof Derek Bell Group Chair	40-45	400	0	0	0	0
Ms Ann Baxter Group Vice Chair	10-15	0	0	0	0	0
Mr Christopher Macklin Group Non-executive Director	5-10	0	0	0	0	0
Mrs Alison Fellows (Care) Group Non-executive Director	5-10	0	0	0	0	0
Prof Elizabeth Barnes Group Non-executive Director	5-10	0	0	0	0	0
Mrs Fay Scullion Group Non-executive Director	5-10	0	0	0	0	0

Name and Title	Salary & fees (£000)	Taxable benefits (£)	Performance-related bonuses (£000)	Long-term performance bonuses (£000)	Pension-related benefits (£000)	Total (£000)
Ms Ali Wilson Group Vice Chair from 05.04.24	10-15	0	0	0	0	0
Ms Ada Burns Group Non-executive Director from 05.04.24	5-10	0	0	0	0	0
Ms Miriam Davidson Group Non-executive Director from 05.04.24	5-10	0	0	0	0	0
Mr David Redpath Group Non-executive Director from 05.04.24	5-10	0	0	0	0	0
Mr Ken Readshaw Group Non-executive Director from 05.04.24	5-10	0	0	0	0	0
Mr Mark Dias Group Non-executive Director from 05.04.24	5-10	0	0	0	0	0
Mrs Alyson Gerner Group Associate Non-executive Director Non-voting member	0-5	0	0	0	0	0
Prof Rudy Bilous Group Associate Non-executive Director Non-voting member	0-5	0	0	0	0	0
Mr Ian Simpson Subsidiaries Chair for North Tees and Hartlepool Solutions LLP and Optimus Health Ltd.	15-20	0	0	0	0	0

Notes

1. Ms Stacey Hunter, Group Chief Executive of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Ms Hunter's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
2. Mr Neil Atkinson, Group Managing Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. From 01.04.24 to 04.04.24 was Managing Director for North Tees and Hartlepool NHS Foundation Trust only. North Tees and Hartlepool NHS Foundation Trust pay Mr Atkinson's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
3. Mr Chris Hand, Group Chief Finance Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mr Hand's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
4. Ms Kate Hudson-Halliday, Interim Director of Finance is charged to the trust in full via invoice from NHS North East and North Cumbria Integrated Care Board. Ms Hudson-Halliday was Director of Finance for North Tees and Hartlepool NHS Foundation Trust from 01.04.24 to 04.04.24.
5. Dr Mike Stewart, Group Chief Medical Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Dr Stewart's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Dr Stewart is not in the NHS pension.
6. Ms Maurya Cushlow, Interim Group Chief Nurse of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 13.01.25 to 31.03.25. South Tees Hospitals NHS Foundation Trust pay Ms Cushlow's salary in full and

recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Ms Cushlow is not in the NHS pension scheme.

7. Dr Hilary Lloyd, Group Chief Nurse of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 05.04.24 to 31.01.25. South Tees Hospitals NHS Foundation Trust pay Ms Lloyds's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust from 05.04.24.

8. Ms Lindsey Robertson, Site Chief Nurse / Director of Patient Safety and Quality of North Tees and Hartlepool NHS Foundation Trust and left 14.04.24. Voting member from 01.04.24 - 04.04.24. 2023/24 salary included compulsory redundancy £178k and payment in lieu of notice £78k.
9. Mrs Rachael Metcalf, Group Chief People Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mrs Metcalf's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.

10. Dr Susannah Cook, Group Chief People Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. Moved to Group role 05.04.24 and left 31.08.24. Include as voting member of North Tees and Hartlepool NHS Foundation Trust from 01.04.24 - 04.04.24. From 05.04.24 to 31.08.24 North Tees and Hartlepool NHS Foundation Trust paid Dr Cook's salary in full and recharged 50% to South Tees Hospitals NHS Foundation Trust.
11. Mr Steve Taylor, Group Director of Estates of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 01.07.24. North Tees and Hartlepool NHS Foundation Trust pay Mr Taylor's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
12. Mr Ken Anderson, Group Chief Information Technology Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 01.05.24 but was North Tees and Hartlepool NHS Foundation Trust site CITO from 01.04.24 - 30.04.24. North Tees and Hartlepool NHS Foundation Trust pay Mr Anderson's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust from 01.05.24. Other remuneration is payment in lieu of annual leave.

13. Mr Stuart Irvine, Group Director of Risk, Assurance and Compliance of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mr Irvine's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.

14. Mrs Jackie White, Group Head of Governance/Company Secretary of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Mrs White's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.

15. Mrs Ruth Dalton, Group Director of Communications of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. North Tees and Hartlepool NHS Foundation Trust pay Mrs Dalton's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
16. Mr Matthew Neligan, Group Chief Strategy Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 14.10.24. North Tees and Hartlepool NHS Foundation Trust pay Mr Neligan's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
17. Dr Anandapuram Dwarakanath, Site Medical Director became Site Medical Director of North Tees and Hartlepool NHS Foundation Trust from 01.07.24. Dr Anandapuram Dwarakanath is over NRA for the existing benefits scheme but not for the 2015 scheme therefore a CETV calculation is only applicable on the 2015 scheme. £120,308.31 of the remuneration included in the table does not relate to the Site Medical Director position.
18. Dr Elaine Gouk, Interim Site Medical Director of North Tees and Hartlepool NHS Foundation Trust to 30.06.24. £26,098.86 of the remuneration included in the table does not relate to the Site Medical Director position.
19. Mrs Rowena Dean, Site Chief Operating Officer of North Tees and Hartlepool NHS Foundation Trust.
20. Ms Beth Swanson, Site Director of Nursing of North Tees and Hartlepool NHS Foundation Trust from 30.09.24
21. Mrs Linda Hunter, Director of Planning and Performance of North Tees and Hartlepool NHS Foundation Trust and left 26.05.24. Salary includes compulsory redundancy payment of £133,333.00 and payment in lieu of notice £28,737.24.
22. Mr Michael Houghton, Director of Transformation to 21.07.24 and Interim Managing Director of NTH Solutions LLP from 22.07.24. Voting member from 01.04.24 to 04.04.24
23. Mr Michael Worden, Managing Director NTH Solutions left 4th March 2025 and was not a member of the NHS Pension Scheme therefore there is no entry in respect of pensionable remuneration shown. Other remuneration is payment in lieu of annual leave.
24. Prof Derek Bell, Group Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Prof Bell's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
25. Ms Ann Baxter, Group Vice Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Ms Baxter's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
26. Mr Christopher Macklin, Group Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mr Macklin's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
27. Mrs Alison Fellows (Care), Group Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and

Hartlepool NHS Foundation Trust pay Mrs Fellows' salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.

28. Prof Elizabeth Barnes, Group Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Prof Barnes' salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
29. Mrs Fay Scullion, Group Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mrs Scullion's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
30. Ms Ali Wilson, Group Vice Chair of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Ms Wilson's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
31. Ms Ada Burns, Group Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Ms Burns' salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
32. Ms Miriam Davidson, Group Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Ms Davidson's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
33. Mr David Redpath, Group Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mr Redpath's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
34. Mr Ken Readshaw, Group Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mr Readshaw's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
35. Mr Mark Dias, Group Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mr Dias' salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
36. Mrs Alyson Gerner, Group Associate Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24 to 31.08.24. South Tees Hospitals NHS Foundation Trust pay Mrs Gerner's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
37. Prof Rudy Bilous, Group Associate Non-executive Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24 to 31.08.24. South Tees Hospitals NHS Foundation Trust pay Prof Bilous' salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.

38. Mr Ian Simpson, Subsidiaries Chair for North Tees and Hartlepool Solutions LLP and Optimus Health Ltd.

* In accordance with NHS England's NHS Foundation Trust Annual Reporting Manual s2.39, disclosure is now shown where one or more senior managers are paid more than £150,000. This is the threshold used in the Civil Service for approval by the Chief Secretary to the Treasury, as set out in guidance issued by the Cabinet Office and is considered a suitable benchmark above which NHS foundation trusts should disclose. Every salary approved by the remuneration committee has been appropriately externally benchmarked and salary levels set to ensure we are attracting the right skills and competencies.

** In accordance with NHS England's NHS Foundation Trust Annual Reporting Manual s2.50, where the calculations for Pension-Related Benefits result in a negative value the result should be reported as zero.

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

Pension information

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

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

Notes:

1. Ms Stacey Hunter, Chief Executive of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Ms Hunter's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.

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

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

Executive Directors	Real increase in pension at pension age (Bands of £2,500)	Real increase to pension lump sum at pension age (Bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (Bands of £5,000)	Cash equivalent transfer value at 1 April 2025 (£000s)	Real increase in cash equivalent transfer value (£000s)	Cash equivalent transfer value at 31 March 2026 (£000s)	Employer's contribution to stakeholder pension (£000s)
Ms Stacey Hunter Group Chief Executive	17.5-20	40-42.5	85-90	220-225	1,481	409	2,022	38
Mr Neil Atkinson Group Managing Director from 05.04.24, previously Trust Managing Director	10-12.5	20-22.5	60-65	155-160	1,090	216	1,400	25
Mr Chris Hand Group Chief Finance Officer from 05.04.24	7.5-10	12.5-15	55-60	140-145	939	141	1,167	26
Ms Kate Hudson-Halliday Interim Director of Finance from 01.04.24 to 04.04.24.	0-2.5	0-2.5	50-55	135-140	1,062	1	1,187	0
Dr Mike Stewart Group Chief Medical Officer	0	0	0	0	0	0	0	0
Ms Maurya Cushlow Interim Group Chief Nurse from 13.01.25 to 31.03.25	0	0	0	0	0	0	0	0
Dr Hilary Lloyd Group Chief Nurse from 05.04.24 to 31.01.25	2.5-5	0-2.5	70-75	195-200	1,624	57	1,824	22
Ms Lindsey Robertson Site Chief Nurse / Director of Patient Safety & Quality left 14.04.24. Voting member from 01.04.24 - 04.04.24	0	0	50-55	140-145	1,182	0	1,209	1
Mrs Rachael Metcalf Group Chief People Officer from 05.04.24	7.5-10	15-17.5	45-50	115-120	738	152	960	21
Dr Susannah Cook Group Chief People	0-2.5	0	40-45	100-105	785	2	860	8

Officer moved to Group role 05.04.24 and left 31.08.24. Include as voting member from 01.04.24 - 04.04.24.								
Mr Steve Taylor Group Director of Estates from 01.07.24	7.5-10	20-22.5	50-55	140-145	869	187	1,191	13
Mr Ken Anderson Group Chief Information Technology Officer from 01.05.24 but was site CITO from 01.04.24 - 30.04.24.	2.5-5	0	5-10	0	65	28	114	19
Mr Stuart Irvine Group Director of Risk, Assurance & Compliance	5-7.5	7.5-10	30-35	75-80	489	87	621	15
Mrs Jackie White Group Head of Governance/Company Secretary	0-2.5	0	40-45	100-105	795	20	882	16
Mrs Ruth Dalton Group Director of Communications	0-2.5	0	10-15	0	104	18	143	16
Mr Matthew Neligan Group Chief Strategy Officer from 14.10.24	2.5-5	2.5-5	60-65	155-160	1,127	55	1,344	12
Dr Anandapuram Dwarakanath Site Medical Director from 01.07.24	2.5-5	0	10-15	0	144	30	223	19
Dr Elaine Gouk Interim Site Medical Director to 30.06.24	0-2.5	0	75-80	205-210	89	11	161	5
Mrs Rowena Dean Site Chief Operating Officer	2.5-5	5-7.5	50-55	140-145	1,070	85	1,243	19
Ms Beth Swanson Site Director of Nursing from 30.09.24	2.5-5	10-12.5	30-35	85-90	490	96	730	9
Mrs Linda Hunter Director of Planning and Performance left 26.05.24	0	0	30-35	80-85	685	0	716	3
Mr Michael Houghton Director of Transformation to 21.07.24 and Interim Managing Director, NTH Solutions LLP from 22.07.24	10-12.5	22.5-25	50-55	140-145	993	255	1,330	18

1. Ms Stacey Hunter, Group Chief Executive of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Ms Hunter's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
2. Mr Neil Atkinson, Group Managing Director of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust from 05.04.24. From 01.04.24 to 04.04.24 was Managing Director for North Tees and Hartlepool NHS Foundation Trust only. North Tees and Hartlepool NHS Foundation Trust pay Mr Atkinson's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
3. Mr Chris Hand, Group Chief Finance Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mr Hand's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
4. Ms Kate Hudson-Halliday, Interim Director of Finance is charged to the Trust in full via invoice from NHS North East and North Cumbria Integrated Care Board. Ms Hudson-Halliday was Director of Finance for North Tees and Hartlepool NHS Foundation Trust from 01.04.24 to 04.04.24.
5. Dr Mike Stewart, Group Chief Medical Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. South Tees Hospitals NHS Foundation Trust pay Dr Stewart's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Dr Stewart is not in the NHS pension.
6. Maurya Cushlow, Interim Group Chief Nurse of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 13.01.25 to 31.03.25. South Tees Hospitals NHS Foundation Trust pay Ms Cushlow's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust. Ms Cushlow is not in the NHS pension scheme.
7. Dr Hilary Lloyd, Group Chief Nurse of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 05.04.24 to 31.01.25. South Tees Hospitals NHS Foundation Trust pay Ms Lloyds's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust from 05.04.24.
8. Ms Lindsey Robertson, Site Chief Nurse / Director of Patient Safety & Quality of North Tees and Hartlepool NHS Foundation Trust and left 14.04.24. Voting member from 01.04.24 - 04.04.24. 2023/24 salary included compulsory redundancy £178k and payment in lieu of notice £78k.
9. Mrs Rachael Metcalf, Group Chief People Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 05.04.24. South Tees Hospitals NHS Foundation Trust pay Mrs Metcalf's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
10. Dr Susannah Cook, Group Chief People Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. Moved to Group role 05.04.24 and left 31.08.24. Include as voting member of North Tees and Hartlepool NHS Foundation Trust from 01.04.24 - 04.04.24. From 05.04.24 to 31.08.24 North Tees and

Hartlepool NHS Foundation Trust paid Dr Cook's salary in full and recharged 50% to South Tees Hospitals NHS Foundation Trust.

11. Mr Steve Taylor, Group Director of Estates of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 01.07.24. North Tees and Hartlepool NHS Foundation Trust pay Mr Taylor's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
12. Mr Ken Anderson, Group Chief Information Technology Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 01.05.24 but was North Tees and Hartlepool NHS Foundation Trust site CITO from 01.04.24 - 30.04.24. North Tees and Hartlepool NHS Foundation Trust pay Mr Anderson's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust from 01.05.24. Other remuneration is payment in lieu of annual leave.
13. Mr Stuart Irvine, Group Director of Risk, Assurance & Compliance of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. North Tees and Hartlepool NHS Foundation Trust pay Mr Irvine's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
14. Mrs Jackie White, Group Head of Governance/Company Secretary of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. South Tees Hospitals NHS Foundation Trust pay Mrs White's salary in full and recharge 50% to North Tees and Hartlepool NHS Foundation Trust.
15. Mrs Ruth Dalton, Group Director of Communications of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation. North Tees and Hartlepool NHS Foundation Trust pay Mrs Dalton's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
16. Mr Matthew Neligan, Group Chief Strategy Officer of North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation from 14.10.24. North Tees and Hartlepool NHS Foundation Trust pay Mr Neligan's salary in full and recharge 50% to South Tees Hospitals NHS Foundation Trust.
17. Dr Anandapuram Dwarakanath, Site Medical Director became Site Medical Director of North Tees and Hartlepool NHS Foundation Trust from 01.07.24. Dr Anandapuram Dwarakanath is over NRA for the existing benefits scheme but not for the 2015 scheme therefore a CETV calculation is only applicable on the 2015 scheme. £120,308.31 of the remuneration included in the table does not relate to the Site Medical Director position.
18. Dr Elaine Gouk, Interim Site Medical Director of North Tees and Hartlepool NHS Foundation Trust to 30.06.24. £26,098.86 of the remuneration included in the table does not relate to the Site Medical Director position.
19. Mrs Rowena Dean, Site Chief Operating Officer of North Tees and Hartlepool NHS Foundation Trust.
20. Ms Beth Swanson, Site Director of Nursing of North Tees and Hartlepool NHS Foundation Trust from 30.09.24
21. Mrs Linda Hunter, Director of Planning and Performance of North Tees and Hartlepool NHS Foundation Trust and left 26.05.24. Salary includes compulsory redundancy payment of £133,333.00 and payment in lieu of notice £28,737.24.

