NHS
Cambridge University Hospitals
NHS Foundation Trust

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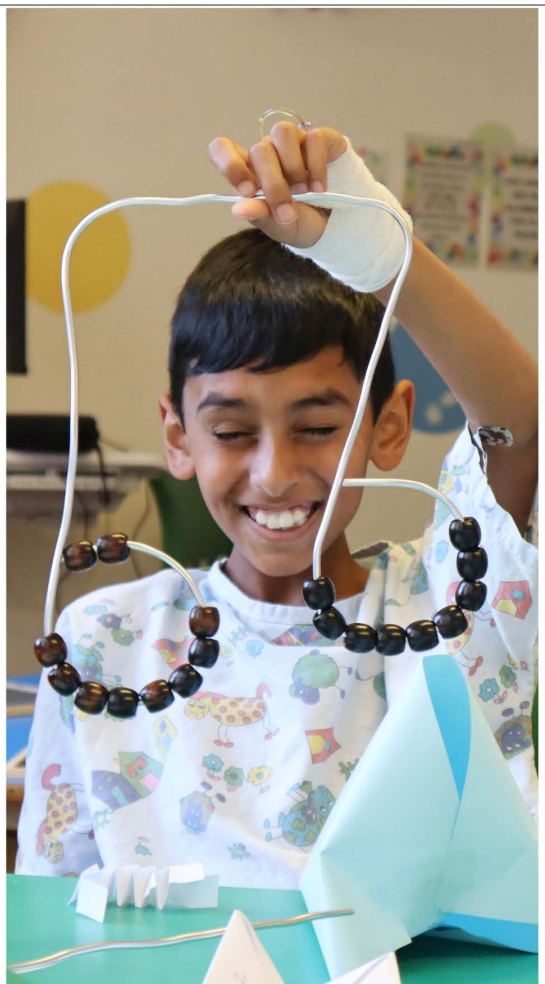
Annual report and accounts **2024/25**



Cambridge University Hospitals
NHS Foundation Trust Annual Report and Accounts 2024/25

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

Contents

1. Statement from the Chair and Chief Executive

Like many NHS trusts across the country, we continue to perform well despite facing some significant challenges over the past year. Thanks to the extraordinary commitment from our staff and partners, we have made good progress in addressing many of these while continuing to deliver a high standard of patient care and maintaining our vital role in the world-leading research and innovation taking place here in Cambridge. This places us in a strong position for the year ahead.

While we have made significant improvements, it is also important for us to be open and honest when things are not right. In February 2025 we announced an external retrospective clinical review into the practice of an orthopaedic surgeon who specialises in paediatric surgery. This followed the conclusion of an initial external review which identified that the outcomes of treatment provide to some patients were below the standard we would expect. We have also commissioned an independent investigation into whether there were opportunities to have identified and addressed these issues sooner. We are very sorry that this has happened and we have apologised unreservedly to our patients and their families. We have put in place a dedicated Patient and Family Liaison Team who will be the primary point of contact for patients and their families for the duration of the external clinical review.

During 2024/25, we have reduced our waiting lists for elective care, improved patient flow and developed new models of care for the future. We also achieved financial break-even for the fifth year running and saw the highest response rate in the staff survey since 2021. However, many of our patients are still waiting too long to be seen and there have continued to be high number of patients accessing our urgent and emergency care services, exacerbated by norovirus and respiratory illnesses.

This growth in demand for care, coupled with restricted finances, have meant that we needed to adapt and find innovative ways to change how we provide services to ensure best possible value for public money.

In 2024 we set out three priorities outlining our commitment to addressing our challenges: improving quality, productivity and patient flow; committing to a focus on culture and leadership; and delivering new models of care.

This means doing everything we can to make patient pathways efficient and smooth at the same time as improving access to services, helping people to stay well and at home for longer, and helping the NHS become more sustainable. We continue to place a strong focus on increasing equality of

healthcare access and outcomes for our patients and working with partners to reduce health inequalities.

In November 2024 we celebrated the official opening of Ely Community Diagnostic Centre (CDC) which is one of two new centres managed by CUH in close collaboration with partners across the Cambridge and Peterborough Integrated Care System. The facility is enabling thousands of patients to access vital diagnostic tests more quickly and efficiently, without having to travel to Addenbrooke's or another acute hospital site. The CDCs also provide us with opportunities to develop new ways of working to address health inequalities and improve patient experience.

It has been a year since we opened the Cambridge Movement Surgical Hub, which is continuing to make a big difference for patients waiting for common surgeries like knee and hip replacements. More than 2,500 operations have been carried out within its three operating theatres since it opened, allowing planned operations to continue despite winter pressures.

We've also expanded the use of our award-winning Virtual Ward which is enabling patients to be safely looked after in their own homes by using technology including wearable medical devices and oversight from specialist clinicians.

We opened an additional discharge lounge over the winter period which doubled the space for patients who are ready and waiting to go home, freeing up beds for those who need them.

In parallel with these improvements, we have continued our programme to modernise our outpatients service. A number of services are now using Remote Clinical Reviews where clinicians review information from the patient via questionnaires and test results in order to make a decision about the best next step. Patient Initiated Follow-Up gives patients and their carers flexibility to arrange their follow-up appointments when they need them, based on their individual circumstances. This frees up clinic appointments for those who need them most and avoids the need for patients to travel to appointments.

We continue to be a world-leading research hospital with over 750 active clinical trials involving over 16,000 people. Bringing the cutting-edge into standard of care is at the core of providing excellence for our patients.

In May 2024 people worldwide were moved by the incredible story of baby Opal, who was able to hear unaided for the first time thanks to ground-breaking gene therapy at Addenbrooke's. Throughout the year we have harnessed the power of technology to help diagnose coeliac disease, manage diabetes, detect epilepsy, and shared our expertise globally by virtually 'parachuting in' specialist doctors to provide care in hospitals around the world. As we prepare for our new cancer hospital, we have revealed new

insights into the genetics of kidney cancers, expanded our work on breast cancer, advanced oesophageal cancer detection and started work to understand what makes some people cancer super survivors.

December 2024 was a record-breaking month for surgery with 2,142 elective operations taking place, despite winter pressures. It marked the highest number of elective procedures ever carried out in that month. We also celebrated a 'Super Sunday' where the highest number of gall bladder operations took place in a single day with the help of high-tech robots. The robots are revolutionising patient care by providing better precision and accuracy which is leading to faster recovery.

Listening to our staff and their lived experience continues to be one of our biggest areas of focus. We were pleased to see an increase in the number of staff taking part in the NHS Staff Survey 2024. More than 7,000 colleagues responded which was a 16.4% increase from the previous year. We are proud to see colleagues acknowledge improvements on many themes where we have focused attention, including more people feeling positive about their work and confidence in the care we provide.

Our scores for race equality and disability equality measures showed positive movement in all areas, including a 6% increase in the proportion of BME staff who believe that CUH provides equal opportunities for career progression. Equality, diversity and inclusion will remain one of our key commitments.

We celebrate CUH as a family welcoming staff from more than 100 countries, of all races, ethnicities, religions, sexualities, gender identities and health and disability statuses – each one of them equally deserving of respect, opportunities and support.

We know there are areas where we need to improve, and we recognise the impact of ongoing pressures, particularly as we navigate the months ahead to meet the requirements set by Government. Meeting these requirements will require very tough choices and we will continue to listen and find ways to support our staff as we move forwards together.

We have made exciting progress on our two new hospitals – the Cambridge Children's Hospital and Cambridge Cancer Research Hospital.

Following the national New Hospital Programme review which concluded in January 2025, we were delighted that the Secretary of State for Health and Social Care confirmed Cambridge Cancer Research Hospital could proceed as planned. The hospital will be in the first wave of the New Hospital Programme, and we were pleased that the Chancellor has since called for the hospital to be prioritised in recognition of its role in unlocking the potential of the Oxford-Cambridge growth corridor. This welcome news was followed by the start off pre-construction work in March. The hospital remains on track

to be built by 2029 and once opened, it will transform the lives of millions of people diagnosed with cancer.

Cambridge Children's Hospital also continues to make good progress. In November 2024 we saw hoardings installed around the site – a visual reminder of how far the project has come. The Outline Business Case for the Cambridge Children's Hospital was approved by ministers in August 2024, and the process of appointing a contractor has begun as work on the Full Business Case continues.

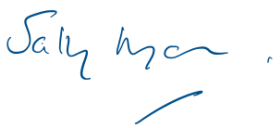
Our journey to develop a vision for the future of our acute services continues, following £3 million investment from the Government in 2024 to support our long-term planning. We have since launched a programme of engagement with staff, patients and partners which will help to shape the direction for how we deliver acute services in the future.

We also welcomed the progress on the new Cambridge South Station which is expected to deliver better transport options and connectivity for 1.8 million passengers, serving a growing community of science and health care specialists, employees and visitors to the Cambridge Biomedical Campus.

Encouraging sustainable travel is one of many measures we are supporting as part of our commitment to reduce our carbon emissions and become net-zero by 2045, as set out in our Action 50 Green Plan.

There is no doubt that the next few years will be a period of reforming and transforming how we provide services. We feel confident that with the skills and dedication of our staff, the collaborative partnerships we are so lucky to be part of and the right focus and energy on the areas that really make a difference to patients, we will tackle our biggest challenges while implementing the care models of the future.

Getting this right will mean we can meet the needs of patients, reduce health inequalities, improve staff experience and deliver better outcomes for the populations we serve.



Sally Morgan
Chair
27 June 2025

Roland Sinker
Chief Executive
27 June 2025

2. Performance report

2.1 Overview

This section of the report provides a summary of the organisation, its purpose, the key risks to the achievement of its objectives and performance during the past year.

2.2 About CUH

Cambridge University Hospitals NHS Foundation Trust (CUH), including both Addenbrooke's and the Rosie Hospitals, was one of the first NHS foundation trusts to be authorised under the Health and Social Care (Community Health and Standards) Act 2003, and came into being in July 2004.

The Trust has its foundation in Addenbrooke's Hospital, which opened in October 1766 in Trumpington Street, Cambridge, as one of the first provincial teaching hospitals in the country. By the 1950s, the hospital was experiencing difficulty accommodating the expansion generated by the introduction of the NHS, and moved to the site on Hills Road. It was officially opened by Her Majesty Queen Elizabeth II in 1962.

CUH employs over 13,000 people and has an annual budget of over £1.5 billion. We provide services as a local hospital for people in Cambridge, South and East Cambridgeshire, and as a specialist hospital for a much wider population. As an academic medical centre, we work across 75 medical and surgical specialties, with corporate and support teams – and health, care, academic and industry partners – to deliver care, learning and research.

Addenbrooke's provides emergency, surgical and medical care for local people and is the Major Trauma Centre for the East of England. It is also a regional centre of excellence for specialist services such as transplantation, cancer, neurosciences, paediatrics and genetics. The Rosie Hospital is a women's hospital and the regional centre of excellence for maternity care. CUH also provides satellite and outreach services at other locations to meet the needs of patients, e.g. in other hospitals, GP practices and in patients' homes.

CUH is an internationally-renowned healthcare organisation. As part of the NHS, we deliver expert care for patients, train the workforce of tomorrow and shape healthcare for the future. Our vision is 'a healthier life for everyone through care, learning and research'.

Each of these three strands is equally important and mutually beneficial: conducting research attracts staff wanting to broaden their skills and enables our patients to benefit from better care sooner; and providing care enables innovative clinical treatments to get into practice sooner.

Our location in Cambridge, as part of an innovation ecosystem, unlocks huge opportunity to go further. As the largest centre of health science and medical research in Europe, we aspire to continue developing the cross-industry partnerships that further improve outcomes for patients while powering economic growth.

We are uniquely situated on the Cambridge Biomedical Campus (CBC), bringing together healthcare, academia, business and the best life science researchers to lead some of the most important biomedical research in the world today. Our partners on the CBC include the University of Cambridge, Royal Papworth Hospital NHS Foundation Trust, Astra Zeneca, GlaxoSmithKline, the Wellcome Trust, Cancer Research UK and the Medical Research Council. Over 20,000 people currently work on the CBC covering 157 acres – and this is growing.

We are part of the Cambridgeshire and Peterborough Integrated Care Board (ICB) and we host the Cambridgeshire South Care Partnership (CSCP) which brings together primary, community, acute and social care providers in the south of the county to deliver integrated care at place and neighbourhood level.

2.3 Key risks

Key risks are identified by the Board of Directors through the Board Assurance Framework (BAF). As at the end of 2024/25, the most significant risks to achieving the organisation's strategic objectives as identified by the Board of Directors are outlined in Table 1. These risks were reviewed by the Board of Directors on 12 March 2025. Risks are scored using a risk matrix with 1 to 5 scores for both the consequence (1 being negligible and 5 being catastrophic) and likelihood (1 being rare and 5 being almost certain). The highest risk score is therefore 25.