22. Mr Michael Houghton, Director of Transformation to 21.07.24 and Interim Managing Director of NTH Solutions LLP from 22.07.24. Voting member from 01.04.24 to 04.04.24.
23. Mr Michael Worden, Managing Director NTH Solutions left 4th March 2025 and was not a member of the NHS Pension Scheme therefore there is no entry in respect of pensionable remuneration shown. Other remuneration is payment in lieu of annual leave

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

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

Fair pay multiple (subject to audit)

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

The CETV figures, and from 2004-2005 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.

Expenditure on consultancy

In 2025/26, expenditure on consultancy was £0.087 million (2024/25 £0.675 million). Consultancy expenditure in the year related clinical coding auditing.

Staff exit packages

In 2025/26, the trust agreed 18 exit packages with members of staff (there was no exit packages agreed in 2024/25).

Note 6.1 Reporting of other compensation schemes - exit packages agreed in 2025/26 Note that columns G, I and M are entered in £000 NHS Trusts - note that the GAM advises local accounts should be in £	Expected sign	A09CY17 Number of compulsory redundancies Accounts 31 Mar 2026 2025/26 No.	A09CY18 Cost of compulsory redundancies Accounts 31 Mar 2026 2025/26 £000	A09CY19 Number of other departures agreed Accounts 31 Mar 2026 2025/26 No.	A09CY20 Cost of other departures agreed Accounts 31 Mar 2026 2025/26 £000	A09CY21 Total number of exit packages Accounts 31 Mar 2026 2025/26 No.	A09CY22 Total cost of exit packages Accounts 31 Mar 2026 2025/26 £000	A09CY23 Number of departures where special payments have been made Accounts 31 Mar 2026 2025/26 No.	A09CY24 Cost of special payment element included in exit packages Accounts 31 Mar 2026 2025/26 £000	Maincode Subcode
Exit package cost band (including any special payment element)										
<£10,000	+			12	77	12	77			STA0560
£10,000 - £25,000	+			3	52	3	52			STA0570
£25,001 - £50,000	+			3	96	3	96			STA0580
£50,001 - £100,000	+					0	0			STA0590
£100,001 - £150,000	+					0	0			STA0600
£150,001 - £200,000	+					0	0			STA0610
>£200,000	+					0	0			STA0620
Total	+	0	0	18	225	18	225	0	0	STA0630

Governors' expenses

In accordance with our constitution, governors are eligible to claim expenses for travel at rates determined by the trust. Out of the Council of Governor membership there were four governors who claimed expenses which totalled £168.64.

Directors' expenses

In 2025/26, expenses paid to those holding the office of director at the trust totalled £10,042. All costs paid related to the reimbursement of travel, subsistence costs and course expenses. Details of remuneration and benefits in kind can be found within the remuneration table.

Analysis of staff costs (subject to audit)

Details of the costs of our workforce are available within Note 9 of the Financial Statements. The note includes information to support employee expenses.

			2025-26	2024-25
	Permanent	Other	Total	Total
	£0	£0	£0	£0
Salaries and wages	£252,823	£672	£253,495	£248,114
Social security costs	£31,780		£31,780	£22,345
Apprenticeship Levy	£1,153		£1,153	£1,027
Employer's contributions to NHS pensions	£42,663		£42,663	£40,754
Pension cost - other	£312		£312	£358
Agency/contract staff	-	£14,956	£14,956	£16,189
NHS Charitable funds staff	£230		£230	£327
Total gross staff costs			**£344,589**	**£329,114**
Recoveries in respect of seconded staff	(£1,176)	-	(£1,176)	(£1,237)

Total staff costs	**-**	**-**	**£343,413**	**£327,877**

Off-payroll engagements

Executive director approval is required for all off-payroll engagements and NTHFT reports to NHS England as required in line with national requirements. Board approval via recommendations from the remuneration committee is required by any off-payroll Board member engagement.

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

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater:	
Number of off-payroll workers engaged during the year ended 31 March 2026:	1
Of which:	
Not subject to-off-payroll legislation	0
Subject to off-payroll legislation and determined as in-scope of IR35	1
Subject to off-payroll legislation and determined as out-of-scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026:	
Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	0

The audit committee

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

The committee was chaired by Ms. Fellows until January 2026 and then Mr. Readshaw took over as chair.

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

Non-executive Directors	Total number attended	% attendance
Mr K Readshaw	6/6	100
Ms A Fellows	5/6	83
Ms C Weldon	1/1	100

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

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

The committee met its responsibilities during 2025-26 by:

- Reviewing the Board Assurance Framework
- Reviewing risk and internal control-related disclosures, such as the Annual Governance Statement
- Reviewing the work and findings of Internal Audit, including the Internal Audit annual plan
- Reviewing the work and findings of External Audit
- Reviewing the work and findings of the Local Counter Fraud Officer and other fraud reports
- Reviewing the process by which clinical audit is undertaken in the organisation
- Reviewing the process by which staff are able to speak up in the organisation
- Monitoring the extent to which our external auditors undertake non-audit work having reference to the Auditors Guidance Note 1 (AGN01) 'General Guidance Supporting Local Audit'
- Reviewing the 2025-26 Financial Statements and Annual Report, prior to submission to the board and NHS England

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

The committee is content that the objectivity and independence of the auditor was not compromised by any of these additional assignments and that these services are allowed services under AGN01.

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

In the review of internal audit and management assurance reports, Audit and Risk Committee identified three High, 43 Medium and 46 Low risk rated findings to improve weaknesses in the design of controls and/or operating effectiveness. Three High risk rated findings have been identified across the reviews carried out during the year. These have been summarised in the annual governance statement.

Charitable Funds Committee

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

Staff report

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

Staff experience and engagement

Staff experience and engagement

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

Staff survey

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

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

Indicators ('People Promise' elements and themes)	2025		2024		2023	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	7.41		7.28	7.44	7.29	7.51
We are recognised and rewarded	5.94		5.87	5.99	5.92	6.11
We each have a voice that counts	6.67		6.60	6.74	6.67	6.84
We are safe and healthy	6.17		6.07	6.27	6.13	6.33
We are always learning	5.54		5.57	5.47	5.64	5.70
We work flexibly	6.31		6.22	6.32	6.24	6.28
We are a team	6.78		6.75	6.76	6.75	6.83
Staff engagement	6.74		6.74	6.89	6.84	6.98
Morale	5.91		5.84	6.01	5.93	6.13

The NHS annual staff survey was carried out in Autumn 2025. The survey mode was mixed, and the sample type was a census with a response rate of 42% (2114 members of staff).

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

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

We are compassionate and inclusive

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

The sub-score trends indicate lower scores in comparison to 2024 and 2023. The trust remains above the national average for Compassionate Culture, Diversity and Equality and Inclusion. We are in line with the national average for Compassionate Leadership. An increased percentage of staff responded positively to the question “My immediate manager is interested in listening to me when I describe challenges I face”.

Throughout 2025/26 we have:

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

Raising concerns and issues

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

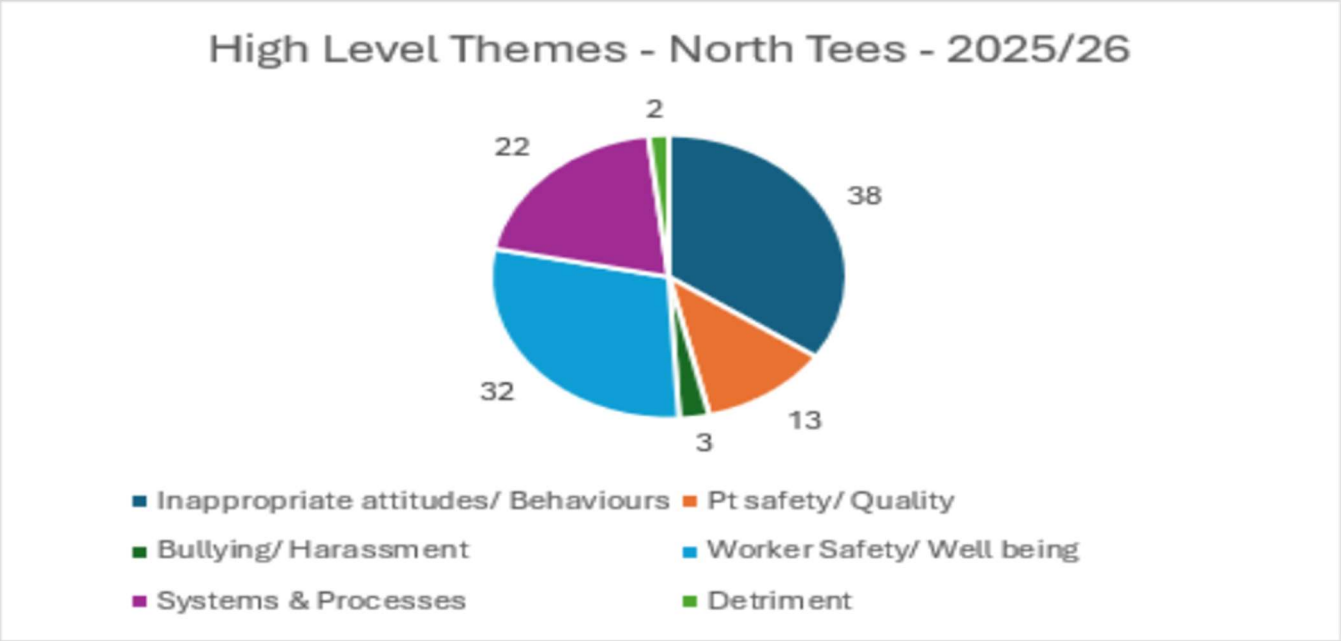
The Freedom to Speak up Guardian provides 37.5 hours of support weekly.

Between 1 April 2025 and 31 March 2026:

- **75 concerns were raised at North Tees (**a **15.38%** increase from 65 in 2024/25).

Anonymous reporting decreased at the trust: with **1.3% (1 case)**, down from 9.2% (6 cases) in 2024/25.

Figure below show the high-level themes recorded against the concerns received in 2025/6



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

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

- A single reporting system that can be utilised across the group model
- Implementing the detriment standard operating procedure across the Clinical Support Units, to support in tackling barriers of detriment for workers speaking up
- Continued engagement with group networks, to help build relationships with the network leads

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

We are recognised and rewarded

This theme includes recognition for good work, feeling valued and satisfaction with level of pay and for this indicator we benchmark above the national average. Our results are lower than last year; however, we did see an increase in the positive scoring for 'My immediate manager values my work (70.67%), this question showed our biggest drop from 2023-2024 (3%) but has now increased by 0.7%.

Throughout 2025/26 we have:

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

We each have a voice that counts

This theme explores how colleagues feel about their work environment with opportunities to use initiative, are trusted to do their role and can make suggestions. For this indicator we benchmark above the national average. Our overall score is lower than last year with the greatest drop in positive responses was with the statement "I am confident that my organisation would address my concern"

Throughout 2025/26 we have:

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

We are safe and healthy

This theme covers staffing, health and wellbeing and bullying. For this indicator we benchmark above the national average. The subtheme of Burnout showed improvements across nearly all the statements with improvements in statements such as “How often, if at all, do you feel burnt out because of your work?”.

Throughout 2025/26 we have:

- Taken forward and embedding feedback from staff survey and health needs assessment survey
- Flu vaccines, health checks, mental health support, weight management and programmes available
- Health and well-being and menopause support, ambassadors and policy in place
- Events such as festival of finance, Christmas savings scheme
- Developing a health inequalities dashboard for the workforce
- Development of a Health and Wellbeing passport and associated managers toolkit
- Developing a reasonable adjustment training for managers
- Embedding of the principles within the sexual safety charter to support staff
- Develop links with external agencies such as Cleveland police in taking forward a zero-tolerance approach to racism and other forms of hate crime

We are always learning

This theme focuses on development opportunities and appraisals. For this indicator we have shown an increase from 2024 to 2025. We are however, below the national average for this theme. The greatest drop in positive responses was with the statement “There are opportunities for me to develop my knowledge and skills”.

Throughout 2025/26 we have:

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

We work flexibly

This theme relates to home life balance and flexible working. For this indicator we benchmark above the national average but have shown a slight decline (0.01) from 2024. A higher percentage of staff responded positively for the statement “I can approach my immediate manager to talk openly about flexible working.”

Throughout 2025/26 we have:

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

We are a team

This theme looks at the support, respect and encouragement from line managers and team working. For this theme the trust is above the national average. We are also above the national average for the subtheme ‘Team Working’ and are in line with the national average for ‘Line Management’.

Throughout 2025/26 we have:

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

Future priorities and targets

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

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

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

Occupational Health and Wellbeing Services

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

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

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

Developing a sustainable workforce

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

Our objectives for developing a sustainable workforce are:

- To further triangulate our workforce planning, performance improvement and financial planning needs to develop a workforce plan which identifies any fragile services and which facilitates the alignment of services and the progression of University Hospitals Tees
- Continue to focus on understanding voluntary turnover and progress plans to address turnover hotspots such as early 'check ins' for newly recruited colleagues and an improved onboarding journey along with continuation of 'itchy feet' and 'stay' conversations with colleagues expressing a wish to leave
- Introducing a digital solution to enable talent management and succession planning

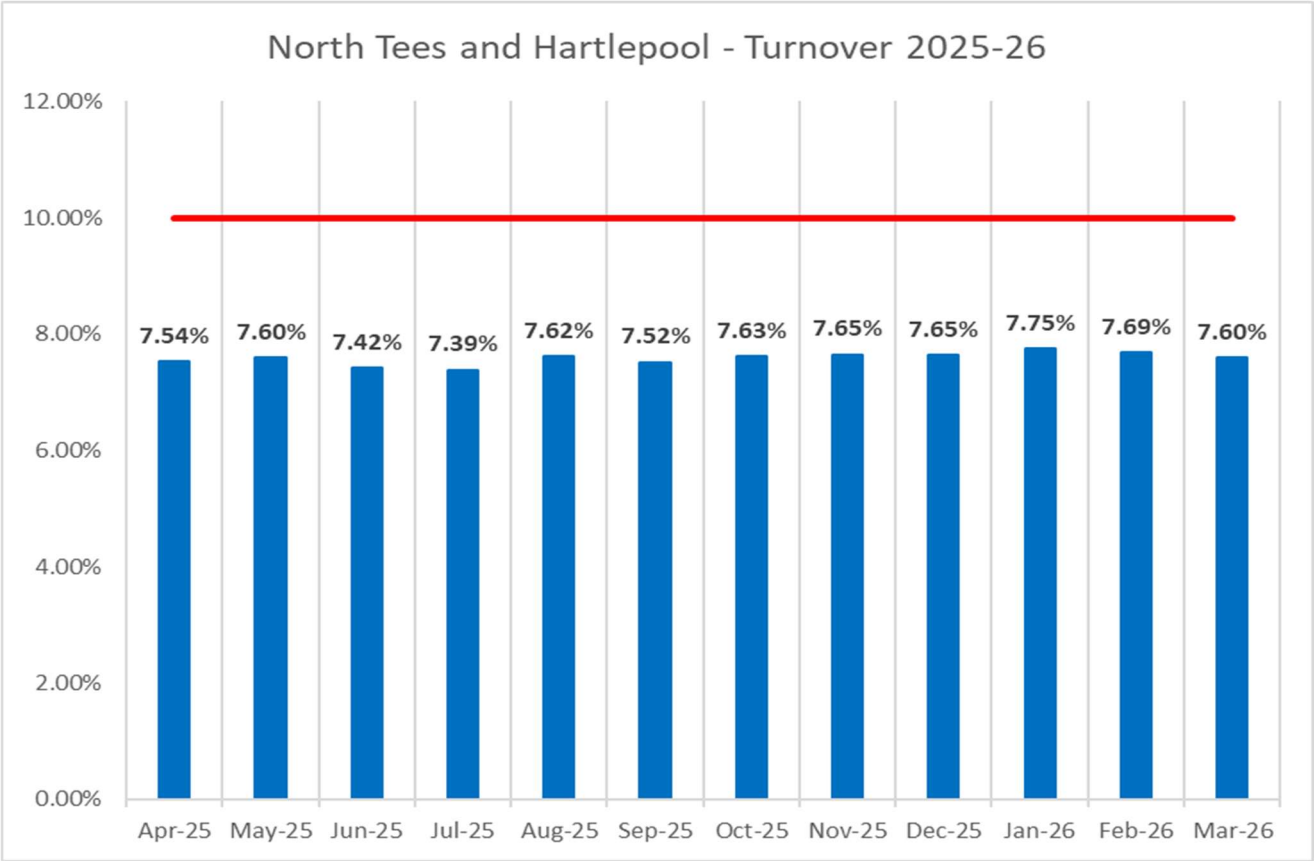
- Promoting the trust as an employer of choice within the local communities and developing a social media Prescence which showcase the available career and job opportunities to increase candidate reach
- Continue with and develop recruitment and selection training for managers to ensure we appoint colleagues who demonstrate the abilities and values of the trust
- Continue to promote the trust within the local community and as an employer of choice to promote vacancy and support the long-term unemployed
- Redesign and reposition career opportunities so that they feel accessible and within the reach of our local community
- Continue to build our relationships with higher education and further education sectors which will provide an opportunity to develop a talent pipeline and enable our colleagues to develop into new roles

Staff turnover

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

The turnover section within the organisation benchmarking tool, NHS Workforce Statistics dashboard is updated on a quarterly basis, in monthly reports, accessible through the following link: Microsoft Power BI. Staff turnover is reported within NHS Hospitals and Community Health Services (HCHS): Summary statistics for HCHS staff in England through NHS Digital. The series utilises data from the Electronic Staff Record (ESR) data warehouse and is an official statistics publication complying with the UK Statistics Authority's Code of Practice.