Table 1: Board Assurance Framework (BAF)

Risk ref.	Strategic commitments	Current risk score	Target risk score	Risk description	Board oversight committee
001	A2, A3	**20**	**8 (Sep 25)**	Due to physical capacity constraints and sub-optimal patient flow, the Trust is not able to deliver timely and responsive urgent and emergency care services, sustainably increase activity levels to reduce waiting lists, while at the same time managing future surges in seasonal viruses and providing decant capacity to address fire safety and backlog maintenance, which adversely impacts on patient outcomes and experience.	Performance and Quality
011	All	**20**	**12 (Apr 27)**	There is a risk that the Trust, as part of the Cambridgeshire and Peterborough ICS, is unable to deliver the scale of financial improvement required in order to achieve a breakeven or better financial performance within the funding allocation that has been set for the next three years, leading to regulatory action and/or impacting on the ability of the Trust to invest in its strategic priorities and provide high quality services for patients.	Performance
005	C3	**20**	**tbc**	A failure to sufficiently prioritise and address estate infrastructure and safety system risks and their ongoing maintenance impacts on patient and staff safety, continuity of clinical service delivery, regulatory compliance and reputation.	Performance
006	C3	**16**	**12 (Dec 27)**	As a result of incomplete fire compartmentation, there is a risk of fire causing harm to patients and staff and impacting on continuity of clinical service delivery.	Performance
008	B4	**16**	**8 (Mar 26)**	There is a risk that the Trust does not reduce inequality of opportunity and discrimination both within its workforce and in the provision of its services, caused by a failure to develop and implement a robust Equality, Diversity and Inclusion Strategy, which leads to poor staff and patient experience and sub-optimal patient outcomes.	BoD, Workforce and Education, and Quality
003	C5	**16**	**12 (Mar 25)**	The Trust does not prioritise and deploy to best effect the limited resources available for IT investment to support staff to deliver improved patient care and experience.	Audit
009a	C3	**16**	**8 (Mar 27)**	The construction and transformation programmes for the Cambridge Cancer Research Hospitals and the Cambridge Children's Hospital experience delays resulting in the need to maintain poor quality facilities for an extended period of time, adverse financial implications and a failure to realise the clinical, operational and wider benefits.	Performance Committee
009b	C3	**16**	**tbc**	Addenbrooke's 3 proposals beyond the CCH and CCRH are not developed or approved in a timely way resulting in the need to maintain poor quality facilities for an extended period of time and a failure to realise the clinical, operational and wider benefits of future schemes.	Addenbrooke's Futures
015	C4	**16**	**12 (Dec 32)**	As a result of a failure to deliver the CUH Green Plan, the Trust does not enhance	Board of Directors

				environmental sustainability and reduce its direct carbon emissions by 10% by 2025 (as a key step towards the national commitment to halve carbon emissions before 2032 and deliver net zero carbon by 2045) nor develop and deliver a credible adaptation plan, which impacts on organisational reputation and regulatory compliance and increases the susceptibility of our services to the effects of climate change.	
010	A1	**16**	**tbc**	There is a risk that partnership working across the Cambridgeshire and Peterborough Integrated Care System (ICS) and the Cambridgeshire South Care Partnership does not deliver interventions and changes in models of care at the scale and pace required to manage demand resulting in a failure to sustain and improve services for patients.	Addenbrooke's Futures
007	B1, B2	**12**	**12 (Mar 25)**	There is a risk that the Trust does not have sufficient staff with appropriate skills to deliver its plans now and in the future which results in poorer outcomes for patients and poorer experience for patients and staff. – This was removed in the AG	Workforce and Education
004	A5	**12**	**8 (Mar 25)**	The Trust does not meet required CQC regulations and continuously improve the quality, safety and experience of all its services which adversely impacts on patient outcomes and experience and on organisational reputation.	Quality
014	C1	**12**	**8 (Apr 25)**	The Trust does not work effectively with regional partners (particularly regarding specialised services) resulting in a failure to sustain and improve services for regional patients and regulatory intervention and/or the recurrence of a financial deficit.	Addenbrooke's Futures
012	C2	**9**	**9 (ongoing)**	The Trust and our industry and research partners – convened through Cambridge University Health Partners (CUHP) – fail to capitalise on opportunities to improve care for more patients now, generate new treatments for tomorrow and power economic growth in life sciences in Cambridge and across the region.	Addenbrooke's Futures

The BAF is used by the Board of Directors and its sub-committees to track progress in seeking assurance that appropriate controls are in place and actions are being taken to mitigate the key risks to the achievement of the Trust's strategic objectives. Further details of how the Board gains assurance that there are effective arrangements in place for internal control and risk management to safeguard public investment, the Trust's assets, patient safety and service quality are included in the Annual Governance Statement (AGS) at Section 3.28.

The processes outlined in the AGS ensure that the BAF is a living document, representing the risks of greatest concern to the Board of Directors. Since the end of the 2024/25 financial year to which this Annual Report relates, the BAF has therefore continued to be reviewed and updated to reflect the latest risk profile for the organisation. For example, a new risk has been added in relation to the paediatric orthopaedic incident and there is active discussion

about strengthening the focus in the BAF on the risks associated with the challenging programme of productivity improvement required in 2025/26.

2.4 Going concern statement

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

2.5 Performance management approach

Our approach to performance management is based on our Operational Plan with clear priorities, objectives and metrics aligned to the NHS England Operational Planning Guidance. A process is in place to ensure staff are clear about the priorities and that these are linked to individual objectives. Arrangements are in place for reporting to our commissioners and regulators, and there is a clear quality message to our patients and the wider public through our Quality Account. The Quality Account for 2024/25 will be published on the Trust's website by 30 June 2025.

Performance is monitored by the Board of Directors through a monthly Integrated Performance Report, with detailed scrutiny and assurance sought by the Performance, Quality and Workforce and Education Committees of the Board. There is a focus across a broad range of metrics covering quality, operational performance, workforce and finance. Clinical divisions review performance through their divisional boards and associated governance arrangements and monthly performance review meetings are held between the executive team and each clinical division, with issues escalated as required to the Management Executive. In addition, there is a weekly taskforce focused on reducing the numbers of patients waiting over 65 weeks from referral to treatment and achieving the cancer waiting time standards.

2.6 Financial performance

Despite increasing pressures on NHS finances in the 2024/25 financial year, the Trust has continued its positive track record of achieving its financial plan for the year, delivering (on an adjusted NHS performance management basis) a breakeven or better position for the fifth year in a row.

The Trust's accounts report a deficit of £14.3m for the financial year; as this position includes adjustments that are outside of NHS performance

management purposes such as a £27.4m impairment of the Trust's estate. This impairment reflects the specific valuation methodology adopted by the Trust (like many other NHS Trusts) which values the site on a 'modern equivalent asset (alternative site)' basis. This valuation methodology has resulted in a reduction in the value of the site, rather than a reduction due to the condition of the Trust's estate (for further details on the accounting treatment, see section 1.7 of the Trust's Annual Accounts). The reported deficit also includes a number of other smaller adjustments that also do not count against the Trust's Adjusted Financial Performance for the year, as defined by NHS England. The Trust's Adjusted Financial Performance for the year was a small surplus of £0.05m.

The Trust continues to grow, with operating income increasing by £188m in 2024/25 to £1,627m. The Trust also continues to invest in its estate, equipment and digital infrastructure, with capital additions in year of £91.8m (£74.1m in 2023/24). Cash reserves remain reasonably strong with a balance of £100.7m as at 31 March 2025 (£139.6m at 31 March 2024).

2.7 Environmental matters, social, community and human rights issues

Taskforce on climate-related financial disclosures (TFCD)

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England. The phased approach incorporates the disclosure requirements of the governance pillar for 2024/25. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

The Board's oversight of climate-related issues

Oversight is driven by the Trust's Green Plan – *Our Action 50 Green Plan (Phase 1: 2022-24)*. This plan was approved by the Board in April 2022. This includes the full governance and delivery assurance arrangements. The Trust's Management Executive is provided with a full plan progress review every six months in relation to progress against the goals and targets for addressing climate-related issues encompassed by the Green Plan. This is subsequently presented to the Board on an annual basis.

This Annual Report includes a dedicated section covering progress and achievement of the Board-approved Green Plan. This reporting is in line with the NHS Standard Contract 2024/25 Service Condition 18.2.3, i.e., “provide an annual summary of progress on delivery of that plan, covering actions taken and planned, with quantitative progress data”.

Management’s role in assessing and managing climate-related issues

Alongside the above, the above the Green Plan has been directly overseen by four working groups (Buildings and Building Services, Purchasing and Waste, Travel and Transport, and Leadership and Engagement). These are scheduled to meet every two months to assure progress against the goals and targets relevant to the Green Plan actions within their respective terms of reference. The activity of the Working Groups is overseen by the Environmental Stewardship Committee which meets every six months and also takes escalation issues from each of the groups as and when required. It is the Chair of Environmental Stewardship Committee that presents the formal six-monthly Green Plan progress reports to the Trust’s Management Executive.

Furthermore, the extant Green Plan was subject to a full internal review by the Trust’s internal auditors. The final report (April 2024) was positive and supportive of the Plan, its delivery and governance – providing “significant assurance with minor improvement opportunities”.

Further detail regarding the activities and policies of CUH in other areas of social, environmental, community and human rights are outlined in Chapter 3, specifically within the equality, diversity and inclusion report and the sustainability and climate change report.

Risk management pillar

The Trust has a Risk Oversight Committee which is responsible for reviewing the Corporate Risk Register and Board Assurance Framework monthly.

Individual risks on the Corporate Risk Register are each owned by a lead Director with an allocated board assurance committee. Each risk is reviewed monthly by the risk owner

The Board Assurance Framework has a climate change risk (BAF 015) which outlines a set of key milestones on the journey to achieving the overarching aim of delivering net zero carbon by 2045.

Additionally, there are linked entries on our Corporate Risk Register regarding the impact of continued climate change on our ability deliver health care services.

Through the various themes of the Green Plan there are a series of outlined timeline targets that reflect the key milestones and lead into detailed actions that manage risk and develop co-benefits for i) physical infrastructure ii) clinical and support practice and iii) supply chain vulnerability.

The Trust seeks to ensure that where it is safe and possible to do so that all major business cases take account of the net zero ambition, and the risk assessment includes the potential impacts of climate change.

Further detail is outlined in Section 1 of the Sustainability and climate change report which outlines the approach taken and the governance model which has been developed to enhance escalation and assurance in section 3.29.

Metrics and target pillar

Through the development of our Green Plan the Trust has sought to have a clear trajectory towards net zero. In doing so we have developed a clear direct emissions descent plan showing our planned trajectory to net zero relative to the 2019/20 baseline figure.

Within this there is clarity on the baseline position relative to Scope 1, 2 and 3 emissions, with a clear focus on addressing those directly controllable emissions categorised in Scopes 1 and 2.

Further detail is outlined in Section 2 of the Sustainability and climate change report which outlines our performance and achievements in section 3.29.

2.8 Emergency Planning, Resilience and Response

Under the Civil Contingencies Act (2004), the Trust is classified as a Category One responder alongside other agencies at the core of an emergency response. As such, the Trust has a statutory duty to:

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plans.
- Put in place business continuity management arrangements.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.

- Share information with other local responders to enhance coordination.
- Cooperate with other local responders to enhance coordination and efficiency.

The roles and responsibilities to manage this are clearly outlined to ensure that the Trust has arrangements in place to respond appropriately to incidents or events affecting the health of the community and minimise any further disruption.

The Trust has an Incident Management plan, which sets out the process by which the organisation will respond to, manage and recover from an incident. The Chief Operating Officer, who has the role of the Accountable Emergency Officer for the Trust, sponsors this plan. The Trust's Lead Resilience Manager, who has the responsibility for ensuring it is reviewed in line with organisational policy, owns this plan.

The Trust's Incident Management plan and the Emergency Department's Major Incident plan along with other planning documents maintained by the Trust Resilience team are required to be reviewed annually to ensure they reflect recent changes in guidance and process.

The Trust's resilience team will prepare and submit the NHS England Emergency Planning, Resilience and Response (EPRR) Core Standards self-assessment later this year, with the deep dive subject expected to be on health inequalities. We hope to regain our fully compliant rating this year and continue to endeavour to be so with engagement from relevant subject matter experts. However, there may be changes due to recent changes announced for NHS England Regional Offices and Integrated Care Boards.

The Trust continues to deliver the gold standard of CBRNe service delivery. Changes to guidance and learnings from incidents are integrated as received and observed.

The EPRR team continues to support the Trust when managing issues that could affect the safe performance of services and patient care. Learning from incidents has been captured and integrated into planning arrangements in line with the EPRR strategy for the Trust.

The Trust continues to participate in emergency planning exercises and training and is an active member of both the Local Resilience Forum and Local Health Resilience Partnership working groups. We attend local and regional exercises. Further to this training capability, the Lead Resilience Manager is also now able to deliver EMERGO system-based training.

We maintain a pool of loggists to support the Trust in an incident. The Lead Resilience Manager remains able to provide in-house training in order to maintain this level of resilience.

To support the response to any incidents that might occur, further training is being delivered to the tactical on-call cohort ahead of them joining the on-call rota. This additional training adds practical elements to the otherwise theory based on-call training.
Emergency Planning priorities for 2025/26 include:

- Preparing the Trust's self-assessment of EPRR Core Standards.
- Continuing to capture and embed learning from incidents to inform future planning arrangements.
- Continuing to prepare and deliver a range of training and exercises across the Trust including inhouse EMERGO exercises and with multi-agency partners by offering CUH as a venue to ensure we maximise our opportunities and engagement.
- Continuing to write, update and test business continuity plans and business impact analyses for all areas of the Trust.
- Ensuring that the Trust's EPRR policies and procedures are current and dovetail with the asks of regional partners.
- Supporting any further contingency work related to RAAC (Reinforced Autoclaved Aerated Concrete) panels while working alongside the local and regional system to ensure evacuation planning is aligned.

2.9 Freedom to Speak Up

The Trust's Freedom to Speak Up Guardian reports to the Director of Corporate Affairs and is supported by a network of local listeners across the organisation. There is a link Non-Executive Director for Freedom to Speak Up.

The Freedom to Speak Up service offers a confidential service to all employees and workers to ensure their concerns are heard and acted upon. The Freedom to Speak Up Guardian works with staff and leaders across the Trust to ensure continued promotion and embedding of an open and listening organisational culture.

The total number of concerns raised with the FTSU service increased from 269 in 2023/24 to 295 in 2024/25.

From April 2022, the National Guardian's Office amended their data collection to four concern theme categories:

- Patient safety/quality
- Worker safety or wellbeing
- Bullying or harassment
- Other inappropriate attitudes or behaviours

The main themes of concerns raised during 2024/25 using the categories prescribed by the NGO were 'worker safety and wellbeing' and 'inappropriate attitudes and behaviours. Concerns can often be categorised within more than one category and experiencing difficulties at work commonly impacts worker wellbeing which accounts for the high number of concerns in this category. The staff groups accounting for the greatest proportion of concerns raised were registered nursing and midwifery staff, administrative and clerical staff and additional clinical support services (largely healthcare support workers).

The 2024 NHS Staff Survey results show that CUH is significantly above the national benchmark average for all of the Speak Up culture questions. For example, 65.9% of CUH staff say that they feel safe to speak up about anything that concerns them in the organisation compared with a national benchmark average of 60.5%.

The Freedom to Speak Up Guardian continues to engage with national, regional and local networks in order to promote learning and development.

2.10 Significant events after the balance sheet date

There were no significant events after the balance sheet date.

2.11 Joint forward plans and capital resource plans

The Trust has worked alongside the Cambridgeshire and Peterborough Integrated Care System (ICS) and system partners in the development of the Joint Forward Plan (JFP). This has included Trust representation and participation in the System Strategic Planning Group (SSPG) which has oversight responsibility for production of the Plan, and the Strategy and Planning Engagement Group which ensures co-ordination, alignment and a collaborative approach across strategies and operational plans.

Direct contribution to the content of the JFP has been provided by a number of system operational groups, which include Trust representatives, as well as existing strategies and plans from across the system.

The JFP across all partners of the Cambridgeshire and Peterborough ICS was submitted in June 2023, and is an ambitious plan that sets out the vision for the next five years of health and care services across Cambridgeshire, Peterborough and Royston.

The plan outlines the key areas of strategic delivery and reform, with the aim of making a demonstrable and sustainable impact on the lives of local people.

A joint capital resource use plan has been developed in collaboration with the Cambridgeshire and Peterborough ICB and partner trusts. Then, following iterations to align with the ICB funding envelope, the Trust's capital budget was agreed as part of this broader plan.

In 2024/25 the Trust performed well against the agreed capital plan and in late 2024 was able to secure additional capital funding from NHS England to accelerate the development of a number of pre-planned initiatives including the Digital Front Door for Outpatients programme, the Digital Front Door for ED programme, the command centre programme and the clinical co-pilot programme.

2.12 Health inequalities

In 2024-2025 Cambridge University Hospitals has, as members of the Cambridge & Peterborough Integrated Care System, continued to work with partners across the public and voluntary sector to help address the underlying causes of healthcare inequalities.

The Medical Director is a member of the Integrated Care Health Inequality Board established in 2022, and the Corporate Head of Nursing is a member of the associated operational group to support delivery of the published Cambridge & Peterborough Integrated Care System Healthcare Inequality Strategy which includes:

- A system-wide approach to addressing health inequalities, underpinned by population health management methodology
- Addressing inequalities through needs-based commissioning through the allocation of NHS funding proportionate to need
- Tackling inequalities in cardiovascular disease through targeted action on hypertension and diabetes

Patient Equality, Diversity and Service user Inclusion Plan

The Trust have developed an outline Patient Equality, Diversity & Service User Inclusion work plan for 2023-2025 to support delivery of the CUH trust strategy. In order to progress our work, an Equality, Diversity and Inclusion Operational Group (EDIOG) has been established to focus on patients, service users and visitors. Members of the group are staff from within the Trust who lead services directly contributing to delivery of our EDI agenda/work and have wider links with voluntary groups and patient networks. The group meets monthly and is chaired by a corporate Head of Nursing as part of the Chief Nurse's portfolio of service delivery and patient experience.

A Smoking Cessation Service for inpatients was launched in March 2024, and has two tobacco dependency advisors who will institute closer integration of smoking cessation services for:

- Acute adult Inpatients for early identification of health inequalities that manifest in smoking rates.
- Adolescents under paediatric care to try and extend some of the service towards adolescent smokers and vapers.
- Maternity to ensure the best start in life.

In 2025/26 the Trust will focus on a number of key measures focused around preventative care and supporting system wide strategic priorities including increasing the number of inpatient referrals to Smoking Cessation Services and increasing the number of 28 day follow up confirmed quits.

Services for patients with a visual impairments

Up to a third of our patients are recorded as visually impaired. The trust has Eye Clinic Liaison officer (ECLO) working to help meet the ever increasing volume of patient need. In addition to patient-facing work, the ECLO role broadly covers many other areas related to advocating for the needs of visually impaired patients; improving accessibility of information and the environment; visual impairment awareness training for staff; connecting with community groups and individuals to improve patient experience for both inpatients and outpatients across the Trust. This role is a positive example of system wide working, establishing strong networks across all sectors to ensure the patients receive optimal care and support.

Learning Disability and Autism

National evidence has shown that people with learning disabilities and autism have poorer health outcomes than others and are more likely to have multiple health conditions. Not having access to the right access/support required increases the chances of avoidable harm and premature death. The Equality Act 2010 places legal requirements for providers to ensure barriers are removed, to enable access to the right care/treatment and improve patient experience.

The Oliver McGowan Mandatory Training on Learning Disability and Autism Level 1 e-learning was successfully rolled out during 2023-2024 and the leads are working with the wider Integrated Care System on the implementation of the face to face elements of Tier 1 & 2 training package. The team are also active members of the Integrated Care System's Learning Disability Improvement Programme working together to review and improve the health response to Learning Disability across Cambridgeshire and Peterborough.

National Screening programmes

The Trust Screening programmes have focussed on health inequalities in the last year, involving collaboration with Healthwatch to reach communities with lower uptakes on the screening services. For example the Breast Screening team are working with national team to research optimal approaches to appointment scheduling, to boost uptake of the service within specific communities.

Working in collaboration with our system health partners and the Cambridge Gypsy Roma and Traveller (GRT) Community Development Officer, the trust is developing a health offer linked to attendance at community 'drop in' sessions using expertise from the trust/primary care to support with patient education and wellbeing such as women's health and screening and to establish trusting relationships with our communities.

Ongoing work

The Trust remains firmly committed to tackling health inequalities, a shared priority with our key partners. This commitment is underpinned by the adoption of the nationally endorsed Core20PLUS approach, which focuses on improving outcomes for the most disadvantaged populations.

CUH has introduced a smoking cessation programme, identifying smokers admitted to hospital and steering them to a community-based counselling service. We have engaged with a number of community partners, including faith groups, the Gypsy, Roma and Traveller community, homeless representatives, LGBTQ+ groups and Cambridge United, Mens Health partnership, to promote better health awareness and to understand how we can improve as a Trust to better meet the needs of our population

The Cambridgeshire South Care Partnership is central to delivering health and wellbeing closer to home. Through the Neighbourhood Health Service, local teams provide structured, proactive interventions aimed at preventing hospital and care home admissions and supporting timely discharge. The Neighbourhood Health Planning Guidelines outline our strategic direction, focusing on reducing pressure on acute services, enhancing access to primary care, and using data to understand and respond to population health needs.

Over the past 12 months we have implemented three system wide citizen facing programmes aimed at reducing hospital demand which are delivered by Integrated Neighbourhooods, those being the Tier 1 and Tier 2 High Impact Users programmes and the Work Well programme, aimed at those struggling to find or retain a job due to a health need. Collectively these

programmes have made a difference to thousands of people in the local area.

Further progress includes the development of Community Diagnostic Centres (CDCs), located in Ely and Wisbech, which are designed to support faster diagnostic pathways and reduce the amount of travel for rural communities. We are also building on the success of targeted cancer screening initiatives, which increased uptake in areas of higher deprivation by allocating resources based on levels of need, thereby also addressing one of the five priority clinical areas of focus within the Core20PLUS5.

Through 2025/26 the Trust plans to make progress in the development of an Integrated EDI and health inequalities strategy, which would lead to a set of priorities that are data informed and driven. The strategy will retain the three pillars of workforce, health inequality and user experience, acknowledging that there are different issues and challenges in each area. This will include the development of a series of key lines of enquiry that would allow us to develop a more data-rich approach to tackling inequity, and allow us to prioritise based on the reality of the resources available, including through making a case for investment if needed. In doing so we will seek to explore the opportunity to leverage resource from public health and the University to improve our internal analytics capacity.

Through the work of the Cambridge South Care Partnership, our locally developed Integrated Neighbourhoods are undertaking health improvement interventions tailored to the needs of their hyper-local populations.

For example, Community appointment days are taking place with increasing frequency in East Cambridgeshire and Cambridge City, and identifies a neighbourhood-level population healthcare need, provides a one-off opportunity to access a range of relevant health and care services in the same venue on the same day and through risk stratification identifies individual patients most likely to benefit from the intervention.

In collaboration with the Cambridgeshire and Peterborough Integrated Care System, the Trust will continue to compile key data measures ahead of formal publication in 2025/26. Further information regarding the work undertaken to address health inequalities can be found in the CUH 2024/25 Quality Account.

3. Accountability report

Directors' report

3.1 Board of Directors

The Board of Directors comprises full-time Executive and part-time Non-Executive Directors, the latter selected for their knowledge, areas of relevant expertise and experience. All directors meet the Fit and Proper Persons Requirements.

The role of the Board of Directors is to provide effective and proactive leadership of the NHS foundation trust, to set the strategic aims of the Trust, ensuring the quality, safety and effectiveness of the services provided; and to ensure that the Trust is well-governed in all aspects of its activities.

The section below demonstrates the balance, completeness and relevance of the skills, knowledge and expertise that each of the directors bring to the foundation trust.

The Board of Directors met 16 times during the 2024/25 year under review, six times in public and 10 times in confidential session.

3.2 Board and committee effectiveness

The performance of the Board of Directors is reviewed collectively as part of a board evaluation process; and individually, with each Board director undertaking performance appraisal with either the Chief Executive for the Executive Directors or the Chair for the Chief Executive and Non-Executive Directors. The Chair is appraised by the Senior Independent Director in consultation with the Lead Governor. Board committees undertake an annual review of their effectiveness against their terms of reference and work programmes and report to the Board of Directors on this.

3.3 Trust Chair

Dr Michael More, CBE – Chair (until 31 December 2024)

Mike became Chair of CUH on 11 April 2017, having served as a Non-Executive Director since September 2013. In December 2019 Mike was re-appointed for a further term of three years starting in April 2020, and in May 2022 he was re-appointed for a final term of office which ended on 31 December 2024.

He was Chair of the Cambridgeshire and Peterborough STP (the forerunner of the Integrated Care System or ICS) from 2018 until 2022, guiding it to successful transition to an ICS. Previously, he had an executive career in central and local government, starting with Cambridgeshire County Council and from 2002 until 2014 was Chief Executive of Suffolk County Council and the City of Westminster respectively.

Baroness Sally Morgan (from 1 January 2025)

Sally took up her role as Chair of CUH in January 2025.

She is also Master of Fitzwilliam College, University of Cambridge, sits on the University Council, and has been a Member of the House of Lords since 2001.