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



Staff consultation

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

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

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

Staff Policies

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

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

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

Staff exit packages

In 2025/26, The trust agreed to an exit package with 18 members of staff (there were zero instances in 2024/25), which cost £226,046.14 (Voluntary Severance Schemes).

In 2025/26, the trust agreed to settlement payments in relation to Employment Tribunal Claims for one individual, which cost £895.00.

Public Sector Equality Duty

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

North Tees

Gender	Headcount	Sum of FTE
Female	4965	4066.28
Male	1237	1043.91
Total	6202	5110.19

Ethnicity	Headcount	Sum of FTE
BME	984	847.25
Not Stated	65	42.73
White	5153	4220.21
Total	6202	5110.19

Religion	Headcount	Sum of FTE
Atheism	939	817.21
Buddhism	30	26.54
Christianity	3088	2557.33
Do not wish to disclose	873	689.01
Hinduism	123	111.24
Islam	166	134.80
Jainism	2	1.00
Judaism	1	1.40
Not Stated	333	234.09
Other	641	531.57
Sikhism	6	6.00
Total	6202	5110.19

Sexual Orientation	Headcount	Sum of FTE
Bisexual	69	56.55
Gay or Lesbian	107	98.46
Heterosexual or Straight	5246	4386.53
Not stated	766	556.45
Other sexual orientation not listed	6	5.72
Undecided	8	6.48
Total	6202	5110.19

Disability	Headcount	Sum of FTE
Learning disability/difficulty	111	88.73
Long-standing illness	114	92.66
Mental Health Condition	47	36.48
No	5012	4212.09
Not Declared	346	244.57
Other	33	29.64
Physical Impairment	29	22.97
Prefer Not to Answer	1	1.00
Sensory Impairment	20	17.40
Yes - Unspecified	451	337.26
Do not wish to disclose	38	27.39
Total	6202	5110.19

Staff group	Headcount	Sum of FTE
Add Prof Scientific and Technic	111	88.13
Additional Clinical Services	1190	974.55
Administrative and Clerical	1187	1004.12
Allied Health Professionals	506	441.17
Estates and Ancillary	716	509.18
Healthcare Scientists	127	109.62
Medical and Dental	487	345.36
Nursing and Midwifery Registered	1876	1636.48
Students	2	1.60
Total	6202	5110.19

Staff group	Headcount	Sum of FTE
Administration and estates	1650	1337.75
Ambulance staff	8	7.03
Healthcare assistants and other support staff	1382	1143.78
Healthcare science staff	121	105.82
Medical and dental	561	345.36
Nursing, midwifery and health visiting learners	0	0.00
Nursing, midwifery and health visiting staff	1859	1637.08
Scientific, therapeutic and technical staff	621	533.38

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

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

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

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

We comply with the Public Sector Equality Duty and Equality, Diversity and Inclusion legislation and NHS contract requirements and align our legal obligations with the NHS Standard Contract and frameworks like the Equality Delivery System (EDS2/EDS2022), WRES and WDES.

Our annual Equality and Diversity report demonstrates our commitment to this and can be viewed on the trust website at Equality and diversity report 2024 - 2025 - North Tees and Hartlepool NHS Foundation Trust.

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

- To engage with our patients, the local community and various stakeholders, in line with the requirements of EDS, to ensure the effective provision of services
- To promote equality, diversity and inclusion across the trust
- To enable our staff to work alongside patients and carers to determine realistic, reasonable adjustments to deliver safe, effective care to people with literacy problems, learning difficulties and dementia
- To explore and reduce the discrimination experienced by our staff, as identified by the NHS annual staff survey, through the development of proactive measures and support mechanisms to be implemented Trust-wide
- Work is underway to review and bring the Equality Objectives together as one across the group for 2026/27, with the national EDI High Impact Actions in mind.

Gender pay gap report

In 2024-25 we reported a mean gender pay gap of 35.71% and a median gender pay gap of 21.77%.

The table below shows our gender pay gap data for the period 31 March 2023 to 31 March 2025.

North Tees	Average **Mean** Gender Pay Gap – Whole Workforce			Average **Median** Gender Pay Gap – Whole Workforce		
	2024/2025	**2023/2024**	**2022/2023**	**2024/2025**	**2023/2024**	**2022/2023**
Male	£30.53	£ 27.45	£ 32.14	£22.99	£21.06	£20.50
Female	£19.63	£18.32	£ 17.79	£17.99	£16.70	£15.68
Difference	£10.90	£9.13	£14.35	£5.01	£4.36	£4.82
Pay gap %	**35.71%**	**33.27%**	**44.65%**	**21.77%**	**20.71%**	**23.51%**

As reported in previous years, there is a greater proportion of male workers within the categories of medical and dental (MandD) and very senior manager (VSM). These roles are the highest paid workers of the organisation and equate to 5.77% of the total workforce.

Our actions to improve the Gender Pay Gap align with University Hospitals Tees strategic objectives as well as support our commitments to the NHS People Plan.

Our Gender Pay Gap report can be access through the following website address Search and compare gender pay gap data - Gender pay gap service - GOV.UK

Workforce Race Equality Scheme and the Workforce Disability Equality Scheme

We continue to progress and strengthen our workforce culture and inclusion agenda, with oversight and assurance provided through the People Committee. Our 2025 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports are published on the trust website. Workforce race equality standards (WDES) report 2025 - North Tees and Hartlepool NHS Foundation Trust and Workforce disability equality standards (WDES) report 2025 - North Tees and Hartlepool NHS Foundation Trust

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

Staff Networks

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

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

Our current staff networks include:

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

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

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

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

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

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

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

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

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

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

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

Apprenticeships

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

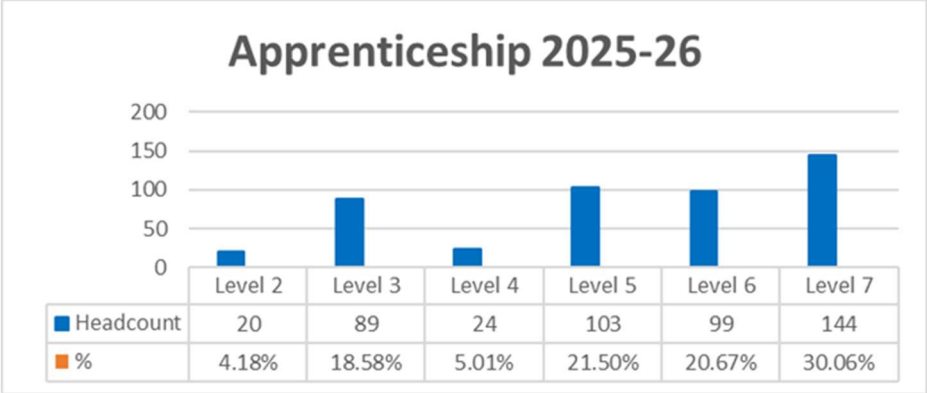
Alongside this internal development, the team has closely monitored national apprenticeship reforms to ensure the organisation remains informed of potential impacts on current programmes and future levy utilisation. Key reforms under review include:

- the transition to the Growth and Skills Levy
- the removal of funding for Level 7 apprenticeships for learners aged 21 and over
- the planned withdrawal of several leadership and management apprenticeship standards at Levels 3–6

- the introduction of shorter-duration apprenticeship units
- a reduction in levy fund expiry from 24 to 12 months
- the removal of the 10% government apprenticeship levy top-up

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

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



	Level 2	Level 3	Level 4	Level 5	Level 6	Level 7
Headcount	20	89	24	103	99	144
%	4.18%	18.58%	5.01%	21.50%	20.67%	30.06%

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

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

NHS Trust Code of Governance

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

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

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

NHS Oversight Framework

Oversight Framework

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

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

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

Segmentation

Across the themes of the NOF (quality of care, finance and use of resources, operational performance, strategic change, leadership and improvement capability) the trust is placed in segment 2 as of quarter 4 2025/26.

EPRR assurance

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

Following the self-assessment for 2025/26 the Trust is compliant with 53 of the 62 standards with the remaining 9 standards assessed as amber (partially compliant) which means that the Trust reported partial compliance for 2025/26 with 85% compliance with the core standards (a 5% increase from 2024/25).

EPRR activity and priorities

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

Application of the Modern Slavery Act

The Modern Slavery and Human Trafficking Act 2015 Act established a duty for commercial organisations to prepare an annual slavery and human trafficking statement to include the steps

the organisation has taken during the year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business.

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

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

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

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

We adhere to the principles inherent within both our safeguarding children and adult's policies. These provide clear guidance so that our employees are clear on how to raise safeguarding concerns, and by ensuring representation via the safeguarding team, on the modern slavery network and the vulnerable, exploited, missing, trafficked strategic and operational groups, we provide a level of compliance with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment and access to training and development opportunities.

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

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

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

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

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

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

Statement of the chief executive's responsibilities as the accounting officer of North Tees & Hartlepool NHS Foundation Trust

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

NHS England has given Accounts Directions which require North Tees & Hartlepool NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of North Tees & Hartlepool NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

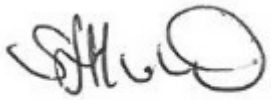
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

As far as I am aware, there is no relevant audit information of which the foundation 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 the *NHS Foundation Trust Accounting Officer Memorandum*:



Stacey Hunter Date: 1 July 2026

Chief Executive and Accounting Officer

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of North Tees and Hartlepool NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in North Tees and Hartlepool NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

The Chief Nurse and Chief Medical Officer are responsible for clinical risk management and this is discharged within the Quality and Safety Team. The Director of Risk, Assurance and Compliance is responsible for non-clinical risk management.

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

The Risk Management Group oversees the operation of the trust's risk management process. Membership of the group includes clinical and non-clinical representation across the Collaboratives/Care Groups, which were subsequently replaced by Clinical Service Units (CSUs), along with director level input.

The Risk Management Group is chaired by the Director of Risk, Assurance and Compliance and is accountable to University Hospitals Tees Management Team.

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

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

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

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

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

The risk and control framework

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Quality and Safety** – Patient experience – Failure to provide care that is compassionate, kind and inclusive; Failure to provide clinically effective treatment in line with best evidence; Patient safety – Failure to protect people from abuse or avoidable harm.
- **Digital** – Investment into the implementation of new digital systems not meeting the needs of the Trust (Group) and its transformation agenda; Failure to protect the information / data we hold as a result of noncompliance with legislation and/or noncompliance with Trust policy; Technical Infrastructure fails to maintain effective cyber defences, negatively impacting operational delivery, security and reputation (Cyber-attack); Pressured resources within digital teams which poses a risk to the delivery of the digital strategy and BAU activity (People & Process).
- **Trust estate** – Failure of Trust infrastructure (including buildings); trust estate does not allow for the provision of optimal clinical services; Reduction of system capacity if the trust is unable to provide services; Non-compliance with legal and regulatory standards of thetrust's estate; Insufficient capital funding to maintain trust estate.
- **People** – A workforce that doesn't have the required knowledge, skills and experience to provide services now and in the future; A culture that doesn't promote positivity, respect, inclusion and a focus on belonging, recognising, and rewarding achievements; Workforce planning and people practices don't support the Trust to deliver its services; Not having a health and wellbeing offer that positively supports organisational efficiency and our colleagues ability to deliver quality patient care.
- **Performance and compliance** – Non-compliance with national standard in accordance with the Oversight Framework, and referral to treatment recovery priorities; Non-compliance with national standards in accordance with the Oversight Framework, and cancer recovery priorities; Non-compliance with national standards in accordance with the Oversight Framework, and Diagnostics recovery priorities.
- **System Working & External Threats** – The Trust isn't strategically positioned locally and regionally to deliver the UHT strategy; The Trust doesn't reform clinical services to meet local and regional need in line with planned timescales.
- **Research & Innovation** – Lack of integration of research with digital infrastructures prevents the delivery of effective research; Growth research is constrained by infrastructure, capacity and culture; Over-reliance on external income leads to R&D financial uncertainty and limits growth; Innovation growth is limited by investment and resource constraints; Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture.
- **Finance** – Adverse financial impact due to system working requirements (Health & Care Act 2022); Insufficient funding in existing contract arrangements for services provided to the population; Inability to controls costs within allocated resources; Inability to deliver the required savings (recurrent/nonrecurrent) within the annual financial plan.

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

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

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

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

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

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

Quality governance arrangements

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

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

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

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

Well-Led

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

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

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

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

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

The trust was inspected by the Care Quality Commission during 2022, which included a Well Led inspection. The report concluded that the ratings had changed from ‘good’ to ‘requires improvement’ with 13 trust wide ‘must do’ actions identified.

Compliance with NHS Provider Licence

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

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

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

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

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

Workforce

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

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

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

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

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

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

Care Quality Commission

North Tees and Hartlepool NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions for all services provided.

The most recent CQC visit took place between the 3 to 26 May 2022. The trust has been rated as 'Requires Improvement', additional detail regarding the recent visit is located in the CQC section on page 95. The Care Quality Commission (CQC) published a report in September 2022, following the inspection of two core services, maternity and children and young people. The trust's overall rating as highlighted below is 'requires improvement'. The report outlined 13 'must do' actions and 18 'should do' actions. The trust has since addressed all the CQC must and should do actions from the inspection.

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

The full inspection report can be found at: http://www.cqc.org.uk/provider/RVW

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

CQC Contact and Communication

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

Register of Interests

The trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past 12 months as required by the Managing Conflicts of Interest in the NHS guidance.

Pension

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

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

The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The financial plan is approved by the Board of Directors and submitted to NHSE, our independent regulator (in exercising its powers originally conferred by Monitor). The process for approving the plan involves the Integrated Care Board (ICB) and the regional NHSE team to create a coordinated strategic and transformational submissions from the North East and North Cumbria ICB. This plan includes forward projections and is monitored by the Resources Committee with key performance indicators and financial sustainability metrics also reviewed monthly by the Executive Team and the Board of Directors at each of its meetings.

The Integrated Care System (ICS) has an overall requirement to deliver the agreed plan with NHSE at the end of the 12-month period.

For the purpose of this report Consolidated Group is the financial statements that present the assets, liabilities, equity, income, expenses and cash flows of North Tees & Hartlepool Trust and its subsidiaries as those of a single entity.

Group is the group of hospitals working together as the University Hospitals Tees, namely North Tees & Hartlepool NHS Trust and South Tees Hospitals NHS Trust.

The Consolidated Group (excluding the North Tees and Hartlepool NHS Foundation Trust General Charitable Fund) recorded an adjusted financial performance surplus in 2025/26 of £3.280 million. At 31 March 2026 the trust's closing cash position (excluding the Charity) amounted to £58.0 million.

The Consolidated Group's (excluding the Charity) deficit within the annual accounts of £11.402 million reconciles to the financial performance surplus of £3.280 million by adjusting for the impairment of assets £14.623 million, donations towards capital expenditure £0.534 million, depreciation on donated assets £0.591 million and DHSC centrally procured inventories for COVID response £0.002 million.

The trust recognises the risk relating to its ageing estate and this is acknowledged as a strategic risk for the trust. The trust will continue in 2025/26 to review and prioritise all capital expenditure bids to minimise clinical and organisational risk.

Financial governance arrangements are managed within the corporate governance framework which includes standing orders, standing financial instructions and a scheme of delegation. financial governance is supported by internal and external audit to ensure economic, efficient and effective use of resources and is monitored by the audit committee.

Internal Audit (AuditOne) provides an independent and objective assurance. Through the agreed audit programme, it assists the trust to accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. The head of internal audit opinion provides good assurance

that there is a sound system of internal control, designed to meet the trust's objectives, and that controls are generally being applied consistently.

The trust's Internal Auditor (AuditOne) has drafted the audit opinion on the adequacy and effectiveness of governance, risk management and control. Their annual opinion for the year ending 31 March 2026 is 'Good assurance' can be given that there is a generally sound system of internal control, governance and risk management designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and inconsistent application of controls put the achievement of particular objectives at risk

Their annual plan, agreed with the audit committee, focussed on key BAF risks and trust strategic priorities, including known areas of weakness. In 2025/26, AuditOne identified three High, 43 Medium and 46 Low risk rated findings for which management actions were agreed to improve weaknesses in the design of controls and/or operating effectiveness. The High risk recommendation related to a the following three audits.

- Waste Sustainability
- Cyber Monitoring Tools
- Sepsis

Information governance

Incident Reporting

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

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

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

All incidents are graded using the NHS Digital breach assessment criteria and our risk assessment tool according to the significance of the breach and the likelihood of those serious consequences occurring. The incidents are also graded according to the impact on the individual or groups of individuals rather than on the trust. Those incidents deemed to be of a high risk are reportable to the Information Commissioners Office (ICO) via the Data Security Protection Toolkit within 72 hours of being reported to the trust.

We actively encourage staff to report any suspected data protection and cyber breaches irrespective of their severity in line with its reporting policy.

Incidents

We reported three incidents to the ICO during the reporting period, an increase from one in the previous year. The reported incidents related to ‘inappropriate access on clinical systems’ and ‘inappropriate disclosure of information’, two incidents have since been closed without action by the ICO and the trust has taken appropriate action to mitigate. One incident remains open as investigation is ongoing, this remains open with the ICO who are seeking further assurance of the trust's actions.

Incident ID	Reported Date	Brief Description	Outcome
22696	14/04/2025	Disclosure of information in error by staff member. Impact on one data subject.	• Incident Closed by ICO • HR disciplinary actions as per policy • Additional staff training given • Low risk of harm
31866	30/10/2025	Disclosure of information in error by staff member. Impact on eighteen data subjects.	• Incident closed by ICO • Additional staff training given and reminding of Trust policy • Low risk of harm
39443	26/03/2026	Inappropriate access of data within a clinical system by staff member in non-compliance with trust policy – Impact on one data subject.	• Incident remains open with ICO who have requested further information. • Investigation ongoing

Data Protection Officer (DPO)

In accordance with UK GDPR Article 37, the trust has an appointed Data Protection Officer (DPO) who provides support, advice and assurance to the board in respect of obligations pursuant to legislation, monitors compliance and acts as a point of contact for data subjects and the supervisory authority (ICO).

Data Protection Assurance

Assurance continues to be provided to the board of Directors that systems and processes are being constantly assessed and improved to ensure that information is safe. In accordance with UK GDPR Article 37, we have an appointed Data Protection Officer (DPO) who provides support, advice and assurance to the board in respect of obligations pursuant to legislation, monitors compliance and acts as a point of contact for data subjects and the supervisory authority (ICO).

The Data Security and Protection Standards for health and care are set out in the National Data Guardian’s (NDG) ten standards and are measured though the completion of the Data Security Protection Toolkit (DSPT). All organisations that have access to NHS patient data and systems

must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

The DSPT is now aligned to the Cyber Assessment framework (CAF). The Cyber Assessment Framework provides a systematic and comprehensive approach to assessing the extent to which cyber and information governance risks to essential functions are being managed.

Assurance

The trust submitted its 2025 DSPT submission on the 30 June 2025. The trust has self-assessed compliance with all standards and all mandatory evidence items were evidenced, meeting all mandatory assertions; therefore, the trust scored as all 'Standards Met' for the DSPT.

The 2025 DSPT was also subject to external audit where 12 outcomes across the five objectives in the Cyber Assessment Framework were externally audited by AuditOne.

The trusts independent risk audit assessed the overall risk across all five objectives as Low and the confidence level of the Independent Assessor in the veracity of the self-assessment as High.

At the time of writing, the status of the 2026 DSPT is that the trust has provided baseline information on all outcomes. The trust is gathering evidence to support the final submission. The final submission date is 30 June 2026.

Assessment Outputs

	Overall risk assurance across all five CAF objectives	Confidence level of the Independent Assessor in the veracity of the self-assessment
Independent Assessment Outputs	Low	High

Data Quality and Governance

The quality reporting structure is fully embedded within the organisation with the quality dashboard and alternative sources of benchmarking data and assurance (North East Quality Observatory Service, NHS Digital and Healthcare Evaluation Data) are used to validate conclusions and recommendations. Internal controls are in place to ensure the accuracy of data and the reporting of measures of performance.

Mandatory training is provided to raise awareness of information governance and control with employees. Internal audits are undertaken.

Review of effectiveness

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

Trust Board

During 2025/26 there were five (5) changes to the Board of Directors:

Leavers included Ann Baxter, Non-executive Director and Vice Chair, Ada Burns, Non-executive Director, Chris Macklin, Non-executive Director, Alison Fellows, Non-executive Director and Elizabeth Barnes, Non-executive Director.

Emma Nunez was appointed as Chief Nursing Officer along with Christopher Day and Celia Weldon as Non-executive Directors.

The changes were approved by the Nomination Committees and endorsed by the Council of Governors and Remuneration Committee as appropriate.

The overarching governance framework for the trust is set out in detail in the Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. The Corporate Governance Structure, Board Committee Terms of Reference, Standing Orders and Standing Financial Instructions were reviewed during the year to ensure the governance framework reflects the organisation of the trust and maintains internal control.

The board has overall responsibility for determining the future direction of the trust and ensuring delivery of safe and effective services in accordance with legislation and principles of the NHS. The trust Board also ensures that the organisation complies with relevant regulatory standards.

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

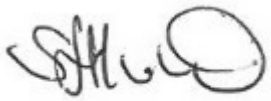
The Audit Committee reviews the work of the other committees within the trust once a year and will seek assurance from internal audit, external audit and counter fraud through the three lines of assurance model and using a range of external bodies and regulators.

In review the system of internal control the Audit Committee have recommended to the board that there are no significant weaknesses.

Conclusion

In conclusion, the trust had the following significant internal control issues in 2025/26.

Signed:



Stacey Hunter

Chief Executive and Accounting Officer

Date: 1 July 2026

Independent auditor's report to the Council of Governors of North Tees and Hartlepool NHS Foundation Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of North Tees and Hartlepool NHS Foundation Trust ('the Trust') and its subsidiaries ('the Group') for the year ended 31 March 2026 which comprise the Group and Trust Statements of Comprehensive Income, the Group and Trust Statements of Financial Position, the Group Consolidated Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026, the Trust Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026, the Group and Trust Statements 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 as interpreted and adapted by HM Treasury's Financial Reporting Manual 2025/26 as contained in the Department of Health and Social Care Group Accounting Manual 2025/26, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust and Group as at 31 March 2026 and of the Trust's and the Group's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the "Auditor's responsibilities for the audit of the financial statements" section of our report. We are independent of the Trust and Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's or the Group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2025/26 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust and Group to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

Based on our understanding of the Trust and Group, we did not identify any laws and regulations that have an indirect effect on the preparation of the financial statements where non-compliance might have a material effect on the financial statements.

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- gaining an understanding of the legal and regulatory framework applicable to the Trust and Group, the environment in which it operates, and the structure of the Trust and Group, and considering the risk of acts by the Trust and Group which were contrary to the applicable laws and regulations, including fraud;
- inquiring with management and the Audit Committee, as to whether the Trust and Group is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- inspecting correspondence, if any, with relevant licensing or regulatory authorities;
- reviewing minutes of meetings in the year;

- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust and Group which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

In addition, we evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, in particular in relation to accruals and provisions, revenue recognition (which we pinpointed to the cut-off assertion), expenditure recognition (which we pinpointed to the cut-off assertion) and significant one-off or unusual transactions.

Our audit procedures in relation to fraud included, but were not limited to:

- making enquiries of management, Internal Audit and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with both management and Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, (Revised 2024) and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in November 2024.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at **www.frc.org.uk/auditorsresponsibilities**. This description forms part of our auditor's report.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in this respect.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2025/26; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Council of Governors of North Tees and Hartlepool NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the NAO that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.

James Collins (Jul 1, 2026 11:14:07 GMT+1)

James Collins, Key Audit Partner
For and on behalf of Forvis Mazars LLP (Local Auditor)

The Corner

Bank Chambers
26 Mosley Street
Newcastle-upon-Tyne
NE1 1DF

01 July 2026

North Tees and Hartlepool NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

North Tees and Hartlepool NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by North Tees and Hartlepool NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……

Name **Stacey Hunter**
Job title **Chief Executive Officer**
Date **01 July 2026**

Consolidated Statement of Comprehensive Income

		Group		Foundation Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000		
Operating income from patient care activities	3	454,675	439,839	454,068	439,217
Other operating income	4	35,433	46,856	30,644	41,415
Operating expenses	7, 9	(501,811)	(481,205)	(498,655)	(475,934)
Operating (deficit) / surplus		**(11,703)**	**5,490**	**(13,943)**	**4,698**
Finance income	11	2,604	3,027	5,357	4,921
Finance expenses	12	(704)	(672)	(3,747)	(2,856)
PDC dividends payable		(2,687)	(2,400)	(2,687)	(2,400)
Net finance costs		**(787)**	**(45)**	**(1,077)**	**(335)**
Other gains	13	829	59	829	59
Corporation tax expense		(42)	(51)	0	0
(Deficit) / surplus for the year		**(11,703)**	**5,453**	**(14,191)**	**4,422**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	8	(1,466)	(10,564)	(1,466)	(10,564)
Revaluations	8, 19, 20.3	1,364	5,276	1,364	5,276
May be reclassified to income and expenditure when certain conditions are met:					
Fair value losses on financial assets mandated at fair value through OCI	21	(116)	(73)	0	0
Total comprehensive (expense) / income for the period		**(11,921)**	**92**	**(14,293)**	**(866)**

Statements of Financial Position

		Group		Foundation Trust	
		31 March 2026	31 March 2025	31 March 2026	31 March 2025
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	14, 15	2,873	1,737	2,868	1,732
Property, plant and equipment	16, 17	150,612	148,485	150,612	148,485
Right of use assets	20	16,271	19,458	16,271	19,458
Other investments / financial assets	21	1,356	1,472	0	0
Receivables	24	1,960	1,874	66,037	60,079
Total non-current assets		**173,072**	**173,026**	**235,788**	**229,754**
Current assets					
Inventories	23	6,701	7,024	6,182	6,467
Receivables	24	24,769	25,167	29,175	26,543
Cash and cash equivalents	25	59,081	59,108	53,678	55,292
Total current assets		**90,551**	**91,299**	**89,035**	**88,302**
Current liabilities					
Trade and other payables	26	(65,518)	(65,486)	(66,556)	(61,340)
Borrowings	28	(4,421)	(5,684)	(4,421)	(5,684)
Provisions	30	(1,988)	(2,614)	(1,889)	(2,462)
Other liabilities	27	(5,098)	(6,619)	(4,807)	(6,554)
Total current liabilities		**(77,025)**	**(80,403)**	**(77,673)**	**(76,040)**
Total assets less current liabilities		**186,598**	**183,922**	**247,150**	**242,016**
Non-current liabilities					
Borrowings	28	(28,723)	(32,897)	(28,723)	(32,897)
Other financial liabilities	29	0	0	(66,791)	(63,574)
Provisions	30	(1,405)	(1,601)	(1,405)	(1,662)
Total non-current liabilities		**(30,128)**	**(34,498)**	**(96,919)**	**(98,133)**
Total assets employed		**156,470**	**149,424**	**150,231**	**143,883**
Financed by					
Public dividend capital		215,015	196,048	215,015	196,048
Revaluation reserve		12,835	12,937	12,835	12,937
Income and expenditure reserve		(73,787)	(62,385)	(77,619)	(65,102)
Charitable fund reserves	22	2,407	2,824	0	0
Total taxpayers' equity		**156,470**	**149,424**	**150,231**	**143,883**

The notes on pages 8 to 52 form part of these accounts.

Name **Stacey Hunter**
Position **Chief Executive Officer**
Date **01 July 2026**

Consolidated Statement of Changes in Taxpayers Equity for the year ended 31 March 2026

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**196,048**	**12,937**	**(62,385)**	**2,824**	**149,424**
Deficit for the year	0	0	(11,402)	(301)	**(11,703)**
Impairments	0	(1,466)	0	0	**(1,466)**
Revaluations	0	1,364	0	0	**1,364**
Fair value losses on financial assets mandated at fair value through OCI	0	0	0	(116)	**(116)**
Public dividend capital received	18,967	0	0	0	**18,967**
Taxpayers' and others' equity at 31 March 2026	**215,015**	**12,835**	**(73,787)**	**2,407**	**156,470**

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

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**186,081**	**18,225**	**(68,211)**	**3,270**	**139,365**
Surplus/(deficit) for the year	0	0	5,826	(373)	**5,453**
Impairments	0	(10,564)	0	0	**(10,564)**
Revaluations	0	5,276	0	0	**5,276**
Fair value losses on financial assets mandated at fair value through OCI	0	0	0	(73)	**(73)**
Public dividend capital received	9,967	0	0	0	**9,967**
Taxpayers' and others' equity at 31 March 2025	**196,048**	**12,937**	**(62,385)**	**2,824**	**149,424**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2026

Foundation Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**196,048**	**12,937**	**(65,102)**	**143,883**
Deficit for the year	0	0	(14,190)	**(14,190)**
Impairments	0	(1,466)	0	**(1,466)**
Revaluations	0	1,364	0	**1,364**
Public dividend capital received	18,967	0	0	**18,967**
Other reserve movements	0	0	1,673	**1,673**
Taxpayers' and others' equity at 31 March 2026	**215,015**	**12,835**	**(77,619)**	**150,231**

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

Foundation Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**186,081**	**18,225**	**(72,692)**	**131,614**
Surplus for the year	0	0	4,421	**4,421**
Impairments	0	(10,564)	0	**(10,564)**
Revaluations	0	5,276	0	**5,276**
Public dividend capital received	9,967	0	0	**9,967**
Other reserve movements	0	0	3,169	**3,169**
Taxpayers' and others' equity at 31 March 2025	**196,048**	**12,937**	**(65,102)**	**143,883**

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.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 22.