Sally was latterly Deputy Chair of Guy's and St Thomas' NHS Foundation Trust (GSTT) and prior to that was Chair of the Royal Brompton and Harefield NHS Trust.

She previously served in Tony Blair's government as Minister of State in the Cabinet Office, Political Secretary to the Prime Minister and Director of Government Relations at 10 Downing Street. She has been Chair of OFSTED, a board member of the Olympic Delivery Authority for the London 2012 Olympic Games and a board member of a number of businesses and charities.

3.4 Non-Executive Directors

Daniel Abrams – Non-Executive Director

Daniel was first appointed to the Board of Directors in September 2017. In March 2020 he was re-appointed for a further three-year term starting on 1 September 2020 and in March 2023 he was re-appointed for a final three-year term starting on 1 September 2023.

Daniel is a non-executive director of Genome Research Ltd (Wellcome Sanger Institute) where he is also the Audit Committee Chair. He was Audit Committee Chair of a portfolio company owned by GHO Capital until his resignation in September 2024. Daniel has previously held executive director positions including as Chief Financial Officer at Volex plc, Fiberweb plc, CDT inc and Xenova plc and senior executive roles at PepsiCo inc and Diageo plc. He is also a former non-executive director of the Biotech Industry Association and Panel member of the FRRP in the FRC.

Daniel has an MA (Hons) Law from Cambridge University and is a qualified chartered accountant, FCA, and barrister-at-law.

Dr Annette Doherty OBE FRSC – Non-Executive Director

Annette was first appointed to the Board of Directors in September 2017. In March 2020 she was re-appointed for a further three-year term starting on 1 September 2020 and in March 2023 she was re-appointed for a final three-year term starting on 1 September 2023.

Annette has 35 years of international experience working within the pharmaceutical sector, including at Warner-Lambert, Pfizer and most recently GSK where she was Senior Vice President, Global Head of Product Development and Clinical Supply. She has been directly involved in the research, development and launch of over 30 new medicines in respiratory, infectious diseases, cancer and inflammatory conditions.

She is currently Chair of Maidstone and Tunbridge Wells NHS Trust and Chair of East Kent Hospitals University NHS Foundation Trust. She is also President of The Royal Society of Chemistry (RSC), St John Ambulance and Tonbridge Grammar School Academy Trust. She has served on the Boards of various research, educational and charitable organisations including the Association for British Pharmaceutical Industry (ABPI) and the Medical Research Council.

She has a BSc in Chemistry and a PhD in Organic Synthesis from Imperial College London and conducted postdoctoral research with a NATO fellowship at Ohio State University.

She was recently elected as the next President of the Royal Society of Chemistry, a charity focusing on education and research to advance the chemical sciences.

In 2009, Annette was awarded an OBE in recognition of her services to the pharmaceutical sector.

Professor Ian Jacobs – Non-Executive Director (until 28 February 2025)

Ian was initially appointed to the Board of Directors for a three-year term commencing on 5 April 2022.

Ian is a surgeon, academic and university leader and previously worked as president and vice chancellor of the University of New South Wales (UNSW), Sydney, where he led an ambitious strategy to establish UNSW as one of the top 50 universities in the world. Prior to this Ian was dean of medicine and vice president of the University of Manchester and dean of medicine at University College London.

Ian qualified in medicine at the University of Cambridge and the University of London and trained as an obstetrician and gynaecologist, before

specialising as a women's cancer surgeon at St Bartholomew's Hospital and University College London Hospital. For the last 35 years Ian has led a research team working on screening for ovarian cancer which included the UK Collaborative Trial of Ovarian Cancer Screening.

In 1985, Ian founded the Eve Appeal charity, which funds research and raises awareness into gynaecological cancers, and in 2005 the Uganda Women's Health Initiative.

On 28 February 2025 Ian stepped down from his role as Non-Executive Director to take up the role of Chair of Barts Health NHS Trust.

Ali Layne-Smith – Non-Executive Director

Ali was appointed to the Board of Directors for a three-year term commencing on 13 January 2022 and was re-appointed for a further three years commencing on 13 January 2025.

Ali is an experienced Executive Human Resources (HR) Director who has worked in demanding and complex organisations in both the private and public sectors.

This has included roles at GE Healthcare and Johnson & Johnson. She was previously the Director of People and Organisational Development at West Midlands Police and the Director of People and Culture at the London Ambulance Service NHS Trust.

Professor Patrick Maxwell – Non-Executive Director (on sabbatical from 1 October 2024 to 31 December 2024)

Patrick is an ex-officio Non-Executive Director and was first appointed in 2012. Patrick is not subject to term limits as a Non-Executive Director.

Patrick Maxwell is Regius Professor of Physic and Head of the School of Clinical Medicine at the University of Cambridge.

As a clinician scientist he has been centrally involved in a series of discoveries that have revealed how changes in oxygenation are sensed, and how genetic alterations cause kidney disease.

Patrick is a Fellow of the Royal College of Physicians and the Academy of Medical Sciences, Director of Cambridge University Health Partners and a Non-Executive Director of Cambridge University Hospitals, Cambridge Enterprise, Scottish Mortgage Investment Trust and the International Biotechnology Trust.

Professor Andrew McCaskie – Non-Executive Director (covering for Patrick Maxwell from 1 October 2024 to 31 December 2024)

Professor Andrew McCaskie is a Professor of Orthopaedic Surgery at the University of Cambridge.

Andrew is the Director of the Arthritis Research UK Tissue Engineering Centre, which brings together many centres; University of Cambridge, Newcastle University, the University of Aberdeen, Keele University/the Robert Jones and Agnes Hunt Hospital NHS Foundation Trust in Oswestry and the University of York.

Dr James Morrow – Non Executive Director

James was appointed to the Board of Directors for a three-year term commencing on 1 November 2023.

He is a Cambridgeshire GP and a partner at Granta Medical Practices, where he was instrumental in its creation and growth to become one of the largest single practices in the East of England with over 58,000 registered patients.

From 2019 to 2023, James was co-chair of the Cambridgeshire South Care Partnership, the umbrella body bringing together all agencies from within the health, local authority and voluntary sectors with the intention of providing better and more integrated services for local residents.

From 2018 to 2022, he served as a Board Member for the Cambridgeshire and Peterborough Sustainability and Transformation Partnership.

James qualified in medicine from the University of Oxford in 1990, after pre-clinical studies at the University of Cambridge. He also has a degree in law.

Professor Sharon Peacock, CBE FMedSci – Non-Executive Director and Senior Independent Director (until 31 March 2025)

Sharon was first appointed to the Board of Directors in October 2015. She was subsequently re-appointed for a second term of three years commencing on 1 October 2018, and for a third three-year term which commenced on 1 October 2021. Her final term was subsequently extended to end on 31 March 2025, taking into account a six-month period of leave of absence from the Board during 2020 to support the national response to the Covid-19 pandemic.

Sharon Peacock is Master of Churchill College Cambridge, Professor of Public Health and Microbiology in the Department of Medicine at the University of Cambridge, an Honorary Fellow of St John's College Cambridge, and a Trustee of the Sir Jules Thorn Charitable Trust.

Sharon has built her scientific expertise around pathogen genomics, antimicrobial resistance, and a range of tropical diseases. She was the founding director of COG-UK (the COVID-19 Genomics UK Consortium), formed in April 2020 to provide SARS-CoV-2 genomes to UK public health agencies, the NHS and researchers. Prior to this, she dedicated more than a decade to the translation of pathogen sequencing into clinical and public health microbiology, as well as using sequencing to examine the transmission of antibiotic-resistant bacteria between humans, livestock, and the environment. Sharon has served and continues to serve the wider science ecosystem through appointments to numerous scientific Boards.

Sharon was made a Fellow of the Royal College of Physicians, London (2002), and a Fellow of the Royal College of Pathologists (2005). She was elected Fellow of the Academy of Medical Sciences (2013); Fellow of the American Academy of Microbiology (2014), Member of the European Molecular Biology Organization (EMBO); and elected to the Academia Europaea (2022). She was awarded a DSc (Honoris causa), Royal Veterinary College, London (2022), and gained a DSc (University of Southampton) in 20233. She was made an Honorary Fellow of the Royal College of Physicians in 2023.

In 2015, Sharon was appointed by Her Majesty The Queen to a Commander of the Order of the British Empire (CBE) for services to Medical Microbiology. She was awarded the Microbiology Society Unilever Colworth Prize for outstanding contribution to translational microbiology (2018); the Microbiology Society Marjorie Stephenson Prize for exceptional contributions to the discipline of microbiology (2023); and received the Medical Research Council Millennium Medal (2021).

After three full terms as a Non-Executive Director, Sharon left her role at CUH on 31 March 2025.

Rohan Sivanandan – Non-Executive Director

Rohan was appointed to the Board of Directors for a three-year term commencing on 1 August 2021 and was re-appointed for a further three years from 1 August 2024.

Rohan worked as an economist and senior executive in the private sector before moving into the education field. He worked across all phases of education, latterly as an education chief officer, before going on to set up his own consultancy specialising in organisational transformation and leadership coaching. He has held several senior executive and non-executive director positions across the education, judicial, health and social care sectors.

Currently, Rohan is a board director for CAFCASS (Children and Family Court Advisory and Support Service), sponsored by the Ministry of Justice, and a lay

member of the Independent Reconfiguration Panel which provides advice to the Secretary of State for Health and Social Care. Rohan is a panel member for the Nursing and Midwifery Council investigations committee and chairs NHS Mental Health Act hearings.

3.5 Executive Directors

Roland Sinker – Chief Executive

Areas of responsibility include: *accounting officer, overall responsibility for management of the Trust, ensuring its obligations and targets are met within a framework of prudent and effective systems of internal control*

Roland has served as Chief Executive of Cambridge University Hospitals NHS Foundation Trust (CUH) since 2015. From 2018 to 2021, he assumed the accountable officer role for the integrated care system partners in Cambridgeshire and Peterborough, who between them serve a population of 1 million people with a health and social care spend of £1.5 billion. The integrated care system and the hospital trust are heavily focused on innovation and improvement, linking with universities and industry to deliver this. He was Chair of the Shelford Group of ten teaching hospitals from 2020 to 2023, and leads nationally on life sciences for NHS England.

CUH is one of the UK's foremost specialist referral centres and delivers world-leading teaching and research as well as providing local care for the people of Cambridgeshire. The Trust is a founding partner in the Cambridge Biomedical Campus, where its neighbours include the world-famous Laboratory of Molecular Biology, part of the University of Cambridge. With a turnover of £1.6 billion, the Trust is a high performing centre for clinical care and patient experience, rated as Good overall and Outstanding for well-led and Caring with the Care Quality Commission. The Trust runs the UK's most digitally developed hospitals and is a multi-award winning centre for the use of digital systems to improve patient care.

Before joining CUH, Roland was chief executive, chief operating officer and strategy director at King's College Hospital NHS Foundation Trust. He began his career in the field of corporate law at Linklaters, based in London and Hong Kong, and later moved to McKinsey to work in strategy consultancy.

Nicola Ayton – Deputy Chief Executive (from April 2024)

Areas of responsibility include: *overall responsibility for management of the Trust, ensuring its obligations and targets are met within a framework of prudent and effective systems of internal control*

Nicola joined Cambridge University Hospitals in 2018 and was appointed to the role of Deputy Chief Executive in April 2024. Prior to that Nicola was Chief Operating Officer for four years having previously been the Director of Strategy and Major Projects.

Nicola has held senior national roles at NHS England including leading on strategy and delivery for New Care Models and the development of Integrated Care Systems. She has also worked in the Prime Minister's Delivery Unit at No 10 Downing Street where she acted as an expert adviser on integrated health and care.

Prior to that Nicola worked as a Senior Policy Adviser in central Government at HM Treasury and the Department of Education. She started her career at Deloitte after graduating from the University of Oxford.

Dr Sue Broster – Director of Innovation, Digital and Improvement

Areas of responsibility include: *Innovation, digital and IT, information governance, and improvement and transformation*

Dr Sue Broster is the Director of Innovation, Digital and Improvement at CUH and a Consultant Neonatologist.

Sue has a strong track record in leading innovation, digital and improvement in large and complex environments. This includes the development of the digital health environment at CUH encompassing: the virtual wards programme; implementation of the whole Trust improvement programme in partnership with the Institute of Healthcare Improvement; transformational change at scale including the recent development of a new paediatric / neonatal retrieval service in the East of England; and has led the setup of the East of England specialist services provider collaborative - a group of 10 hospitals within the East of England working together to achieve the best outcomes for the population of the East region by delivering integrated, preventative, high-quality specialised care closer to home. Sue has a wealth of experience working with academic, industry and other NHS partners.