Statements of Cash Flows

		Group		Foundation Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating (Deficit) / surplus		(11,703)	5,490	(13,941)	4,698
Non-cash income and expense:					
Depreciation and amortisation	7.1	17,680	18,297	17,679	18,295
Net impairments	8	14,623	5,644	14,623	5,644
Income recognised in respect of capital donations	4	(534)	(12,186)	(534)	(12,186)
Decrease / (increase) in receivables and other assets		817	(1,416)	(8,073)	(33,794)
Decrease / (increase) in inventories		323	(398)	285	(322)
(Decrease) / increase in payables and other liabilities		(2,845)	(2,159)	5,212	31,218
Decrease in provisions		(842)	(4,334)	(850)	(4,348)
Movements in charitable fund working capital		(108)	16	0	0
Tax paid		(42)	(51)	0	0
Other movements in operating cash flows		(307)	65	1,365	3,230
Net cash flows from operating activities		**17,062**	**8,968**	**15,766**	**12,435**
Cash flows from investing activities					
Interest received		2,510	2,948	5,357	4,921
Purchase of intangible assets		(1,850)	(897)	(1,850)	(897)
Purchase of PPE		(29,019)	(39,420)	(29,019)	(39,420)
Sales of PPE		21	78	21	78
Receipt of cash donations to purchase assets		841	12,079	841	12,079
Net cash flows from charitable fund investing activities		94	79	0	0
Net cash flows used in investing activities		**(27,403)**	**(25,133)**	**(24,650)**	**(23,239)**
Cash flows from financing activities					
Public dividend capital received		18,967	9,967	18,967	9,967
Movement on loans from DHSC		(1,088)	(1,088)	(1,088)	(1,088)
Capital element of lease liability repayments		(3,543)	(3,066)	(3,543)	(3,066)
Interest on loans		(427)	(453)	(3,471)	(2,637)
Interest paid on lease liability repayments		(267)	(207)	(267)	(207)
PDC dividend paid		(3,328)	(1,880)	(3,328)	(1,880)
Net cash flows from financing activities		**10,314**	**3,273**	**7,270**	**1,089**
Decrease in cash and cash equivalents		**(27)**	**(12,892)**	**(1,614)**	**(9,715)**
Cash and cash equivalents at 1 April - brought forward		**59,108**	**72,000**	**55,292**	**65,007**
Cash and cash equivalents at 31 March	25.1	**59,081**	**59,108**	**53,678**	**55,292**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the accounts 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 accounts have been prepared in accordance with the GAM 2025/26 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. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation

Subsidiaries

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

NHS Charitable Funds

The trust is the corporate trustee to North Tees and Hartlepool NHS Foundation Trust General Charitable Fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Optimus Health Limited and North Tees and Hartlepool Solutions Limited Liability Partnership

The amounts consolidated are drawn from the draft accounts of the subsidiaries for the year to 31 March 2026 for Optimus Health Limited and North Tees and Hartlepool Solutions Limited Liability Partnership (LLP). The trust is 95% shareholder of the LLP and Northumbria Healthcare Facilities Management Limited was 5% shareholder up to 30th March 2026.The 5% shareholding transferred to South Tees Hospitals NHS Foundation Trust on 31st March 2026.

Note 1.4 Revenue from contracts with customers

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

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

Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The main source of income for the trust is contracts with commissioners for health care services. 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). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. 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. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs 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.

The trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

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. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to Integrated Care Boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements 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.

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 grant 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.

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 accounts 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 schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of The Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust 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 scheme 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.

NEST Pension Scheme
The trust (and its subsidiaries, North Tees and Hartlepool Solutions LLP and Optimus Health Limited) offers the National Employment Savings Trust (NEST) to employees. This is a defined contribution pension scheme.

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 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 a cost of at least £5,000; or
• collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

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

Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to

acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. 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 buildings, where the construction is completed by the trust's subsidiary - North Tees and Hartlepool Solutions LLP and the costs have recoverable VAT for the trust.

The trust has a contract with Cushman and Wakefield for production of the MEA valuation. The name of the surveyor is Jim Stevenson, Associate, Registered Valuer, BSc (Hons) MRICS. Cushman and Wakefield also produced the MEA valuation for 2024/25 financial year.

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

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

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

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

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

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

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

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

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

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

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

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

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

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

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

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
Land	-	-
Buildings, excluding dwellings	15	88
Dwellings	56	77
Plant & machinery	2	25
Transport equipment	5	15
Information technology	2	10
Furniture & fittings	5	12

Land has an infinite life.

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

Note 1.9 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.

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

Software

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

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

Impairments
Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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	7
Licences & trademarks	10	10

Note 1.10 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.

Note 1.11 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.

Note 1.12 Financial assets and financial liabilities

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

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

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through 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 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 as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

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

The trust has irrevocably elected to measure all charitable funds assets at fair value through other comprehensive income.

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 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 all Non NHS debtors:
- 100% expected credit losses is assumed on all invoices over 9 months old;
- 90% expected credit losses is assumed on all invoices between 6 months and 9 months;
- 75% expected credit losses is assumed on all invoices between 3 months and 6 months;
- 50% expected credit losses is assumed on all invoices between 1 month and 3 months; and
- 0% expected credit losses is assumed on all invoices between 0 months and 1 month.

For overseas visitors and for BUPA invoices 100% expected credit losses has been assumed on all outstanding invoices. The BUPA debtor balance relates to invoices over 12 months old and all of these invoices are in dispute.

For NHS, expected credit losses have been assumed on specific disputed invoices and where no agreement for receipt has been received via the agreement of balances exercise, the trust has applied the same percentage credit loss as with Non NHS debtors, based on the age of the outstanding debt.

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 1.13 Leases
A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. As mandated by the DHSC GAM 2025/26, the trust does not apply lease accounting to new contracts for the use of intangible assets.

The trust determines the term of the lease 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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

The trust has vehicle leases which do not qualify as low value, but are immaterial to the trust. Following the requirements of IAS 1 Presentation of Financial Statements, the trust has not applied IFRS 16 to those immaterial leases (regardless of those leases failing to qualify as leases of low-value underlying assets).

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 1.14 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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

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 30.3 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 1.15 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 1.16 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 1.17 Corporation tax
Foundation Trusts are exempt from corporation tax on their principal healthcare income streams under section 519A Income and Corporation Taxes Act 1988. In determining whether other income may be taxable, a three-stage test must be employed which asks whether the activity is an authorised activity related to the provision of core healthcare, whether the activity is actually or potentially in competition with the private sector, and whether the annual profits of the activity are in excess of £50k per trading activity. The trust has assessed its car parking and catering income against this criteria and does not have any corporation tax liability in the current or prior year.

Optimus Health Limited has carried out its own tax computation and corporation tax is payable on its trading year of £42k (2024/25 £51k). The trust has assessed that no tax liability arises from North Tees and Hartlepool Solutions LLP.

Note 1.18 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 1.19 Foreign exchange
The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
- monetary items are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

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 2025/26.

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 to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

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. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the accounts.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE assets currently subject to revaluation have a total book value of £98.635m at 31 March 2026 (£97.959m at 31 March 2025).

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the trust and its valuers currently adopt an 'alternative site' assumption for the majority of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £74.236m at 31 March 2026 (£75.260m at 31 March 2025). The impact could be material for the trust but cannot be currently quantified.

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 accounts:

a) The trust's land and buildings non-current assets are valued by Cushman and Wakefield on an annual basis. The trust changed valuer in 2024/25, in line with University Hospital Tees Group. A full valuation exercise and physical inspection was carried out in 2024/25 and a desktop exercise in 2025/26. The trust commissions a full physical valuation of all land and buildings every five years and in other years, a table exercise is carried out and only areas of significant capital spend in year will be physically inspected. The remaining life applied to land and building assets is provided by Cushman and Wakefield but in the financial year 2021/22, a detailed structural survey was commissioned by the trust and the report produced by Faithful and Gould Limited, indicated that the majority of the buildings on the North Tees site have a maximum remaining life of 10 years. This detailed report has been reviewed by Cushman and Wakefield and the valuation report has been amended accordingly. The majority of the buildings on the North Tees site now have a maximum life of 5 years at the end of March 2026.

b) The inclusion of the three trust subsidiaries in the consolidated accounts is a critical judgement. Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

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:

a) The useful economic life (UEL) of each category of fixed asset is assessed when acquired by the trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets. The average UEL for tangible fixed assets is 8 years (2024/25: 10 years) and annual depreciation is £13.681m (2024/25: £14.153m), therefore on average if all assets were to increase or decrease by 1 year in UEL, the impact would be £1.7m per annum (2024/25: £1.3m) in depreciation.

b) When arriving at the valuation for property, trust management engages a qualified surveyor to assist them in forming estimates. The value of land and buildings for the trust is £98.635m (2024/25: £97.959m) and a 1% change in value would equate to £0.986m (2024/25: £0.980m).

c) For right of use assets, the trust determines the term of the lease with reference to the non-cancellable period and any options to extend or terminate the lease which the trust is reasonably certain to exercise. Where there is no lease agreement in place, the trust has formed a judgement on the length of the lease and therefore the lease liability. This applies to 7 property leases at 31 March 2026 with a NBV of £0.183m (At 31 March 2025, 10 leases with a NBV £0.364m) and total liability of £0.153m (At 31 March 2025 £0.417m). All 7 of these leases have been deemed to have a lease term of 5 years and are all due to be renewed in March 2027.

Note 2 Operating Segments

The Board of Directors act as the Chief Operating Decision Maker for the trust and the monthly financial position of the trust is presented/reported to them as a single segment. The trust conducts the majority of its business with Health Bodies in England. Transactions with entities in Scotland, Ireland and Wales are conducted in the same manner as those within England. Organisations which contribute 5% or more of the trust's income in either year are set out in the table below. Further information can be found in note 36, Related Party Transactions.

	2025/26	2024/25
NHS North East and North Cumbria ICB	82%	80%
North East and Yorkshire Regional Office (incl NHSE NEC Hub)	5%	6%

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)	**2025/26 £000**	**2024/25 £000**
Acute services		
Income from commissioners under API contracts - variable element*	75,196	66,941
Income from commissioners under API contracts - fixed element*	294,154	285,385
High cost drugs income from commissioners	20,189	20,326
Other NHS clinical income	864	874
Community services		
Income from commissioners under API contracts*	40,696	45,766
Income from other sources (e.g. local authorities)	3,655	850
All services		
Private patient income	163	96
National pay award central funding***	0	854
Additional pension contribution central funding**	16,871	16,100
Other clinical income	2,887	2,647
Total income from activities	**454,675**	**439,839**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

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

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2025/26 £000**	**2024/25 £000**
NHS England	52,938	49,607
Integrated care boards	395,032	386,640
Local authorities	3,655	850
Non-NHS: private patients	163	96
Non-NHS: overseas patients (chargeable to patient)	122	115
Injury cost recovery scheme	951	790
Non NHS: other	1,814	1,741
Total income from activities	**454,675**	**439,839**

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

	2025/26	2024/25
	£000	£000
Income recognised this year	122	115
Cash payments received in-year	38	61
Amounts added to provision for impairment of receivables	86	59
Amounts written off in-year	0	0

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,576	0	**1,576**	1,487	0	**1,487**
Education and training	17,316	0	**17,316**	16,707	0	**16,707**
Non-patient care services to other bodies	8,253		**8,253**	8,434		**8,434**
Receipt of capital grants and donations and peppercorn leases		534	**534**		12,186	**12,186**
Revenue from operating leases		724	**724**		549	**549**
Charitable fund incoming resources		242	**242**		559	**559**
Other income	6,788	0	**6,788**	6,934	0	**6,934**
Total other operating income	**33,933**	**1,500**	**35,433**	**33,562**	**13,294**	**46,856**

Other income includes: LLP sales £1.600m (2024/25 £1.853m); car parking £2.129m (2024/25 £1.939m); catering income £1.178m (2024/25 £1.176m); lease cars £0.920m (2024/25 £0.859m); quality control labs £0.219m (2024/25 £0.219m); and the remainder is made up of miscellaneous other revenue streams.

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	4,838	3,025
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0	0

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2026 £000	31 March 2025 £000
within one year	5,098	6,619
after one year, not later than five years	0	0
after five years	0	0
Total revenue allocated to remaining performance obligations	**5,098**	**6,619**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26 £000	2024/25 £000
Income from services designated as commissioner requested services	430,235	418,418
Income from services not designated as commissioner requested services	59,631	67,718
Total	**489,866**	**486,136**

Note 5.4 Fees and charges (Group)

HM Treasury requires disclosure of fees and charges income. The trust does not receive income from charges to service users where income from that service exceeds £1m.

Note 6 Operating leases - North Tees and Hartlepool NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where the trust is the lessor. The income relates to rental income for the trusts buildings. There are no risks arising from the arrangements that impact on the trust.

Note 6.1 Operating leases income (Group)

	2025/26 £000	2024/25 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	724	549
Total in-year operating lease income	**724**	**549**

Note 6.2 Future lease receipts (Group)

	31 March 2026 £000	31 March 2025 £000
Future minimum lease receipts due in:		
- not later than one year	755	567
- later than one year and not later than two years	387	243
- later than two years and not later than three years	327	232
- later than three years and not later than four years	317	170
- later than four years and not later than five years	317	160
- later than five years	2,635	2,048
Total	**4,738**	**3,420**

Note 7 Operating expenses

Note 7.1 Operating expenses (Group)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	7,576	11,899
Purchase of healthcare from non-NHS and non-DHSC bodies	3,396	5,426
Staff and executive directors costs	342,726	327,877
Remuneration of non-executive directors	148	156
Supplies and services - clinical (excluding drugs costs)	38,100	32,496
Supplies and services - general	6,325	7,240
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	31,457	30,436
Inventories written down	114	206
Consultancy costs	87	675
Establishment	4,553	4,966
Premises	17,352	19,855
Transport (including patient travel)	610	780
Depreciation on property, plant and equipment	16,954	17,835
Amortisation on intangible assets	726	462
Net impairments	14,623	5,644
Movement in credit loss allowance: contract receivables / contract assets	1,323	871
Decrease in other provisions	(541)	(1,447)
Change in provisions discount rate(s)	(31)	3
Fees payable to the external auditor		
audit services- statutory audit	220	209
Internal audit costs	257	256
Clinical negligence	12,845	11,458
Legal fees	282	468
Insurance (as a policy holder)	501	458
Research and development	36	22
Education and training	832	1,564
Expenditure on low value leases	710	470
Redundancy	225	162
Car parking & security	(2)	36
Hospitality	0	37
Losses, ex gratia & special payments	8	10
Other NHS charitable fund resources expended	399	675
Total	**501,811**	**481,205**

External audit fees include the group fee from Forvis Mazars and the charity and subsidiary fees from Robson Laidler. This value is exclusive of VAT.

Note 7.2 Limitation on auditor's liability (Group)
The limitation on auditor's liability for external audit work is unlimited (2024/25: £1,000k).

Note 8 Impairment of assets (Group)

	2025/26 £000	2024/25 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	14,623	5,644
Total net impairments charged to operating surplus / deficit	**14,623**	**5,644**
Impairments charged to the revaluation reserve	1,466	10,564
Total net impairments	**16,089**	**16,208**

Changes in market price of £14.6m (2024/25 £5.6m) relate to the MEA valuation and IFRS16 peppercorn leases valuation as at 31 March 2026 and corresponding decreases in individual building valuations. The revaluation reserve has decreased by £0.1m (2024/25 £5.3m decrease) also, so an overall reduction in value of £14.7m (2024/25 £10.9m reduction).

The main reason for the impairment and revaluation reduction is as a result of the combination of build cost increase (circa 1.6% once national tender price index and regional factor are combined) and the larger decreasing effect of the buildings being 1 year older. Also for Peterlee and the Community Diagnostic Hub, there is a small build cost increase and a larger impact from the buildings being 1 year older. This is offset by increases in non-specialist assets due to new assets purchased in 2025/26 and RAAC (reinforced autoclaved aerated concrete) work. The value at Hartlepool is also reduced by part of the decarbonisation project work being operational at the end of March 2026.

The trust's valuer is Cushman and Wakefield. The MEA valuation has reduced for the reasons described and the remaining life applied to the buildings is broadly consistent with previous years valuations. A detailed structural survey report produced by Faithful and Gould Limited at the start of 2021/22, indicated that the majority of the buildings on the North Tees site have a maximum remaining life of 10 years. This detailed report has been reviewed by Cushman and Wakefield and the MEA report has been amended accordingly. At 31 March 2026, the remaining life on the majority of the buildings on the North Tees site is now 5 years.

Note 9 Employee benefits (Group)

Note 9.1 Employee benefits (Group)

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	256,409	248,114
Social security costs	28,862	22,345
Apprenticeship levy	1,153	1,027
Employer's contributions to NHS pensions	42,663	40,754
Pension cost - other	316	358
Temporary staff (including agency)	14,956	16,189
NHS charitable funds staff	230	327
Total gross staff costs	**344,589**	**329,114**
Recoveries in respect of seconded staff	(1,176)	(1,237)
Total staff costs	**343,413**	**327,877**
Of which		
Costs capitalised as part of assets	687	0

Note 9.2 Retirements due to ill-health (Group)
During 2025/26 there were 7 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £322k (£71k in 2024/25).

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

Note 9.3 Directors' remuneration (Group)

The aggregate amounts payable to directors were:

	Group	
	2025/26	**2024/25**
	£000	**£000**
Salary	874	2,053
Taxable benefits	5	15
Other remuneration	0	0
Employer's pension contributions	181	303
Total	**1,060**	**2,371**

Further details of directors' remuneration can be found in the remuneration report.

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 accounts do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 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.

Expected contributions for financial year 2026/27 are £43,543k.

Note 11 Finance income (Group)

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	2,510	2,948
NHS charitable fund investment income	94	79
Total finance income	**2,604**	**3,027**

Note 12 Finance expenditure (Group)

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	417	445
Interest on lease obligations	267	207
Total interest expense	**684**	**652**
Unwinding of discount on provisions	20	20
Total finance costs	**704**	**672**

Note 13 Other gains / (losses) (Group)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	843	59
Losses on disposal of assets	(14)	0
Total other gains / (losses)	**829**	**59**

The main gain on disposal is due to termination of a ROU lease, resulting in a gain of £831k. There are other smaller gains on termination of ROU leases and the loss on disposal is as a result of plant and equipment assets. These items had a NBV of £35k when disposed and the trust received sale proceeds of £21k resulting in a net loss of £14k.

Note 14 Intangible assets (Group)

Note 14.1 Intangible assets - 2025/26

Group	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2025 *	**2,427**	**8**	**0**	**2,435**
Additions	(15)	0	1,865	**1,850**
Disposals / derecognition	(197)	0	0	**(197)**
Cost at 31 March 2026	**2,215**	**8**	**1,865**	**4,088**
Amortisation at 1 April 2025	**695**	**3**	**0**	**698**
Provided during the year	726	0	0	**726**
Reclassifications	(12)	0	0	**(12)**
Disposals / derecognition	(197)	0	0	**(197)**
Amortisation at 31 March 2026	**1,212**	**3**	**0**	**1,215**
Net book value at 31 March 2026	**1,003**	**5**	**1,865**	**2,873**
Net book value at 1 April 2025	**1,732**	**5**	**0**	**1,737**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Assets previously revalued are now carried forward at "deemed historic cost as an appropriate proxy for valuation".

Note 14.2 Intangible assets with zero net book value - 2025/26

Group	Software licences	Licences & trademarks	Intangible assets under construction	Total
Gross carrying amount of assets fully written down	123	0	0	123
	123	**0**	**0**	**123**

Note 14.3 Intangible assets - 2024/25

Group	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024	**1,437**	**8**	**0**	**1,445**
Additions	897	0	0	**897**
Reclassifications	93	0	0	**93**
Valuation / gross cost at 31 March 2025	**2,427**	**8**	**0**	**2,435**
Amortisation at 1 April 2024	**234**	**2**	**0**	**236**
Provided during the year	461	1	0	**462**
Amortisation at 31 March 2025	**695**	**3**	**0**	**698**
Net book value at 31 March 2025	**1,732**	**5**	**0**	**1,737**
Net book value at 1 April 2024	**1,203**	**6**	**0**	**1,209**

Note 14.4 Intangible assets with zero net book value - 2024/25

Group	Software licences	Licences & trademarks	Intangible assets under construction	Total
Gross carrying amount of assets fully written down	10	0	0	10
	10	**0**	**0**	**10**

Note 15 Intangible assets (Foundation Trust)

Note 15.1 Intangible assets - 2025/26

Foundation Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Cost at 1 April 2025 *	**2,427**	**0**	**2,427**
Additions	(15)	1,865	**1,850**
Disposals / derecognition	(197)	0	**(197)**
Cost at 31 March 2026	**2,215**	**1,865**	**4,080**
Amortisation at 1 April 2025	**695**	**0**	**695**
Provided during the year	726	0	**726**
Reclassifications	(12)	0	**(12)**
Disposals / derecognition	(197)	0	**(197)**
Amortisation at 31 March 2026	**1,212**	**0**	**1,212**
Net book value at 31 March 2026	**1,003**	**1,865**	**2,868**
Net book value at 1 April 2025	**1,732**	**0**	**1,732**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Assets previously revalued are now carried forward at "deemed historic cost as an appropriate proxy for valuation".

Note 15.2 Intangible assets with zero net book value - 2025/26

Foundation Trust	Software licences	Intangible assets under construction	Total
Gross carrying amount of assets fully written down	123	0	**123**
	123	**0**	**123**

Note 15.3 Intangible assets - 2024/25

Foundation Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024	**1,437**	**0**	**1,437**
Additions	897	0	**897**
Reclassifications	93	0	**93**
Valuation / gross cost at 31 March 2025	**2,427**	**0**	**2,427**
Amortisation at 1 April 2024	**234**	**0**	**234**
Provided during the year	461	0	**461**
Amortisation at 31 March 2025	**695**	**0**	**695**
Net book value at 31 March 2025	**1,732**	**0**	**1,732**
Net book value at 1 April 2024	**1,203**	**0**	**1,203**

Note 15.4 Intangible assets with zero net book value - 2024/25

Foundation Trust	Software licences	Intangible assets under construction	Total
Gross carrying amount of assets fully written down	10	0	**10**
	10	**0**	**10**

Note 16 Property, plant and equipment (Group)

Note 16.1 Property, plant and equipment - 2025/26

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025	**3,320**	**94,639**	**0**	**14,653**	**57,049**	**659**	**34,605**	**3,057**	**207,982**
Additions	418	15,679	1,023	270	8,031	0	5,136	62	**30,619**
Impairments	(30)	(20,534)	(45)	0	0	0	0	0	**(20,609)**
Reversals of impairments	2	265	0	0	0	0	0	0	**267**
Revaluations	230	(943)	0	0	0	0	0	0	**(713)**
Reclassifications	(1)	4,612	0	(3,861)	(687)	0	(72)	(4)	**(13)**
Disposals / derecognition	0	0	0	0	(5,679)	(14)	(6,192)	0	**(11,885)**
Valuation/gross cost at 31 March 2026	**3,939**	**93,718**	**978**	**11,062**	**58,714**	**645**	**33,477**	**3,115**	**205,648**
Accumulated depreciation at 1 April 2025	**0**	**0**	**0**	**0**	**32,173**	**637**	**25,353**	**1,334**	**59,497**
Provided during the year	0	5,521	1	0	5,361	6	2,448	344	**13,681**
Impairments	0	(3,463)	(1)	0	0	0	0	0	**(3,464)**
Reversals of impairments	0	(750)	0	0	0	0	0	0	**(750)**
Revaluations	0	(2,077)	0	0	0	0	0	0	**(2,077)**
Reclassifications	0	769	0	0	(771)	0	0	1	**(1)**
Disposals / derecognition	0	0	0	0	(5,644)	(14)	(6,192)	0	**(11,850)**
Accumulated depreciation at 31 March 2026	**0**	**0**	**0**	**0**	**31,119**	**629**	**21,609**	**1,679**	**55,036**
Net book value at 31 March 2026	**3,939**	**93,718**	**978**	**11,062**	**27,595**	**16**	**11,868**	**1,436**	**150,612**
Net book value at 1 April 2025	**3,320**	**94,639**	**0**	**14,653**	**24,876**	**22**	**9,252**	**1,723**	**148,485**

Note 16.2 Property, plant and equipment with zero net book value - 2025/26

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
Gross carrying amount of assets fully written down									
	0	0	0	0	14,572	605	16,388	301	31,866
Total	**0**	**0**	**0**	**0**	**14,572**	**605**	**16,388**	**301**	**31,866**

Note 16.3 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024	**7,760**	**75,356**	**115**	**15,267**	**54,303**	**680**	**31,937**	**2,834**	**188,252**
Additions	0	8,319	0	22,463	5,109	0	2,761	222	**38,874**
Impairments	(4,443)	(29,241)	(171)	0	0	0	0	0	**(33,855)**
Reversals of impairments	0	12,966	0	0	0	0	0	0	**12,966**
Revaluations	0	4,227	0	0	0	0	0	0	**4,227**
Reclassifications	3	23,012	56	(23,077)	5	0	(93)	1	**(93)**
Disposals / derecognition	0	0	0	0	(2,368)	(21)	0	0	**(2,389)**
Valuation/gross cost at 31 March 2025	**3,320**	**94,639**	**0**	**14,653**	**57,049**	**659**	**34,605**	**3,057**	**207,982**
Accumulated depreciation at 1 April 2024	**0**	**0**	**0**	**0**	**29,192**	**640**	**22,906**	**1,000**	**53,738**
Provided during the year	0	6,019	5	0	5,330	17	2,448	334	**14,153**
Impairments	0	(3,604)	(5)	0	0	0	0	0	**(3,609)**
Reversals of impairments	0	(1,366)	0	0	0	0	0	0	**(1,366)**
Revaluations	0	(1,049)	0	0	0	0	0	0	**(1,049)**
Reclassifications	0	0	0	0	0	1	(1)	0	**0**
Disposals / derecognition	0	0	0	0	(2,349)	(21)	0	0	**(2,370)**
Accumulated depreciation at 31 March 2025	**0**	**0**	**0**	**0**	**32,173**	**637**	**25,353**	**1,334**	**59,497**
Net book value at 31 March 2025	**3,320**	**94,639**	**0**	**14,653**	**24,876**	**22**	**9,252**	**1,723**	**148,485**
Net book value at 1 April 2024	**7,760**	**75,356**	**115**	**15,267**	**25,111**	**40**	**9,031**	**1,834**	**134,514**

Note 16.4 Property, plant and equipment with zero net book value - 2024/25

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
Gross carrying amount of assets fully written down	**0**	**0**	**0**	**0**	**11,998**	**530**	**14,635**	**125**	**27,288**
Total	**0**	**0**	**0**	**0**	**11,998**	**530**	**14,635**	**125**	**27,288**

Note 16.4 Property, plant and equipment financing - 31 March 2026

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	3,939	92,830	978	658	25,739	16	11,682	1,363	**137,205**
Owned - donated/granted	0	888	0	10,404	1,856	0	186	73	**13,407**
NBV total at 31 March 2026	**3,939**	**93,718**	**978**	**11,062**	**27,595**	**16**	**11,868**	**1,436**	**150,612**

Note 16.5 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	3,320	93,743	0	1,008	23,422	22	8,999	1,624	**132,138**
Owned - donated/granted	0	896	0	13,645	1,454	0	253	99	**16,347**
NBV total at 31 March 2025	**3,320**	**94,639**	**0**	**14,653**	**24,876**	**22**	**9,252**	**1,723**	**148,485**

Note 16.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	1,707	3,031	0	0	0	0	0	0	**4,738**
Not subject to an operating lease	2,232	90,687	978	11,062	27,595	16	11,868	1,436	**145,874**
NBV total at 31 March 2026	**3,939**	**93,718**	**978**	**11,062**	**27,595**	**16**	**11,868**	**1,436**	**150,612**

Note 16.7 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	1,758	1,662	0	0	0	0	0	0	**3,420**
Not subject to an operating lease	1,562	92,977	0	14,653	24,876	22	9,252	1,723	**145,065**
NBV total at 31 March 2025	**3,320**	**94,639**	**0**	**14,653**	**24,876**	**22**	**9,252**	**1,723**	**148,485**

Note 17 Property, plant and equipment (Foundation Trust)

Note 17.1 Property, plant and equipment - 2025/26

Foundation Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025	**3,320**	**94,639**	**0**	**14,653**	**57,038**	**659**	**34,605**	**3,057**	**207,971**
Additions	418	15,679	1,023	270	8,031	0	5,136	62	**30,619**
Impairments	(30)	(20,534)	(45)	0	0	0	0	0	**(20,609)**
Reversals of impairments	2	265	0	0	0	0	0	0	**267**
Revaluations	230	(943)	0	0	0	0	0	0	**(713)**
Reclassifications	(1)	4,612	0	(3,861)	(687)	0	(72)	(4)	**(13)**
Disposals / derecognition	0	0	0	0	(5,679)	(14)	(6,192)	0	**(11,885)**
Valuation/gross cost at 31 March 2026	**3,939**	**93,718**	**978**	**11,062**	**58,703**	**645**	**33,477**	**3,115**	**205,637**
Accumulated depreciation at 1 April 2025	**0**	**0**	**0**	**0**	**32,162**	**637**	**25,353**	**1,334**	**59,486**
Provided during the year	0	5,521	1	0	5,361	6	2,448	344	**13,681**
Impairments	0	(3,463)	(1)	0	0	0	0	0	**(3,464)**
Reversals of impairments	0	(750)	0	0	0	0	0	0	**(750)**
Revaluations	0	(2,077)	0	0	0	0	0	0	**(2,077)**
Reclassifications	0	769	0	0	(771)	0	0	1	**(1)**
Disposals / derecognition	0	0	0	0	(5,644)	(14)	(6,192)	0	**(11,850)**
Accumulated depreciation at 31 March 2026	**0**	**0**	**0**	**0**	**31,108**	**629**	**21,609**	**1,679**	**55,025**
Net book value at 31 March 2026	**3,939**	**93,718**	**978**	**11,062**	**27,595**	**16**	**11,868**	**1,436**	**150,612**
Net book value at 1 April 2025	**3,320**	**94,639**	**0**	**14,653**	**24,876**	**22**	**9,252**	**1,723**	**148,485**

Note 17.2 Property, plant and equipment with zero net book value - 2025/26

Foundation Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
Gross carrying amount of assets fully written down	0	0	0	0	14,572	605	16,388	301	**31,866**
Total	**0**	**0**	**0**	**0**	**14,572**	**605**	**16,388**	**301**	**31,866**

Note 17.3 Property, plant and equipment - 2024/25

Foundation Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024	**7,760**	**75,356**	**115**	**15,267**	**54,292**	**680**	**31,937**	**2,834**	**188,241**
Additions	0	8,319	0	22,463	5,109	0	2,761	222	**38,874**
Impairments	(4,443)	(29,241)	(171)	0	0	0	0	0	**(33,855)**
Reversals of impairments	0	12,966	0	0	0	0	0	0	**12,966**
Revaluations	0	4,227	0	0	0	0	0	0	**4,227**
Reclassifications	3	23,012	56	(23,077)	5	0	(93)	1	**(93)**
Disposals / derecognition	0	0	0	0	(2,368)	(21)	0	0	**(2,389)**
Valuation/gross cost at 31 March 2025	**3,320**	**94,639**	**0**	**14,653**	**57,038**	**659**	**34,605**	**3,057**	**207,971**
Accumulated depreciation at 1 April 2024	**0**	**0**	**0**	**0**	**29,182**	**640**	**22,906**	**1,000**	**53,728**
Provided during the year	0	6,019	5	0	5,329	17	2,448	334	**14,152**
Impairments	0	(3,604)	(5)	0	0	0	0	0	**(3,609)**
Reversals of impairments	0	(1,366)	0	0	0	0	0	0	**(1,366)**
Revaluations	0	(1,049)	0	0	0	0	0	0	**(1,049)**
Reclassifications	0	0	0	0	0	1	(1)	0	**0**
Disposals / derecognition	0	0	0	0	(2,349)	(21)	0	0	**(2,370)**
Accumulated depreciation at 31 March 2025	**0**	**0**	**0**	**0**	**32,162**	**637**	**25,353**	**1,334**	**59,486**
Net book value at 31 March 2025	**3,320**	**94,639**	**0**	**14,653**	**24,876**	**22**	**9,252**	**1,723**	**148,485**
Net book value at 1 April 2024	**7,760**	**75,356**	**115**	**15,267**	**25,110**	**40**	**9,031**	**1,834**	**134,513**

Note 17.4 Property, plant and equipment with zero net book value - 2024/25

Foundation Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
Gross carrying amount of assets fully written down	0	0	0	0	11,998	530	14,635	125	**27,288**
Total	**0**	**0**	**0**	**0**	**11,998**	**530**	**14,635**	**125**	**27,288**