Mike Keech – Chief Finance Officer

Areas of responsibility include*: financial strategy, financial planning, financial management, estates and facilities, commissioning and contracting and statutory accounts.*

Mike has been the Chief Finance Officer at CUH since November 2020, having previously worked as Director of Finance at Milton Keynes University Hospital NHS Foundation Trust. Prior to that, Mike held a number of roles at Monitor (now NHS Improvement) with a focus on supporting organisations and systems to develop long term plans to ensure financial sustainability.

Mike originally trained with the accountancy firm Deloitte and is member of the Institute of Chartered Accountants in England and Wales (ICAEW).

Dr Ashley Shaw – Medical Director

Areas of responsibility include: *professional medical governance; medical revalidation clinical outcomes; infection prevention and control; research and development; medicines management; clinical networks; GP liaison; undergraduate education; post-graduate education.*

Ashley took up the post of Medical Director for CUH in November 2017. He joined the Trust as a Consultant Radiologist with an interest in cancer imaging in 2004 and became Divisional Director for Investigative Sciences in 2012, subsequently for Division B from 2014.

Ashley leads and is responsible for the professional activities of the medical staff within CUH, medical research, postgraduate medical education, infection prevention and control, medicines, medical equipment and information governance within the organisation. Ashley continues to practice as a radiologist.

Ashley's term of office as Medical Director ended on 31 March 2025. Dr Sue Broster was Interim Medical Director from 1 April 2025 and was subsequently appointed as the Trust's substantive Chief Medical Officer.

Claire Stoneham – Director of Strategy and Major Projects

Areas of responsibility include: *establishing and agreeing strategic choices, business planning, working with partners across the Integrated Care System and East of England, and delivering major new hospital developments.*

Claire joined CUH in June 2020 from the Department of Health and Social Care, following a secondment in to the role of Executive Programme Director for the Cambridgeshire and Peterborough Sustainability and Transformation Partnership.

During a 15 year career, her national roles included the Director of Provider Efficiency and Performance, covering NHS performance standards, hospital discharge, efficiency savings and cost recovery; and Principal Private Secretary to the Secretary of State for Health.

Claire is responsible for the Trust's strategy, including how we work with partners across the Integrated Care System, East of England region and on the Cambridge Biomedical Campus, and for the programme of major projects under the Addenbrooke's 3 umbrella, including the Cambridge Children's and Cancer Research Hospitals.

Lorraine Szeremeta – Chief Nurse

Areas of responsibility include: *nursing and midwifery strategy and standards, executive lead for maternity safety, quality and safety and patient experience, safeguarding children and vulnerable adults, professional lead for allied health professionals, and executive lead for psychological medicine services.*

Lorraine joined CUH as Chief Nurse in July 2018, coming to the organisation from University College London Hospitals, where she had worked as Deputy Chief Nurse for the surgery and cancer board for 5 years. During her time in London she also worked on a part time seconded basis on the pan London Capital Nurse programme, leading on retention workstreams.

Lorraine has held a number of senior management and nursing roles throughout her career in a number of different organisations, and has a keen interest in staff development and organisational culture. She is co-chair of the Shelford Group's Safer Nursing Care Tool Steering Group and a member of the NHSI Safe Staffing Faculty Steering Group. She is also Chair of the Shelford Chief Nurse group and the Chief Nurse for the East Genomic Medicine Service Alliance (GMSA).

Ian Walker – Director of Corporate Affairs

Areas of responsibility include: *corporate governance, communications, public engagement, medico-legal services, foundation trust membership and raising concerns.*

Ian joined the Trust in May 2017, having previously worked at Barts Health NHS Trust for 14 years as Director of Corporate Affairs and Trust Secretary. Prior to that, Ian worked at Her Majesty's Treasury where he undertook a wide range of roles, including on health policy and funding.

In his role Ian leads on corporate governance, public engagement, medico-legal services, communications and foundation trust membership. Ian is also executive lead for raising concerns.

David Wherrett – Director of Workforce

Areas of responsibility: *human resources, diversity and inclusion, staff health and wellbeing, medical staffing, education, learning and development, temporary staffing and volunteering.*

David Wherrett is the Trust's Director of Workforce, joining CUH in April 2014 and leading on all aspects of the Trust's workforce agenda.

David has a wide ranging experience of leading workforce and organisational development teams in various organisations. He has spent the majority of his career in the NHS, primarily in hospitals. His focus is to ensure that CUH staff have a positive experience of work, are able deliver excellent care for patients, outstanding research and great education opportunities.

3.6 Register of interests

At the time of their appointment, all directors are asked to declare any interests on the register of directors' interests and are expected to declare any changes to the register of interest on an ongoing basis.

The register is available online at https://cuh.mydeclarations.co.uk/. The register is reviewed on a quarterly basis and maintained by the Director of Corporate Affairs.

3.7 Appointment of Chair and Non-Executive Directors

The Council of Governors has responsibility for appointing the Chair and the other Non-Executive Directors (except in the case of the Regius Professor of Physic) in accordance with the Constitution and in line with relevant legislation.

Candidates are nominated by the Council of Governors' Nomination and Remuneration Committee. This Committee comprises two public governors, two patient governors, one staff governor and one partnership governor. It is chaired by the Chair of the Trust for Non-Executive Director appointments only, and by a governor (currently Partnership Governor Karen Woodey) for all its other functions including the appointment of the Trust Chair.

Non-Executive Directors are normally appointed for a term of three years. Following this term, and subject to satisfactory performance appraisal, a Non-Executive Director is eligible for consideration by the Council of Governors for re-appointment for subsequent terms of up to three years each up to a maximum cumulative total of nine years' service.

In May 2022 the Council of Governors amended the Trust Constitution to allow a Chair, in exceptional circumstances, to serve on the Board of Directors for a cumulative maximum period of 12 years.

When undertaking its nomination responsibilities, the Committee reviews the structure, size and composition (including skills, knowledge and experience) required of the Board of Directors compared to its current position and makes recommendations for change when appropriate.

The removal of a Non-Executive Director requires the approval of three quarters of members of the Council of Governors. Details of the criteria for

disqualification from holding the office of a director can be found in the Constitution.

Disclosures of the remuneration paid to the Chair and Non-Executive Directors (and also to the Chief Executive and Executive Directors) are given in the remuneration report at section 3.22.

3.8 Non-Executive Directors' expenses

CUH is committed to reimbursing expenses incurred on Trust business to the Chair and Non-Executive Directors at rates set by the Council of Governors. A copy of the policy is available from the Director of Corporate Affairs.

Corporate governance report

3.9 Attendance at Board meetings in 2024/25

Meeting dates

2024: 10 April, 8 May, 12 June, 10 July, 10 September, 18 October, 12 November, 11 December

2025: 22 January, 12 February, 12 March

There were two separate meetings of the Board of Directors on the dates listed above in each of May, July, September and November 2024 and in January 2025. A total of 16 Board meetings were therefore held in 2024/25.

Table 2: Attendance at Board meetings in 2024/25

Name	Title	Attendance
Dr Michael More [1]	Trust Chair	10/12
Baroness S Morgan [2]	Trust Chair	4/4
Daniel Abrams	Non-Executive Director	16/16
Nicola Ayton	Deputy Chief Executive	16/16
Dr Sue Broster	Director of Innovation, Digital and Improvement	14/16
Dr Annette Doherty	Non-Executive Director	15/16
Professor Ian Jacobs [3]	Non-Executive Director	13/15
Mike Keech	Chief Finance Officer	16/16
Ali Layne-Smith	Non-Executive Director	16/16
Professor Patrick Maxwell [4]	Non-Executive Director	9/12

Professor Andrew McCaskie [5]	Non-Executive Director	2/4
Dr James Morrow	Non-Executive Director	16/16
Professor Sharon Peacock	Non-Executive Director	15/16
Dr Ashley Shaw	Medical Director	14/16
Roland Sinker	Chief Executive	16/16
Rohan Sivanandan	Non-Executive Director	16/16
Claire Stoneham	Director of Strategy and Major Projects	16/16
Lorraine Szeremeta	Chief Nurse	16/16
Ian Walker	Director of Corporate Affairs	16/16
David Wherrett	Director of Workforce	16/16

[1] Dr Michael More left the Trust on 31 December 2024.
[2] Baroness Sally Morgan joined the Trust on 1 January 2025.
[3] Ian Jacobs left the Trust on 28 February 2025.
[4] Professor Patrick Maxwell took a sabbatical from 1 October 2024 to 31 December 2024.
[5] Professor Andrew McCaskie covered for Professor Maxwell between 1 October 2024 and 31 December 2024.

3.10 Committees of the Board of Directors

The Board of Directors is required to establish and maintain an Audit Committee and a Remuneration Committee. Further details about the Audit Committee and the Remuneration Committee are contained in Sections 3.11 (Audit Committee) and 3.22 (Remuneration and Nomination Committee).

The Board of Directors has also established the following committees of the Board:

- Addenbrooke's Futures Committee
- Performance Committee
- Quality Committee
- Workforce and Education Committee

The membership of the committees is determined by the Chair of the Trust in consultation with the Board of Directors. Any changes to the membership of committees are reported to the Board of Directors.

Table 3 below shows Board committee membership as at 31 March 2025.

Table 3: Committee membership as at 31 March 2025

Board Committee	Membership
Audit Committee	NEDs: Daniel Abrams (Chair), Dr Annette Doherty, Prof Sharon Peacock *Note: John Crompton was appointed as a NED from 1 April 2025 and became a member of the Audit Committee in succession to Sharon Peacock. He has therefore been a member of the Committee during the period of the review and approval of the Annual Report and Accounts for 2024/25.*
Remuneration and Nomination Committee	NEDs: Ali Layne-Smith (Chair), all Non-Executive Directors including the Trust Chair are members
Quality Committee	NEDs: Dr James Morrow (Chair) Prof Sharon Peacock, Rohan Sivanandan Executive Directors: Chief Nurse and Medical Director
Performance Committee	NEDs: Dr Annette Doherty (Chair), Daniel Abrams, Ian Jacobs *(until 28 February 2025)* Executive Directors: Chief Finance Officer and Medical Director
Workforce and Education Committee	NEDs: Rohan Sivanandan (Chair), Ali Layne-Smith, Prof Patrick Maxwell Executive Directors: Director of Workforce, Chief Nurse and Medical Director
Addenbrooke's Futures Committee	NEDs: Prof Ian Jacobs, Dr James Morrow, Prof Patrick Maxwell Executive Directors: Director of Strategy and Major Projects, Chief Nurse, Medical Director

Table 4: Attendance of committee members at Board Committee meetings in 2024/25

Addenbrooke's Futures Committee

Name	Title	Attendance
Professor Ian Jacobs	Chair	5/5
Dr James Morrow	Non-Executive Director	5/5
Professor Patrick Maxwell	Non-Executive Director	3/5
Dr Ashley Shaw	Medical Director	3/5
Claire Stoneham	Director of Strategy and Major Projects	4/5
Lorraine Szeremeta	Chief Nurse	3/5
Dr Sue Broster	Director of Innovation, Digital and Improvement	5/5

Audit Committee

Name	Title	Attendance
Daniel Abrams	Committee Chair	5/5
Dr Annette Doherty	Non-Executive Director	5/5
Professor Sharon Peacock	Non-Executive Director	5/5

Performance Committee

Name	Title	Attendance
Dr Annette Doherty	Committee Chair	11/11
Daniel Abrams	Non-Executive Director	10/11
Nicola Ayton - *to 30 April 2024*	Chief Operating Officer	1/1
Professor Ian Jacobs - *to 28 February 2025*	Non-Executive Director	10/10
Mike Keech	Chief Finance Officer	11/11
Dr Ashley Shaw	Medical Director	11/11

Quality Committee

Name	Title	Attendance
Professor Sharon Peacock	Committee Chair	6/6
Dr James Morrow – *Chair from January 2025*	Non-Executive Director	6/6
Dr Ashley Shaw	Medical Director	6/6

Rohan Sivanandan	Non-Executive Director	5/6
Lorraine Szeremeta	Chief Nurse	5/6

Remuneration and Nomination Committee

Name	Title	Attendance
Ali Layne-Smith	Committee Chair	4/4
Daniel Abrams	Non-Executive Director	4/4
Dr Annette Doherty	Non-Executive Director	3/4
Professor Ian Jacobs	Non-Executive Director	2/4
Professor Patrick Maxwell – on sabbatical from 1 October	Non-Executive Director	1/2
Professor Andrew McCaskie – *from 1 October 2024 to 31 December 2024*	Non-Executive Director	1/1
Dr Michael More - *Until 31 December 2024*	Trust Chair	2/3
Baroness Sally Morgan – *from 1 January 2025*	Trust Chair	0/1
Dr James Morrow	Non-Executive Director	4/4
Professor Sharon Peacock	Non-Executive Director	1/4
Rohan Sivanandan	Non-Executive Director	2/4

Workforce and Education Committee

Name	Title	Attendance
Rohan Sivanandan	Committee Chair	4/4
Ali Layne-Smith	Non-Executive Director	4/4
Professor Patrick Maxwell	Non-Executive Director	0/4
Dr Ashley Shaw	Medical Director	3/4
Lorraine Szeremeta	Chief Nurse	4/4
David Wherrett	Director of Workforce	4/4

Other Directors and Senior Managers attend committees as required.