Note 17.5 Property, plant and equipment financing - 31 March 2026

Foundation Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	3,939	92,830	978	658	25,739	16	11,682	1,363	**137,205**
Owned - donated / granted	0	888	0	10,404	1,856	0	186	73	**13,407**
Total net book value at 31 March 2026	**3,939**	**93,718**	**978**	**11,062**	**27,595**	**16**	**11,868**	**1,436**	**150,612**

Note 17.6 Property, plant and equipment financing - 31 March 2025

Foundation Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	3,320	93,743	0	1,008	23,422	22	8,999	1,624	**132,138**
Owned - donated / granted	0	896	0	13,645	1,454	0	253	99	**16,347**
Total net book value at 31 March 2025	**3,320**	**94,639**	**0**	**14,653**	**24,876**	**22**	**9,252**	**1,723**	**148,485**

Note 17.7 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Foundation Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	1,707	3,031	0	0	0	0	0	0	**4,738**
Not subject to an operating lease	2,232	90,687	978	11,062	27,595	16	11,868	1,436	**145,874**
Total net book value at 31 March 2026	**3,939**	**93,718**	**978**	**11,062**	**27,595**	**16**	**11,868**	**1,436**	**150,612**

Note 17.8 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Foundation Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	1,758	1,662	0	0	0	0	0	0	**3,420**
Not subject to an operating lease	1,562	92,977	0	14,653	24,876	22	9,252	1,723	**145,065**
Total net book value at 31 March 2025	**3,320**	**94,639**	**0**	**14,653**	**24,876**	**22**	**9,252**	**1,723**	**148,485**

Note 18 Donations of property, plant and equipment

	2025/26 £000	2024/25 £000
Navigational Bronchoscopy	270	62
Blue Prism robotic automation software	200	0
Affiniti CVx Advanced	62	0
Airconditioning in Library Area	59	0
Breast Tray Instruments	54	0
Paxman Scalp Cooling System Single Patient	44	0
Vivid IQ Premium	36	0
Anaesthetic Machine	32	0
Multifiltrate Pro Machine in Critical Care	18	0
Ventilator HAMILTON-T1	15	0
Smots™ ceiling mounted camera system X 2	15	0
3 x FC161 Handheld Fundus Camera	14	0
Gynae Couch	12	0
Glidescope	9	0
Decarbonisation Project at Hartlepool	0	10,409
Health and Social Care Academy	0	881
Nurses Welfare Facilities	0	125
Ultrasound Scanners	0	110
Haematology Equipment	0	110
Video Cystoscope	0	83
Snowdrop and Oasis Suites	0	61
Robotic Surgery	0	41
Therapy Garden	0	14
Other	1	183
	841	**12,079**

Note 19 Revaluations of property, plant and equipment

	2025/26 £000	2024/25 £000
Impairment charged / (credited) to the Statement of Comprehensive Income		
Buildings excluding dwellings	14,591	2,735
Dwellings	44	166
Land	27	2,489
Total	**14,662**	**5,390**
(Decrease) / increase in Revaluation Reserve		
Buildings excluding dwellings	(331)	(3,295)
Dwellings	0	0
Land	229	(1,953)
Total	**(102)**	**(5,248)**

The trust's valuer is Cushman and Wakefield. The name of the surveyor is Jim Stevenson, Associate, RICS Registered Valuer. The effective date of the valuation is 31 March 2026.

The impairment of £14.7m (2024/25 £5.4m) relates to the MEA valuation as at 31 March 2026 and corresponding decreases in individual building valuations. The revaluation reserve has decreased by £0.1m (2024/25 £5.2m decrease) also, so an overall reduction in value of £14.6m (2024/25 reduction £10.6m).

The main reason for the impairment and revaluation reduction is as a result of the combination of build cost increase (circa 1.6% once national tender price index and regional factor are combined) and the larger decreasing effect of the buildings being 1 year older. Also for Peterlee and the Community Diagnostic Hub, there is a small build cost increase and a larger impact from the buildings being 1 year older. This is offset by increases in non-

specialist assets due to new assets purchased in 2025/26 and RAAC (reinforced autoclaved aerated concrete) work. The value at Hartlepool is also reduced by part of the decarbonisation project work being operational at the end of March 2026.

The remaining life applied to the buildings is broadly consistent with previous years valuations. A detailed structural survey report produced by Faithful and Gould Limited at the start of 2021/22, indicated that the majority of the buildings on the North Tees site have a maximum remaining life of 10 years. This detailed report has been reviewed by Cushman and Wakefield and the MEA report has been amended accordingly. At 31 March 2026, the remaining life on the majority of the buildings on the North Tees site is now 5 years.

Note 20 Leases - North Tees and Hartlepool NHS Foundation Trust as a lessee

This note details information about leases for which the trust is a lessee.

72% of the net book value of all right of use assets relates to properties. The lessor for the majority of these properties is either NHS Property Services or Community Health Partnerships. 18% of the net book value of all right of use assets relates to managed service contracts for Radiology and Pathology. The remaining leases relate to plant and machinery.

The trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives.

Note 20.1 Right of use assets - 2025/26

Group and Foundation Trust	Property (land and buildings)	Plant & machinery	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025	**18,223**	**8,699**	**6,062**	**32,984**	**17,961**
Additions	0	1,460	0	**1,460**	0
Remeasurements of the lease liability	261	329	0	**590**	261
Reversal of impairments	39	0	0	**39**	39
Disposals / derecognition	(134)	0	(2,818)	**(2,952)**	(134)
Valuation/gross cost at 31 March 2026	**18,389**	**10,488**	**3,244**	**32,121**	**18,127**
Accumulated depreciation at 1 April 2025	**4,935**	**4,500**	**4,091**	**13,526**	**4,824**
Provided during the year	1,754	1,496	23	**3,273**	1,716
Disposals / derecognition	(79)	0	(870)	**(949)**	(79)
Accumulated depreciation at 31 March 2026	**6,610**	**5,996**	**3,244**	**15,850**	**6,461**
Net book value at 31 March 2026	**11,779**	**4,492**	**0**	**16,271**	**11,666**
Net book value at 1 April 2025	**13,288**	**4,199**	**1,971**	**19,458**	**13,137**

Net book value of right of use assets leased from other NHS providers	0
Net book value of right of use assets leased from other DHSC group bodies	11,666

Note 20.2 Right of use assets - 2024/25

Group and Foundation Trust	Property (land and buildings)	Plant & machinery	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024	**17,799**	**6,326**	**6,062**	**30,187**	**17,578**
Additions	140	671	0	**811**	98
Remeasurements of the lease liability	584	1,702	0	**2,286**	584
Impairments	(300)	0	0	**(300)**	(299)
Valuation/gross cost at 31 March 2025	**18,223**	**8,699**	**6,062**	**32,984**	**17,961**
Accumulated depreciation at 1 April 2024	**3,151**	**3,005**	**3,694**	**9,850**	**3,078**
Provided during the year	1,790	1,495	397	**3,682**	1,752
Impairments	(6)	0	0	**(6)**	(6)
Accumulated depreciation at 31 March 2025	**4,935**	**4,500**	**4,091**	**13,526**	**4,824**
Net book value at 31 March 2025	**13,288**	**4,199**	**1,971**	**19,458**	**13,137**
Net book value at 1 April 2024	**14,648**	**3,321**	**2,368**	**20,337**	**14,500**

Net book value of right of use assets leased from other NHS providers	0
Net book value of right of use assets leased from other DHSC group bodies	13,137

Note 20.3 Revaluations of right of use assets

Revaluations have taken place in year on peppercorn leases as detailed below. The impairment and revaluation impact on peppercorn leases is also included in note 8 and note 19.

70% of the net book value of all non peppercorn leases relates to property leases and as they are subject to annual rent reviews, the cost model can function as a proxy for valuation.

	2025/26	2024/25
	£000	£000
Impairment charged / (credited) to the Statement of Comprehensive Income		
Buildings excluding Dwellings	(39)	254
Total	**(39)**	**254**

Increase in Revaluation Reserve	2025/26	2024/25
	£000	£000
Land	0	(40)
Total	**0**	**(40)**

The trust's valuer is Cushman and Wakefield. The name of the surveyor is Jim Stevenson, Associate, RICS Registered Valuer. The effective date of the valuation is 31 March 2026. The impairment value includes (£0.0m) impairment reversal (2024/25 £0.3m impairment) for IFRS16 peppercorn leases and the revaluation reserve includes a decrease of £0.0m (2024/25 £0.0m decrease) for IFRS16 peppercorn leases.

Note 20.4 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 28.

	Group and Foundation Trust	
	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**20,421**	**20,432**
Lease additions	1,460	769
Lease liability remeasurements	590	2,286
Interest charge arising in year	267	207
Early terminations	(2,846)	0
Lease payments (cash outflows)	(3,810)	(3,273)
Carrying value at 31 March	**16,082**	**20,421**

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. The trust has vehicle leases which do not qualify as low value, but are immaterial to the trust. Following the requirements of IAS 1 Presentation of Financial Statements, the trust has not applied IFRS 16 to those immaterial leases (regardless of those leases failing to qualify as leases of low-value underlying assets), these leases are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 20.5 Maturity analysis of future lease payments at 31 March 2026

	Group and Foundation Trust	
	Total 31 March 2026	Of which leased from DHSC group bodies: 31 March 2026
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	3,184	1,635
- later than one year and not later than five years;	8,707	5,991
- later than five years.	4,964	4,163
Total gross future lease payments	**16,855**	**11,789**
Finance charges allocated to future periods	(773)	(446)
Net lease liabilities at 31 March 2026	**16,082**	**11,343**
Of which:		
Leased from other NHS providers		0

Leased from other DHSC group bodies	11,343

Note 20.6 Maturity analysis of future lease payments at 31 March 2025

	Group and Foundation Trust	
	Total 31 March 2025	Of which leased from DHSC group bodies: 31 March 2025
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	4,438	1,907
- later than one year and not later than five years;	9,278	6,196
- later than five years.	7,557	5,429
Total gross future lease payments	**21,273**	**13,532**
Finance charges allocated to future periods	(852)	(565)
Net finance lease liabilities at 31 March 2025	**20,421**	**12,967**
Of which:		
Leased from other NHS providers		0
Leased from other DHSC group bodies		12,967

Note 21 Charitable fund investments non-current

	Group	
	2025/26	2024/25
	£000	£000
Carrying value at 1 April - brought forward	**1,472**	**1,545**
Net impairments	(116)	(73)
Carrying value at 31 March	**1,356**	**1,472**

Note 22 Analysis of charitable fund reserves

The trust has consolidated the accounts of the North Tees and Hartlepool NHS Foundation Trust General Charitable Fund within these statements.

	31 March 2026	31 March 2025
	£000	£000
Unrestricted funds:		
Unrestricted income funds	1,293	1,584
Restricted funds:		
Other restricted income funds	1,114	1,240
	2,407	**2,824**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 23 Inventories

	Group		Foundation Trust	
	2026	2025	2026	2025
	£000	£000	£000	£000
Drugs	1,718	1,795	1,254	1,311
Consumables	4,983	5,229	4,928	5,156
Total inventories	**6,701**	**7,024**	**6,182**	**6,467**

Inventories recognised in expenses for the year were £61,398k (2024/25: £55,276k). Write-down of inventories recognised as expenses for the year were £114k (2024/25: £206k).

Note 24 Receivables

Note 24.1 Receivables

	Group		Foundation Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Contract receivables	17,569	16,882	17,009	16,889
Allowance for impaired contract receivables / assets	(4,515)	(3,478)	(4,393)	(3,440)
Prepayments	6,474	6,477	6,894	5,832
PDC dividend receivable	517	0	517	0
VAT receivable	3,936	4,473	3,594	2,068
Corporation and other taxes receivable	27	15	27	15
Other receivables	736	761	5,527	5,179
NHS charitable funds receivables	25	37	0	0
Total current receivables	**24,769**	**25,167**	**29,175**	**26,543**
Non-current				
Contract receivables	1,448	1,267	1,448	1,267
Other receivables	512	607	64,589	58,812
Total non-current receivables	**1,960**	**1,874**	**66,037**	**60,079**
Of which receivable from NHS and DHSC group bodies:				
Current	12,411	7,511	12,105	7,450
Non-current	512	607	512	607

Note 24.2 Allowances for credit losses - 2025/26

	Group	Foundation Trust
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2025 - brought forward	**3,478**	**3,440**
New allowances arising	3,033	2,977
Changes in existing allowances	(113)	(291)
Reversals of allowances	(1,597)	(1,528)
Utilisation of allowances (write offs)	(286)	(205)
Allowances as at 31 Mar 2026	**4,515**	**4,393**

Note 24.3 Allowances for credit losses - 2024/25

	Group	Foundation Trust
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2024 - brought forward	**2,941**	**2,903**
New allowances arising	2,302	2,302
Changes in existing allowances	58	58
Reversals of allowances	(1,489)	(1,489)
Utilisation of allowances (write offs)	(334)	(334)
Allowances as at 31 Mar 2025	**3,478**	**3,440**

Note 24.4 Exposure to credit risk

The majority of the trust's income comes from contracts with other public sector bodies, the trust therefore has low exposure to credit risk. The maximum exposure as at 31 March 2026 is in receivables from private sector bodies. Note 24.1 details total receivables for the Group at £26,704k (2024/25 £27,041k). The receivable value attributable to private sector bodies is £954k (2024/25 £5,783k). This is calculated as £26,704k (2024/25 £27,041k), less NHS and DHSC £12,923k (2024/25 £8,118k), prepayments £6,474k (2024/25 £6,477k), VAT receivable £3,936k (2024/25 £4,473k) and injury cost recovery debtor £2,417k (2024/25 £2,190k).

Note 25 Cash and cash equivalents movements

Note 25.1 Cash and cash equivalents movements

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

	Group		Foundation Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**59,108**	**72,000**	**55,292**	**65,007**
Net change in year	(27)	(12,892)	(1,614)	(9,715)
At 31 March	**59,081**	**59,108**	**53,678**	**55,292**
Broken down into:				
Cash at commercial banks and in hand	10	3,816	2	0
Cash with the Government Banking Service	59,071	55,292	53,676	55,292
Total cash and cash equivalents as in SoFP	**59,081**	**59,108**	**53,678**	**55,292**
Total cash and cash equivalents as in SoCF	**59,081**	**59,108**	**53,678**	**55,292**

Note 25.2 Third party assets held by the trust

North Tees and Hartlepool NHS Foundation Trust held cash and cash equivalents which relate to monies held by the trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Foundation Trust	
	31 March 2026	31 March 2025
	£000	£000
Bank balances	26	24
Total third party assets	**26**	**24**

Note 26 Trade and other payables

Note 26.1 Trade and other payables

	Group		Foundation Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Trade payables	22,676	21,508	10,283	9,039
Capital payables	2,590	990	2,590	990
Accruals	29,566	32,877	33,107	36,893
Social security costs	6,393	5,807	5,983	5,446
Other taxes payable	42	51	0	0
PDC dividend payable	0	124	0	124
Pension contributions payable	3,617	3,504	3,459	3,333
Other payables	551	422	11,134	5,515
NHS charitable funds: trade and other payables	83	203	0	0
Total current trade and other payables	**65,518**	**65,486**	**66,556**	**61,340**
Of which payables from NHS and DHSC group bodies:				
Current	4,614	7,558	4,309	7,409
Non-current	0	0	0	0

Note 26.2 Early retirements in NHS payables above

There are no early retirement amounts included within NHS payables in financial year 2025/26 (2024/25: none).

Note 27 Other liabilities

	Group		Foundation Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	5,098	6,619	4,807	6,554
Total other current liabilities	**5,098**	**6,619**	**4,807**	**6,554**

Deferred income has decreased by £1.5m for the Group due mainly to NHS North East and North Cumbria Integrated Care Board reduction of £0.5m, Stockton Borough Council reduction £0.5m and NHS England reduction £0.3m.