3.11 Audit Committee

Membership of this committee is made up of Non-Executive Directors and the committee was chaired by Daniel Abrams for the entire reporting period.

The committee's primary role is to oversee the governance and assurance process and the effectiveness of the risk management system and the control environment, including the Trust's financial systems and annual financial statements. It considers any matters concerning the external auditors, and also the adequacy of the Trust's internal audit arrangements.

The committee's terms of reference are available on the Trust website.

Meeting dates

The Audit Committee met as follows:

2024: 24 April, 11 June, 18 September and 27 November
2025: 26 February

A summary of attendance at the Audit Committee during 2024/25 is included in Table 4 in Section 3.10.

In addition, the Audit Committee met on 10 June and 25 June 2025 to consider the 2024/25 Annual Report and Accounts. As noted in Table 3 in Section 3.10, John Crompton replaced Sharon Peacock as a member of the Audit Committee for these two meetings.

Significant issues – update following Audit Committee

The Audit Committee met on 10 June 2025 and 25 June 2025 to consider the financial statements for the period for the period 2024/25. The Audit Committee reviewed the financial statements and identified no significant issues with the statements.

External auditors

During 2023/24, the Council of Governors accepted the recommendation from the Audit Committee to re-appoint Mazars LLP as the Trust's external auditors for a further two years (2024/25 and 2025/26).

Mazars LLP reports to the Council of Governors through the Audit Committee. Mazars' accompanying report on the financial statements is based on its examination conducted in accordance with Code of Audit Practice as issued by the National Audit Office. Their work includes a review of the Trust's internal control structure for the purposes of designing their audit procedures.

The external audit process is subject to annual review by the Trust in terms of competency, efficiency and the relationship between the Trust and its auditors. The Audit Committee meets with the auditors (Internal and

External) without any of the Trust's Executive Directors present prior to each meeting to improve its knowledge of their contribution.

Non-audit work may be performed by the external auditors where the work is clearly audit-related and the external auditors are best placed to do that work. For such assignments the Audit Committee approved protocol is followed which ensures all such work is properly considered. The processes in place ensure auditor objectivity and independence is safeguarded.

Audit Fees

The statutory audit fee, including quality account and whole of government accounts and others is included in Note 3 to the accounts.

Internal auditors

During 2019/20, following a tender process, KPMG were re-appointed as the internal auditors for the Trust with effect from 1 April 2020.

The internal auditors are responsible for undertaking the internal audit functions on behalf of the Trust. The Head of Internal Audit reports to each meeting of the Audit Committee on the audit activity undertaken.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the 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. Further details are provided in the Annual Governance Statement at Section 3.28.

3.12 Remuneration and Nomination Committee of the Board of Directors

The work of the Remuneration and Nomination Committee is described in Section 3.22.

There is also a Governors' Nomination and Remuneration Committee which oversees the appointment and remuneration of Non-Executive Directors as described in Section 3.4.

3.13 Cost statement

The Trust has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector information guidance during 2024/25.

3.14 Better payment practice code

The Trust's performance against the better payment practice code in 2024/25 was as follows:

Better payment practice code	Expected Sign	19ACTYTD01 Current YTD Actual 31/03/2025 YTD Number	19ACTYTD Current YTD Actual 31/03/2025 YTD £'000
Non NHS			
Total bills paid in the year	+	173,630	669,433
Total bills paid within target	+	155,083	587,167
Percentage of bills paid within target	%	89.3%	87.7%
NHS			
Total bills paid in the year	+	3,915	97,852
Total bills paid within target	+	2,184	60,281
Percentage of bills paid within target	%	55.8%	61.6%
Total			
Total bills paid in the year	+	177,545	767,285
Total bills paid within target	+	157,267	647,448
Percentage of bills paid within target	%	88.6%	84.4%

3.15 Quality Plan

In 2022 the Trust published a three-year strategy which articulated our vision to deliver a healthier life for everyone through care, learning and research. We seek to achieve this as a Trust, as a core provider within a wider health and care system, as part of a dynamic biomedical campus and through our role locally, regionally, nationally and internationally.

Our three core strategic pillars - Improving patient care, Supporting our staff, and Building for the future – remain fundamental to our approach, but we have focused this year particularly on the changes we need to make across the Trust to continue to provide the best care for our patients and to keep improving services

Providing high quality care to our patients is at the heart of our trust strategy. We are committed to continuously improving our services to provide safe care, the best possible outcomes for our patients and an overall positive experience for all, including our staff.

Quality is also at the core of our Nursing, Midwifery and AHP strategy, with a commitment to *'embed fully the accreditation programme, encouraging*

ownership of data at ward/department level so teams can see how well they are doing and run their own quality improvement projects'.

As part of this strategy, the Quality Programme has been developed to support the delivery of high-quality care every day, quality assurance to monitor this, and support continual improvement.

The Good Quality Care, Everyday in Our Hospitals was launched in spring 2024 and consists of 3 key work streams - Care Quality Assurance, Safety Culture and Statutory and Regulatory compliance. Within each of these key work streams, there are detailed plans and improvement projects underway, so for example in the care quality assurance work stream, we are working on the following four objectives:

- Improving 'first impressions' of the organisation with a programme called "Our Place"
- Ensuring educational excellence by supporting staff to have the competence and confidence in their roles,
- A focus on good quality care with a harm free care programme led by the Heads of Nursing
- Implementing consistent standards through ward accreditation.

The programme has a strong emphasis on staff engagement, provision of exceptional patient care, and continuous improvement, while celebrating areas of excellence.

In spring 2025 the Trust will refresh its current strategic direction of travel, recognising the need to develop our core services, including in terms of short and longer-term productivity gains, to build the foundation for the change needed to meet demographic pressures and deliver sustainable healthcare through new models of care.

3.16 Income statement

CUH has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that the Trust's 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. Other income which the Trust has received has had no impact on its provision of goods and services for the purposes of the health service in England.

3.17 Statement regarding disclosure to auditors

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all of the steps that

they ought to have taken as directors to be aware of any relevant audit information and to establish that the auditors are aware of that information.

3.18 Patient care

Improvements in patient/carer information

It is important to the Trust that the information provided to patients, families and carers is of a high quality and appropriate for people from a variety of backgrounds.

The Reader Panel are thirty one volunteers from the local community. They review from a patient's perspective approximately ten new adult patient information leaflets per month.

The members provide feedback to the leaflet author on suggestions to ensure that the information:

- has a patient-friendly tone.
- any medical terminology is clearly explained in everyday language.
- Appropriate images are used to support written explanations.
- text meets the NHS England recommendation for patient accessible resources to have a readability score of 9-11 years old.

During 2024/25 the Panel reviewed 78 new leaflets.

The “readability score” indicates how easy it is for someone to read text. This is important to ensure that patients and their families/carers can access and understand medical instructions, treatment options as well as preventive measures. This in turn can help foster patient confidence and active engagement with their treatment.

Compliance of in-date patient information leaflets and procedure specific consent forms is reported monthly to each division’s governance forums and escalated to the Patient Experience Group where appropriate.

MyChart provides patients with electronic access (via a mobile app or website) to their clinical records held at the Trust. At the end of March 2025 there were 282,467 patients with an active MyChart account. Over the last year, 68% of patients who attended Outpatients used MyChart, an increase of 11% from 2023/24.

A total of 4.3 million test results were released to patients, and the portal had been accessed by over 9 million logins.

The Accessible Information Standard

The Accessible Information Standard (AIS) sets out the requirements for NHS organisations to identify, record, flag, share and meet patients' and carers' information and communication support needs – for example, providing printed information in a large typeface, or arranging for a British sign Language interpreter to attend a patient's appointment. Systems are in place across the Trust to meet our obligations, and over the year a steering group continued to work towards improving our performance against the Standard.

The Trust's website complies with accessibility standards and can be used by people with a range of needs.

Patients and carers are invited to tell us about their communication and information needs, and staff - supported by the CUH Accessibility Team - work to meet the needs. Improvements have been made to record patients' information and communication needs in our electronic patient record system: the recording system has been standardised and improved so that it is easier for staff to record and see patients' needs.

However, the provision of communication and information in appropriate formats is not always consistent for all patients and carers. Work continues on the development of an automated system for the provision of individual patient communications in accessible formats.

As a result of this work, we have achieved Shaw Trust accreditation and ranked in the top 3 of all NHS websites for accessibility on the Silktide index in March 2025.

The work undertaken has not only ensured compliance with regulations but also significantly improved user experience for all visitors ensuring an inclusive and accessible digital platform.

Information on complaints handling

The Trust welcomes patient feedback and aims to make the complaints process accessible and responsive. The information from complaints investigations is used to make improvements to treatment and patients' experience of care.

In 2024/25 CUH received 911 complaints, a 23% increase on the previous year's total of 739.

The overall rate of complaints was 0.06% of activity, the same as the previous year at 0.06% ('activity' here means patient episodes, e.g. an

inpatient stay or an outpatient attendance). This is also similar to other Trusts with published data (range 0.06% - 0.08%).

Of the total number of complaints received in 2024/25, investigated and closed at the date of reporting (807 at 1 April 2025), 181 were fully upheld, 319 were partially upheld and 264 were not upheld after investigation. Where complaints are not upheld – where it is considered that there were no shortfalls in the care provided – an explanation is provided, and apology for the patient's negative experience. 147 cases received in 2024/25 remain open as the time of reporting.

The complaints regulations require NHS organisations to acknowledge complaints within three working days. In 2024/25, we achieved this in 90% of cases.

Under current legislation, NHS organisations have six months to resolve a complaint: this allows for flexibility and agreement with the complainant as to an appropriate timescale for investigating and responding. CUH aims to provide a response in as timely a manner as possible, and for the year 2024/25 responded to 57% of the complaints closed to date within the initial set timeframe

The complaints team continues to work closely with the divisional teams in order to ensure timely and comprehensive responses to complaints and this includes regular meetings with the divisional teams to discuss any complaint related issues and difficult cases.

Following a review of the complaint triage process, complainants are now contacted to ensure the team meet their expectations and meetings (either face to face or via Teams) and telephone calls from senior staff are encouraged to support early resolution. Response time frames have now been set to 30 working days for a telephone call, 45 working days written response and 60 working days for a complex written response or meeting.

Feedback so far has seen complainants express that they have felt listened to and appreciated having options of different ways to resolve their complaint (for example through a telephone call and discussion instead of a letter).

The PALS team took part in an improvement project to reduce their backlog of open cases including process mapping and different ways of working. In 2024/25 CUH received 5,709 PALS concerns and closed 5,690, maintaining that improvement and at the time of this report they have 240 open cases. In 2024/25 the 84% of PALS concerns were closed within the 10 day timeframe.

3.19 Stakeholder engagement

Patient experience

The Patient Experience Group, chaired by the Chief Nurse, monitors activities relating to learning from and improving patient experience. The group meets bi-monthly and has governor representation to ensure that the views of members and the public are heard.
Information reviewed by the Group includes complaints, concerns and compliments, the 'Friends and Family Test' survey results, local and national patient survey results, the work of Trust patient participation groups, reports from Trust operational groups such as the Carers' Working Group and the Patient Communications Group, and other sources of feedback such as that received by Healthwatch. Patient experience data are also reviewed at specialty clinical governance meetings, divisional governance meetings and cross-divisional groups such as the Outpatients Board.

Results of the Friends and Family Test surveys show that the Trust continues to be rated very positively by patients.

The Trust participated in the relevant national survey programmes over the year and action plans were prepared after consideration of the findings. Local surveys are also carried out to supplement as required.

Patient participation groups are active in several services across the Trust, and the groups undertook a variety of projects over the year.

Cambridge University Health Partners (CUHP) and Academic Health Science Centre

Cambridge University Health Partners (CUHP) is one of eight Academic Health Science Centres in England whose mission is to improve patient healthcare by bringing together the NHS, industry and academia.

The partners are Cambridgeshire and Peterborough NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust, Royal Papworth Hospital NHS Foundation Trust and the University of Cambridge.

By inspiring and organising collaboration, CUHP aims to ensure that patients reap the benefits of the world class research, clinical services and industry based in Cambridge and the surrounding area.

For more information on CUHP please see www.cuhp.org.uk.

Consultation with local authorities covering the membership area

The Trust works with a range of local authorities across the region including as a member of the Cambridgeshire and Peterborough Integrated Care System.

Education and training

CUH is a teaching hospital for medical undergraduates and postgraduates, Nurses, Midwives and Allied Health Professions. Patient-centred teaching is one of our core activities and is central to our vision. We are the teaching hospital for the University of Cambridge through the School of Clinical Medicine and the Postgraduate Medical Centre which provide the infrastructure and support to facilitate the education, training and continuing development of postgraduate professionals in hospital medicine, general practice and dentistry.

At CUH, we work in partnership with 12 higher education institutions to facilitate 900 clinical placements for pre-registration Nursing, Midwifery and Allied Health Professionals per year. The Clinical Education Team provide teaching, clinical supervision and facilitation of learning to these students alongside the practice educators, supervisors and assessors within the clinical environment. In addition to the traditional university degree programmes, CUH also provides a 'grow your own' apprenticeship pathway with degree apprenticeships for Assistant Practitioner, Nursing, Nursing Associate, Health Care Science, Physiotherapy, Occupational Therapy, Operating Department Practitioners and Diagnostic Radiographers. CUH is currently supporting 403 clinical apprenticeships within the Trust.

Research and development

In partnership with the University of Cambridge, Cambridge University Hospitals hosts a NIHR Biomedical Research Centre, a NIHR Clinical Research Facility (CRF), a NIHR Experimental Cancer Medicine Centre, and a NIHR HealthTech Research Centre and the NIHR Bioresource. The UK Clinical Research Collaboration registered Cambridge Clinical Trials Unit (CCTU) and Cambridge Epidemiology and Trials Unit deliver research in priority areas of health and social care and public health across all phases of clinical trials, involving NHS organisations, academia, and industry.

NIHR Cambridge Biomedical Research Centre (BRC)

The NIHR Biomedical Research Centre has been awarded £86.2m for the period 2022 to 2027 to translate scientific discoveries from the laboratory into the clinic. It supports research across 13 thematic areas - antenatal, maternal and child health; cancer; cardiovascular and respiratory disease; data science and population health; devices and advanced therapeutics; genomic medicine; imaging; immunity, inflammation and transplantation; infectious disease threats; mental health; neurodegenerative disease and dementia; neuroscience; nutrition, obesity, metabolism and endocrinology.

NIHR BioResource

The NIHR BioResource, a national recallable resource involving over 120 NHS organisation and over 270,000 volunteers from the general population, and patients with rare and common diseases. It is one of four key infrastructures supporting population level genomic projects in the Life Science Industrial Strategy. A recent focus has been on increasing inclusivity through the Improving Black Health Outcomes study and the DNA Children and Young People's Health Resource.

Cambridge Clinical Research Centre (CCRC)

The NIHR Cambridge Clinical Research Facility (CRF) was awarded £15,200,000 for the period 2022 to 2027 to support experimental medicine research, working in partnership with industry, UKRI, other NIHR Infrastructure, charity partners and the wider NHS.

NIHR HealthTech Research Centre

The NIHR HealthTech Research Centre in Brain Injury has been awarded £3m for the period 2024 to 2029 to support new technologies designed to improve the experience of people affected by disorders of the brain or spine, and make these technologies more widely available.

3.20 Trust membership

The membership

The foundation trust membership of CUH is split into three constituencies: patient, public and staff.

Public Membership

Any person who is 16 years of age or over and who lives within our membership area is eligible for public membership.

Table 5: The membership area

Braintree District Council	Bumpstead electoral ward
Cambridge City Council	All wards
East Cambridgeshire District Council	All wards
East Hertfordshire District Council	Buntingford; Braughing and Standon, The Mundens, and Little Hadham and The Pelhams electoral wards

North Hertfordshire District Council	Ermine; Royston Palace; Royston Meridian and Royston Heath electoral wards
South Cambridgeshire District Council	All wards
Uttlesford District Council	Ashdon; Clavering; Debden and Wimbish; Littlebury, Chesterford and Wenden Lofts; Newport; Saffron Walden Audley; Saffron Walden Castle; Saffron Walden Shire; The Sampfords; Takeley and Thaxted and the Eastons electoral wards
West Suffolk Council	Clare, Hundon and Kedington; Exning All Haverhill Wards (West, North, East, South, Central and South East); Newmarket East; Newmarket North; Newmarket West and Withersfield electoral wards

Patient membership

Any individual who has been a patient at any of the Trust's hospitals from 5 July 1948, or who has been a carer of a patient who meets that criterion, is eligible for patient membership, regardless of where they live, as long as they are aged 16 years or over.

Staff membership

All staff at CUH with contracts of employment of at least 12 months, or contracts with no fixed term, are automatically members unless they choose to opt out. Registered volunteers are also automatically members of the staff constituency. The Trust greatly values the contribution that employees of partner organisations on the Campus make to CUH and for this reason staff membership includes, on application, all employees of organisations based on the Campus who provide services to CUH.

Membership data

At 31 March 2025, there were 21,600 members (2024: 21,179). The breakdown is as follows: patient members – 3,370 (2024: 3,526); public members – 4,324 (2024: 4,457) and staff members - 13,906 (2024: 13,196).

Membership strategy

The current membership strategy sets out our vision for a representative, active and engaged membership, grouped around five key areas:

1. Maintaining and continuing to build a representative membership of our constituencies
2. Ensuring members are informed and that their views are valued and listened to
3. Increasing the proportion of total membership who wish to be more actively involved and promote more effective, more modern and more timely communication with members
4. Ensuring a high level of interest/participation and attracting high quality candidates for the annual governor elections
5. Aligning engagement activities with other local health bodies and campus partners to have a constituent-centred approach

The promotion of membership is incorporated into the Trust's Patient and Public Involvement (PPI) Framework as a way of keeping people linked in and informed about opportunities to get involved in service development and research at CUH.

3.21 Council of Governors

The Council of Governors is composed of 19 elected governors (eight patient, seven public and four staff) and 8 partnership governors (two further positions identified in the Constitution are not currently appointed to). The Council is chaired by the Trust Chair.

Dr Neil Stutchbury was re-appointed to the role of Lead Governor for a second two-year term with effect from 1 October 2023.

Dr Jane Biddle was re-appointed to the role of Deputy Lead Governor with effect from 1 December 2023.

Table 6: Patient governors

The table below shows patient governors during 2024/25, representing and elected by the patient members of Cambridge University Hospitals NHS Foundation Trust.

Dr Josiane Chuisseu	Term ended on 30 June 2024.
Ms Sarah Dixon	Elected in 2024 for a first term of three years.
Miss Ruth Greene	Re-elected in 2022 for a third term of three years.
Ms Maureen Haldane	Elected in 2024 for a first term of three years.
Ms Elizabeth Howe	Elected in 2023 for a first term of three years.
Dr Julia Loudon	Term ended on 30 June 2024.

Dr Howard Sherriff	Re-elected in 2022 for a second term of three years.
Mr Robin Stevens	Elected in 2023 for a first term of three years.
Dr Neil Stutchbury	Re-elected in 2023 for a third term of three years.
Mr Daniel Trajkovski	Elected in 2024 for a first term of three years.
Mrs Adele White	Term ended on 30 June 2024.

Table 7: Public governors

The table below shows public governors during 2024/25, representing and elected by the public members of Cambridge University Hospitals NHS Foundation Trust.

Dr John Lee Allen	Re-elected in 2024 for a second term of three years.
Dr Jane Biddle	Re-elected in 2023 for a third term of three years.
Mr Chris Cumberland	Elected in 2023 for a first term of three years.
Ms Gemma Downham	Term ended on 30 June 2024.
Ms Melisa Lee	Re-elected in 2022 for a second terms of three years.
Dr Helena Rubinstein	Elected in 2024 for a first term of three years.
Dr Carina Tyrrell	Re-elected in 2023 for a second term of three years.
Dr Will Watson	Elected in 2024 for a first term of three years.

Table 8: Staff governors

The table below shows staff governors during 2024/25, representing and elected by the staff members of Cambridge University Hospitals NHS Foundation Trust.

Mr Frank Allan	Elected in 2023 for a first term of three years.
Ms Elisa Ferraro	Term ended on 30 June 2024.
Mr Mahad Nur	Elected in 2022 for a first term of three years.
Mr Vernon Johnson	Elected in 2024 for a first term of three years.

Ms Gill Shelton	Term ended on 30 June 2024.
Dr Chris White	Elected in 2024 for a first term of three years.

Governor elections 2024

Table 9: Election turnout

Governor Election turnout by constituency in 2021, 2022, 2023 and 2024

Constituency	2021	2022	2023	2024
Patient constituency	Candidates elected unopposed	18.3%	18.5%	17.7%
Public constituency	17.2%	17.5%	16.3%	16.4%
Staff constituency	17.5%	15.0%	15.7%	17.1%

Table 10: Partnership governors

Partnership governors during 2024/25, representing and appointed by external organisations to the Council of Governors are shown in the table below.

Anglia Ruskin University	Dr Rachael Cubberley	Appointed in June 2022 for a three-year term.
Cambridge Biomedical Campus Research Organisations	Ms Karen Woodey	Appointed in June 2024 for a second three-year term.
Cambridge City Council	Cllr Rachel Wade	Stood down from the Council of Governors in May 2024.
Cambridge City Council	Cllr Cameron Holloway	Appointed in May 2024 for a 12-month term.
Cambridgeshire and Peterborough NHS Foundation Trust	Mr Stephen Legood	Re-appointed in February 2021 for a three-year term.
Cambridgeshire County Council	Cllr Susan van de Ven	Appointed in June 2024 for a 12-month term.
Royal Papworth Hospital NHS Foundation Trust	Dr Stephen Webb	Appointed in June 2024 for a second three-year term.
University of Cambridge	Professor Peter St George-Hyslop	Stood down from the Council of Governors in June 2024.
University of Cambridge	Professor John Clarkson	Re-appointed in September 2023 for

		second three-year term.

Register of governors' interests

At the time of their appointment, all Governors are asked to declare any interests on the register of directors' interests and are expected to declare any changes to the register of interest on an ongoing basis.

The register is available online at https://cuh.mydeclarations.co.uk/. The register is reviewed on a quarterly basis and maintained by the Director of Corporate Affairs.

Governor expenses

Governors participating in events such as Council meetings whose expenses are not paid by another organisation are entitled to claim reasonable expenses. Expenses are reimbursed at rates agreed by the Council of Governors, which has adopted HMRC approved amounts. Expenses to be reimbursed include:

Travel by car, motor cycle or bicycle; public transport on a like for like basis on provision of a receipt; receipted costs for caring arrangements at previously agreed rates of up to £10 per hour; expenses for a companion required to enable the individual to participate and costs for interpretation. Governor expenses are reported in the remuneration report at Section 3.22. The full policy is available from the Director of Corporate Affairs.

Table 11: Attendance at Council of Governors' meetings in 2024/25

There were seven meetings of the Council of Governors during 2024/25, four in public and three in private. The Chief Executive, Non-Executive Directors and Executive Directors also attended where appropriate.

Name	Title	Attendance
Dr Michael More[1 2]	Trust Chair	6/6
Baroness Sally Morgan[3]	Trust Chair	1/1
Mr Frank Allan	Staff Governor	7/7
Dr John Lee Allen	Patient Governor	2/7
Dr Jane Biddle	Public Governor	7/7
Dr Josiane Chuisseu	Patient Governor	0/2
Prof John Clarkson	Partnership Governor	4/7
Dr Rachael Cubberley	Partnership Governor	0/7
Mr Chris Cumberland	Public Governor	3/7
Ms Sarah Dixon	Patient Governor	5/5

Ms Gemma Downham	Public Governor	2/2
Ms Elisa Ferraro	Staff Governor	0/2
Ms Ruth Greene	Patient Governor	6/7
Ms Maureen Haldane	Patient Governor	5/5
Cllr Cameron Holloway	Partnership Governor	2/7
Ms Elizabeth Howe	Patient Governor	4/7
Mr Vernon Johnson	Staff Governor	0/5
Ms Melissa Lee	Public Governor	7/7
Mr Stephen Legood	Partnership Governor	0/7
Dr Julia Loudon	Patient Governor	2/2
Mr Mahad Nur	Staff Governor	7/7
Dr Helena Rubinstein	Public Governor	5/5
Mr Daniel Trajkovski	Patient Governor	4/5
Ms Gill Shelton	Staff Governor	2/2
Dr Howard Sherriff	Patient Governor	7/7
Mr Robin Stevens	Public Governor	4/7
Professor Peter St George Hyslop	Partnership Governor	0/2
Dr Neil Stutchbury	Patient Governor	7/7
Dr Carina Tyrrell	Patient Governor	3/7
Cllr Susan van de Ven	Partnership Governor	4/7
Cllr Rachel Wade	Partnership Governor	n/a
Dr Will Watson	Public Governor	5/5
Dr Stephen Webb	Partnership Governor	0/7
Mrs Adele White	Patient Governor	2/2
Dr Chris White	Staff Governor	5/5
Ms Karen Woodey	Partnership Governor	4/7

Please note that the above table takes into account the following:

[1] Dr Michael More was not eligible to attend one meeting due to a conflict of interest in relation to the agendas.
[2] Dr Michael More left the Trust on 31 December 2024.
[3] Baroness Sally Morgan joined the Trust on 1 January 2025.