Note 28 Borrowings

Note 28.1 Borrowings

	Group and Foundation	
	31 March 2026	31 March 2025
	£000	£000
Current		
Loans from DHSC	1,237	1,246
Lease liabilities	3,184	4,438
Total current borrowings	**4,421**	**5,684**
Non-current		
Loans from DHSC	15,825	16,914
Lease liabilities	12,898	15,983
Total non-current borrowings	**28,723**	**32,897**

Note 28.2 Reconciliation of liabilities arising from financing activities (Group)

Group and Foundation Trust - 2025/26	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2025	**18,160**	**20,421**	**38,581**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,088)	(3,543)	**(4,631)**
Financing cash flows - payments of interest	(427)	(267)	**(694)**
Non-cash movements:			
Additions	0	1,460	**1,460**
Lease liability remeasurements	0	590	**590**
Application of effective interest rate	417	267	**684**
Early terminations	0	(2,846)	**(2,846)**
Carrying value at 31 March 2026	**17,062**	**16,082**	**33,144**

Group and Foundation Trust - 2024/25	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2024	**19,256**	**20,432**	**39,688**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,088)	(3,066)	**(4,154)**
Financing cash flows - payments of interest	(453)	(207)	**(660)**
Non-cash movements:			
Additions	0	769	**769**
Lease liability remeasurements	0	2,286	**2,286**
Application of effective interest rate	445	207	**652**
Carrying value at 31 March 2025	**18,160**	**20,421**	**38,581**

Note 29 Other financial liabilities

	Group		Foundation Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Non-current				
Other financial liabilities	0	0	(66,791)	(63,574)
Total non-current other financial liabilities	**0**	**0**	**(66,791)**	**(63,574)**

* This is the financial creditor of the trust with its subsidiary, North Tees and Hartlepool Solutions LLP. The financial creditor comprises amounts due to the LLP for capital spend incurred on behalf of the trust which is reimbursed under the master services agreement.

There is also a value of £10,688k (2024/25 £4,911k) included in current trade and other payables. This provides a total liability of £77,479k (2024/25 £68,485k). The significant increase in the financial creditor is due mainly to the Community Diagnostic Centre capital scheme completion, Hartlepool decarbonisation capital scheme and phase 2 of the robotic theatre capital scheme.

Note 30 Provisions for liabilities and charges analysis

Note 30.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**531**	**619**	**121**	**2,944**	**4,215**
Change in the discount rate	(10)	(21)	0	(41)	**(72)**
Arising during the year	81	64	125	50	**320**
Utilised during the year	(84)	(62)	(41)	(27)	**(214)**
Reversed unused	(80)	(22)	(56)	(752)	**(910)**
Unwinding of discount	12	8	0	34	**54**
At 31 March 2026	**450**	**586**	**149**	**2,208**	**3,393**
Expected timing of cash flows:					
- not later than one year;	81	62	149	1,696	**1,988**
- later than one year and not later than five years;	324	246	0	108	**678**
- later than five years.	45	278	0	404	**727**
Total	**450**	**586**	**149**	**2,208**	**3,393**

- Pensions: early departure costs provision is in relation to employees who were in the pre-95 pension scheme and have been made redundant prior to 2006. The provision is the enhanced element of the lump sum plus any interest charge on the early payment of the lump sum.
- Pensions: injury benefits provision is to provide support for staff who sustain an injury, disease or other health condition which is attributable to their employment.
- Legal claims provision is for third party injury claims against the trust. This can include staff, contractors or the public.

Other provisions include:

- Clinician pension tax liability for which there is a corresponding income accrual.
- A provision for specific trust and subsidiary employment cases and legal cases.

Note 30.2 Provisions for liabilities and charges analysis (Foundation Trust)

Foundation Trust	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**531**	**619**	**65**	**2,909**	**4,124**
Change in the discount rate	(10)	(21)	0	(41)	**(72)**
Arising during the year	81	64	78	50	**273**
Utilised during the year	(84)	(62)	(41)	(27)	**(214)**
Reversed unused	(80)	(22)	(17)	(752)	**(871)**
Unwinding of discount	12	8	0	34	**54**
At 31 March 2026	**450**	**586**	**85**	**2,173**	**3,294**
Expected timing of cash flows:					
- not later than one year;	81	62	85	1,661	**1,889**
- later than one year and not later than five years;	324	246	0	108	**678**
- later than five years.	45	278	0	404	**727**
Total	**450**	**586**	**85**	**2,173**	**3,294**

- Provisions for the trust are the same as for the Group, detailed on the previous page, with the exception of £3k Optimus provisions (NEST ERS pension contribution) and £96k LLP provisions (specific employment case and legal claim provision for third party injury claims against the LLP which can include staff, contractors or the public).

Note 30.3 Clinical negligence liabilities

At 31 March 2026, £132,925k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of North Tees and Hartlepool NHS Foundation Trust (31 March 2025: £135,329k).

Note 31 Contingent assets and liabilities

	Group		Foundation Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	35	0	35	0
Gross value of contingent liabilities	**35**	**0**	**35**	**0**
Amounts recoverable against liabilities	0	0	0	0
Net value of contingent liabilities	**35**	**0**	**35**	**0**

This is the difference between the provision for NHS Resolution legal claims based on probability and the full cost payable by the trust if all claims were successful.

Note 32 Contractual capital commitments

	Group		Foundation Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Property, plant and equipment	2,339	7,026	2,339	7,026
Intangible assets	330	133	330	133
Total	**2,669**	**7,159**	**2,669**	**7,159**

Note 33 Defined benefit pension schemes

	2025/26	2024/25
NEST Payments	£000	£000
Foundation Trust	93	138
North Tees and Hartlepool Solutions LLP	215	213
Optimus Health Limited	8	8
Total	**316**	**359**

Note 34 Financial instruments

Note 34.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the trust has with commissioners and the way those commissioners are financed, the 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 trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's Standing Financial Instructions and policies agreed by the Board of Directors. 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.

Credit risk
Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2026 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 Integrated Care Boards, 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 34.2 Carrying values of financial assets (Group)
Carrying value is a reasonable approximation for fair value for financial assets and financial liabilities.

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	15,777	0	**15,777**
Cash and cash equivalents	57,972	0	**57,972**
Consolidated NHS Charitable fund financial assets	0	2,490	**2,490**
Total at 31 March 2026	**73,749**	**2,490**	**76,239**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	16,054	0	**16,054**
Cash and cash equivalents	57,590	0	**57,590**
Consolidated NHS Charitable fund financial assets	0	3,027	**3,027**
Total at 31 March 2025	**73,644**	**3,027**	**76,671**

Note 34.3 Carrying values of financial assets (Foundation Trust)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	84,207	0	**84,207**
Cash and cash equivalents	53,678	0	**53,678**
Total at 31 March 2026	**137,885**	**0**	**137,885**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	78,722	0	**78,722**
Cash and cash equivalents	55,292	0	**55,292**
Total at 31 March 2025	**134,014**	**0**	**134,014**

Note 34.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	17,062	0	**17,062**
Obligations under leases	16,082	0	**16,082**
Trade and other payables excluding non financial liabilities	49,541	0	**49,541**
Provisions under contract	3,393	0	**3,393**
Consolidated NHS charitable fund financial liabilities	83	0	**83**
Total at 31 March 2026	**86,161**	**0**	**86,161**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	18,160	0	**18,160**
Obligations under leases	20,421	0	**20,421**
Trade and other payables excluding non financial liabilities	49,713	0	**49,713**
Provisions under contract	4,215	0	**4,215**
Consolidated NHS charitable fund financial liabilities	203	0	**203**
Total at 31 March 2025	**92,712**	**0**	**92,712**

Note 34.5 Carrying values of financial liabilities (Foundation Trust)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	17,062	0	**17,062**
Obligations under leases	16,082	0	**16,082**
Trade and other payables excluding non financial liabilities	118,851	0	**118,851**
Provisions under contract	3,294	0	**3,294**
Total at 31 March 2026	**155,289**	**0**	**155,289**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	18,160	0	**18,160**
Obligations under leases	20,421	0	**20,421**
Trade and other payables excluding non financial liabilities	110,736	0	**110,736**
Provisions under contract	4,124	0	**4,124**
Total at 31 March 2025	**153,441**	**0**	**153,441**

Note 34.6 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.

	Group		Foundation Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
In one year or less	56,033	58,214	58,370	55,368
In more than one year but not more than five years	13,740	21,273	38,914	40,925
In more than five years	17,161	14,077	58,005	57,148
Total	**86,934**	**93,564**	**155,289**	**153,441**

Note 35 Losses and special payments

	2025/26		2024/25	
Group and Foundation Trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Stores losses and damage to property	15	114	5	206
Total losses	**15**	**114**	**5**	**206**
Special payments				
Compensation under court order or legally binding arbitration award	1	1	1	0
Ex-gratia payments	15	8	24	10
Total special payments	**16**	**9**	**25**	**10**
Total losses and special payments	**31**	**123**	**30**	**216**
Compensation payments received				

Store losses and damage to property in 2024/25 included stock write off for Optimus Health Limited for prior years going back to 2014/15 of £138k. There is therefore an increase in stock write off £46k which relates to trust pharmacy and critical care write off.

Note 36 Related parties

North Tees and Hartlepool NHS Foundation Trust is a public benefit corporation established under the National Health Service Act 2006. Monitor (NHS England), the Independent Regulator for NHS Foundation Trusts, has the power to control the trust within the meaning of IAS27 "Consolidated and Separate accounts".

NHS England does not prepare group accounts but does prepare separate NHS Foundation Trust Consolidated Accounts. The NHS FT Consolidated Accounts are included within the Whole of Government Accounts. NHSE is accountable to the Secretary of State for Health and Social Care and therefore the trust's ultimate parent is the Department of Health and Social Care.

The transactions included in the note relate to transactions with non Government bodies and intra-group transactions between the trust and its subsidiaries. The note does not include all of the main entities within the public sector that the trust has had dealings with as this is not required in accordance with IAS 24. These entities are however listed below.

The Foundation Trust

	31 March 2026				31 March 2025			
	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£	£	£	£	£
Prof Derek Bell - Chair, Lay Council Member, Newcastle University Mr Chris Day - Non-Executive Director, Vice Chancellor and President at Newcastle University	0	55,600	0	7,300	0	0	0	0
Ms Stacey Hunter - Chief Executive, Director of Health Innovation North East and North Cumbria Ltd.	(18,900)	37,500	0	60,000	0	54,031	0	7,500
Ms Stacey Hunter - Chief Executive, Member of UHA Executive Steering Committee (hosted by NHS Providers)	(31,987)	0	0	0	(31,987)	0	0	0
Prof Elizabeth Barnes - Non-Executive Director to 30.06.26, Governor University of Sunderland.	(32,026)	26,019	(1,125)	32,019	(43,749)	24,000	(3,280)	42,944
Mrs Alison Fellows (Care) - Non-Executive Director, family member is a partner at Ward Hadaway Solicitors.	0	0	0	0	(9,271)	0	0	0
Mrs Alison Fellows - Non-Executive Director, Governor of the Board, Northumbria University and Member of its Audit Committee.	(1,588)	0	0	0	(3,176)	400	0	0
Mr Stuart Irvine - Director of Strategies, Assurance and Compliance / Company Secretary. Chair of Hartlepool College of Further Education and family members x 2 employees at Hartlepool College of Further Education.	(300)	9,330	0	0	(1,646)	14,150	0	0

The Foundation Trust

	31 March 2026				31 March 2025			
	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
Ms Ada Burns - Non-Executive Director to 30.09.26. Governor and Chair of the Board of Governors, Teesside University.	(37,870)	8,551	(4,634)	0	(32,563)	8,772	(2,250)	0
Mr Christopher Macklin - Non-Executive Director to 30.04.26, Chair, Audit One.	(268,398)	0	(2,351)	0	(384,479)	0	0	0
Ms Ann Baxter - Vice Chair, Independent Scrutineer of Safeguarding / Chair of Statutory Safeguarding Partnership, Darlington Borough Council.	(4,913)	0	0	179	(5,016)	0	(361)	179
All Joint Executive Directors and Non-Executive Directors, South Tees Hospitals NHS Foundation Trust.	(17,466,298)	8,552,842	(584,197)	2,158,756	(12,296,151)	8,159,199	(1,692,283)	558,482

DHSC related party information

Middlesbrough Football Club	0	1,000	0	0	0	0	0	0
NHS Confederation	0	0	0	0	(15,613)	0	0	0

Main Public Sector Entities the trust has dealt with within 2025/26

NHS England

Integrated Care Boards

Department of Health and Social Care

Other NHS providers

Local authorities

The trust has two subsidiary companies Optimus Health Limited and North Tees and Hartlepool Solutions LLP. The tables below total all intra-group transactions for 2025/26 and 2024/25 with related parties and list the subsidiary directors.

North Tees and Hartlepool Solutions LLP

	31 March 2026				31 March 2025			
	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£	£	£	£	£
All directors	(110,397,252)	2,929,922	0	218,805	(89,907,611)	2,995,078	(300)	0

List of directors - these are trust directors that sit on the Board of North Tees and Hartlepool Solutions LLP

Mr David Redpath - Chair

Mr Ian Simpson - Non-Executive Director

Mr Neil Atkinson - Director

Mr Chris Hand - Director

Optimus Health Limited

	31 March 2026				31 March 2025			
	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£	£	£	£	£
All directors	(9,065,073)	1,303,124	0	0	(8,009,153)	85,877	(281,093)	0

List of directors - these are trust directors that sit on the Board of Optimus Health Limited

Mr David Redpath - Chair

Mr Ian Simpson - Non-Executive Director

Note 37 Events after the reporting date

There has not been any subsequent events impacting on the North Tees and Hartlepool NHS Foundation Trust Accounts between the period 31st March 2026 and 26th June 2026.

Note 38 Movement between deficit for the year and control total performance

	Group	
	2025/26 £000	**2024/25 £000**
Adjusted financial performance (control total basis):		
a) (Deficit) / surplus for the period	(11,703)	5,453
b) Remove impact of consolidating NHS charitable fund	301	373
c) Remove net impairments not scoring to the Departmental expenditure limit	14,623	5,644
d) Remove I&E impact of capital grants and donations	57	(11,601)
e) Remove net impact of inventories received from DHSC group bodies for COVID response	2	133
Adjusted financial performance surplus	**3,280**	**2**

a) This is the overall (deficit) / surplus achieved by the trust in the financial year, including any non cash items such as impairments.

b) North Tees and Hartlepool NHS Charitable Funds financial position for the year is included in the Group (deficit) / surplus but charitable funds performance does not impact on control total and is therefore removed.

c) Impairments of non-current assets are non cash items and do not impact on control total and are therefore removed. The significant impairment in 2025/26 and 2024/25 financial years is in relation to the annual valuation of the trust's land and buildings by a qualified surveyor. In 2025/26 this is as a result of the combination of build cost increase (circa 1.6% once national tender price index and regional factor are combined) and the larger decreasing effect of the buildings being 1 year older. Also for Peterlee and the Community Diagnostic Hub, there is a small build cost increase and a larger impact from the buildings being 1 year older. This is offset by increases in non-specialist assets due to new assets purchased in 2025/26 and RAAC (reinforced autoclaved aerated concrete) work. The value at Hartlepool is also reduced by part of the decarbonisation project work being operational at the end of March 2026.

In 2024/25 financial year, the main reason for the material impairment is as a result of a reduction in value for the Community Diagnostic Hub building project which was completed in year; a reduction in value for the robotic theatre project which was completed in year; and a reduction in land value due to a change in assumption regarding required floor area for alternative site MEA valuation.

The trust's valuer is Cushman and Wakefield. The MEA valuation has reduced for the reasons described and the remaining life applied to the buildings is broadly consistent with previous years valuations. A detailed structural survey report produced by Faithful and Gould Limited at the start of 2021/22, indicated that the majority of the buildings on the North Tees site have a maximum remaining life of 10 years. This detailed report has been reviewed by Cushman and Wakefield and the MEA report has been amended accordingly. At 31 March 2026, the remaining life on the majority of the buildings on the North Tees site is now 5 years.

d) Capital grants and donations received by the trust for the specific purpose of purchasing capital equipment does not impact on control total and is therefore removed. Donated asset income is material for the trust in 2024/25 due to a grant from Salix for Hartlepool decarbonisation over the financial year 2023/24 and 2024/25, totalling £13.4m.

e) During the pandemic, the Department of Health and Social Care provided NHS organisations with personal protective equipment for staff, visitors and patients due to issues with the supply chain. This has continued from financial year 2020/21 to 2023/24 and was given to the trust free of charge. For this reason, any closing stock cost or benefit to the trust does not impact on control total and is therefore removed. The trust has no remaining closing stock of personal protective equipment provided by the Department of Health and Social Care for free at the end of March 2026.