The attendance of the remainder of the Council of Governors takes into account the start and end dates reflected in Tables 6, 7 and 8.

Governor activities

During 2024/25 the Council of Governors continued to focus on ensuring that:

1. Non-Executive Directors are held to account for the performance of the Board of Directors.

2. The views of members, patients and the wider local community are brought directly to the directors.
3. Governors remain up-to-date on key issues of concern and interest.

Governors' access to papers is via a secure portal. Governors are provided regularly with Trust news, wider NHS news, relevant national policy initiatives and press coverage information.

As part of the code of conduct, all governors on appointment/election are expected to sign up to the fact that they have read and will abide by our policy for governor communication with members and the public. The emphasis is, as always, on encouraging interaction, listening and capturing views, speaking on behalf of members and thereby being able to influence opinions and decisions before feeding-back to members and the public.

The Trust's Annual Public Meeting took place on 18 September 2024 and provided attendees with a review of 2023/24 and an update on current and future developments.

The Lead Governor reports to all Board of Directors' meetings held in public. Governors meet informally with Non-Executive Directors on a quarterly basis to discuss Trust issues, priorities and developments as they arise. They also attend Board assurance committees in an observer capacity. These interactions assist them in fulfilling their duty to hold the Non-Executive Directors to account.

Members of the public who wish to contact member of the Council of Governors can do so by visiting the following link on our website:- https://www.cuh.nhs.uk/about-us/governors/contact-a-governor/

3.22 Remuneration report

Annual statement on remuneration

The members of the Remuneration and Nomination Committee will comprise the Chair of the Trust and all Non-Executive Directors. The committee met four times in 2024/25.

During 2024/25, the Board of Directors' Remuneration and Nomination Committee maintained its overview of Executive Directors' salaries, following the principles established for Executive and senior salaries in 2015/16 (from the external review commissioned in that year). Beyond a 5% pay uplift, there were no substantial changes to senior managers' remuneration during the year.

Additionally, during 2024/25 the Board of Directors and Remuneration and Nomination Committee:

- Oversaw the process for recruitment and appointment of the Chief Operating Officer who took post in April 2025
- Oversaw the process for recruitment and appointment of the Chief Medical Officer who took post in May 2025
- Considered the annual review of Director, VSM and Senior Clinician Pay and the National Pay Award
- Received a summary of the objectives of the Executive Directors for 2024/25
- Reviewed in the year performance of Executive Directors
- Considered Executive Director succession planning
- Considered the Trust's Fit and Proper Persons Test policy

Ali Layne-Smith
Remuneration and Nomination Committee Chair
27 June 2025

Senior managers' remuneration policy

CUH is aware of public attention given to the levels of remuneration of senior managers within the NHS. CUH has always strived to operate with openness and transparency when reviewing and setting the pay levels for senior management and we will continue to do this going forward.

To determine Board of Director level salaries, the Remuneration and Nomination Committee may use one or more of the following:

- Benchmarking data surveyed confidentially among CUH's peer group.
- NHS Employers' annual salary survey of NHS Chief Executives and Executive Directors.
- IDS NHS Boardroom pay report and other benchmark information.
- NHS and other relevant advertised jobs databases.
- The prevailing market position, including the ability to recruit and retain individuals.

Any amendments to salary are decided by the Remuneration and Nomination Committee on the basis of the size and complexity of the job portfolio. Annual salary is inclusive of other payments such as bonus, overtime, long hours, on-call, standby, etc. Additional payments do not

feature in Executive Directors' remuneration. The Trust has no plans to introduce performance related pay. The salaries of the Medical Director and the Director of Innovation, Digital and Improvement are in accordance with the terms and conditions of service of the consultant contract 2003 plus a responsibility allowance determined by the Committee payable for the duration of office.

Chief Executive and Executive Director performance is measured against objectives set at the beginning of the financial year and agreed by the Remuneration and Nomination Committee.

There are no special contractual compensation provisions for the early termination of Executive Directors' contracts. Early termination by reason of redundancy is subject to the normal provisions of the 'Agenda for Change: NHS terms and conditions of service' handbook (section 16); or, for those above the minimum retirement age, early termination by reason of redundancy or 'in the interests of the efficiency of the service' is in accordance with the NHS Pension Scheme. Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.

Pay awards agreed nationally for other staff groups working at CUH, including staff on Agenda for Change contracts and medical and dental staff, are determined by the Department of Health/NHS Pay Review Body, which looks at salaries and pay conditions across the NHS.

The Remuneration and Nomination Committee follows Trust policies on diversity and inclusion as described in the staff report. This is in support of the Trust's workforce strategy, of which inclusion is one of the five commitments.

Service Contract Obligations

All senior managers have a standard CUH employment contract and no service contracts are in place. Each individual Executive Director and Non-Executive Director has their appointment date, unexpired term and notice period listed in Table 13.

Policy on Payment for Loss of Office

All senior managers are required to have a six-month period in their employment contract. Compensation in the event of early termination for substantive directors is in accordance with contractual entitlements. There were no exceptions to this policy during 2024/25.

Future Policy table

The future policy table below gives a description of each of the components of the remuneration package for senior managers, which comprise the wider senior managers' remuneration policy.

Table 12: Future policy table

How the component supports the strategic aims of the Trust	How the component operates	Maximum potential value of the component	Description of framework used to assess performance
Salary			
Salary is determined using benchmark data in order to attract, reward and retain individuals of the right caliber to lead the delivery of the Trust's aims and objectives.	Agreed by the Remuneration and Nomination Committee using benchmark ranges. Salaries are reviewed annually to account for the cost of living, and any changes are normally effective from 1 April each year.	As set out in the Statement of remuneration found in Table 13.	The Trust's values-based appraisal and objective setting process is used for all staff, including Executive Directors.
Pension-related benefits			
Pension benefits (which may be opted out of) are part of the total remuneration of Executive Directors to attract, reward and retain individuals to lead the delivery of the Trust's aims and Objectives.	Pension is available as a benefit to Executive Directors and follows the national NHS Pension Scheme contribution rules	Contributions and entitlements are in accordance with the NHS Pension Scheme for all employees who are members.	Not applicable.
Pension Contribution Alternative Award Policy			
There is no pension contribution alternative award policy in place.	Not applicable.	Not applicable.	Not applicable.

Table 13: Executive Director contractual terms

Executive Director	Date in post	Unexpired term	Notice
Chief Executive	16.11.15	Permanent	Six months
Deputy Chief Executive	08.04.24	Permanent	Six months
Chief Finance Officer	09.11.20	Permanent	Six months
Chief Nurse	23.07.18	Permanent	Six months
Director of Corporate Affairs	15.05.17	Permanent	Six months
Director of Innovation, Digital and Improvement	01.05.23	Permanent	Six months
Director of Strategy and Major Projects	01.06.20	Permanent	Six months
Director of Workforce	01.04.14	Permanent	Six months
Medical Director	01.11.17	1 years	Six months

Remuneration and Nomination Committee of the Board of Directors

Membership of the committee comprises Non-Executive Directors and the Trust Chair with the Chief Executive in attendance. The Director of Workforce and Director of Corporate Affairs also attend meetings of the committee where appropriate.

The Committee met four times during 2024/25. The Committee was chaired by Ali Layne-Smith, who was appointed as Chair in March 2022.

The role of the Committee is to:

- Act under the delegated authority of the Board of Directors to approve and oversee the arrangements for the appointment, termination and remuneration of the Chief Executive and all Executive Directors. In addition, the Committee will be responsible for agreeing the remuneration for any other posts with remuneration outside the Agenda for Change pay framework.

Statement of directors' remuneration - Subject to Audit

The Board's Remuneration and Nomination Committee oversees pay arrangements for posts whose salaries are not determined through national term and conditions. This includes but is not limited to the Executive Directors of the Trust (both voting and non-voting executive Board members). The Committee is mindful of discharging its obligations in respect of salaries above £150,000. This salary is updated as set out in the guidance from NHS England updated in March 2018. It considers each new post and the process to be followed on an individual basis.

The Governors' Nomination and Remuneration Committee establishes remuneration for Non-Executive Directors.

NHS England published in September 2019 a new framework to align remuneration for chairs and Non-Executive Directors (NEDs) of NHS trusts and NHS foundation trusts. For NEDs this required NHS foundation trusts to move towards a standard basic remuneration of £13,000 per annum from 1 April 2021, or to provide the rationale for diverging from this in the trust's Annual Report. At the point at which the national framework was introduced, the standard remuneration for the Trust's Non-Executive Directors was £14,000 per annum and had been set at this level since 2012. The Council of Governors agreed in June 2023 to increase the level of NED remuneration from £14,000 per annum to £15,500 per annum, and agreed to maintain it at this level in June 2024.

The Trust's approach to the remuneration of the Chair and additional responsibility allowances for Non-Executive Directors is compliant with the national framework.

Fair pay disclosures - Subject to Audit

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2024-25 was £317,500 (2023-24, £312,500). This is a change between years of 1.60%.

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

For employees of the Trust as a whole, the range of remuneration in 2024/25 was from £12.25 to £351,200 (2023-24 £10.33 to £343,742). The percentage change in average employee remuneration between years 2024/25 and 2023/2024 is 5.1% (2023/2024 and 2022 /2023 is 5%).

There were two employees that received remuneration in excess of the highest paid director in 2024-25 (2023-24: 1 employee).

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

Table 14: Fair pay disclosure 2024/25

2024/2025	25th percentile	Median	75th percentile
Salary component of pay	£53,560	£39,820	£29,114
Total pay and benefits excluding pension benefits	£53,560	£39,820	£29,114
Pay and benefits excluding Pension: Pay ratio for highest paid director	5.93	7.97	10.91

*** There is no significant movement noted. Ratios are in line with the prior period.

Table 15: Fair pay disclosure 2023/24

2023/2024	25th percentile	Median	75th percentile
Salary component of pay	£52,359	£38,951	£27,454
Total pay and benefits excluding pension benefits	£52,359	£38,951	£27,454
Pay and benefits excluding Pension: Pay ratio for highest paid director	5.97	8.02	11.38

Table 16: Statement of remuneration 2024/25 – Subject to Audit

	Salary (bands of £5,000)	Taxable Expense payments taxable to the nearest £100	Performance pay and bonuses (bands of £5,000)	Long-term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Other (totalled to the nearest £5,000)	Total (a to e) (bands of £5,000)
Name and title	**£'000**		**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Dr Ashley Shaw, Medical Director	90-95	-	-	-	122.5-125	210-215	425-430
Claire Stoneham, Director of Strategy and Major Projects	160-165	900	-	-	42.5-45	0-5	205-210
David Wherrett, Director of Workforce	190-195	-	-	-	-	0	190-195
Ian Walker, Director of Corporate Affairs	155-160	700	-	-	32.5-35	0-5	190-195
Lorraine Szeremeta, Chief Nurse	190-195	-	-	-	62.5-65	0	250-255
Mike Keech, Chief Finance Officer	205-210	1,600			57.5-60	0-5	265-270
Nicola Ayton, Deputy chief executive	235-240	-	-	-	65-67.5	0	305-310
Roland Sinker, Chief Executive	315-320	1,100	-	-	1187.5-1190	0-5	1505-1510
Dr Susan Broster, Interim Chief Medical Officer	255-260	-	-	-	170-172.5	0	425-430

Alison Layne-Smith NED	15-20	100	-	-	-	0-5	15-20
Andrew Mc Caskie NED	0-5	-				0	0-5
Dr Annette Doherty, NED	15-20	300	-	-	-	0-5	15-20
Daniel Abrams, NED	15-20	300	-	-	-	0-5	15-20
Ian Jacobs, NED	10-15	-	-	-	-	0	10-15
Dr Michael More, Chair (up to 31 Dec 24)	45-50	-	-	-	-	0	45-50
Professor Patrick Maxwell, NED	10-15	-	-	-	-	0	10-15
Rohan Sivanandan NED	15-20	-	-	-	-	0	15-20
Professor Sharon Peacock, NED	15-20	-	-	-	-	0	15-20
Baroness Sally Morgan, Chair (since 1 Jan 2025)	10-15	200				0-5	10-15
Dr James Morrow, NED	15-20	-	-	-	-	0	15-20

* Other remuneration for one Director relates to their pay in respect of clinical duties.

** Prof Patrick Maxwell is the Regius Professor of Physic at the University of Cambridge. He is employed and paid by the University of Cambridge. The Trust paid £11,636 in 2024/25 to the University of Cambridge in recognition of his time spent at Board meetings. Andrew McCaskie covered for Prof Patrick Maxwell from October 2024 to December 2024. He is employed and paid by the University of Cambridge. The Trust paid £3,881 in 2024/25 to the University of Cambridge in recognition of his time spent at Board meetings.

Table 17: Statement of remuneration 2023/24 - Subject to Audit

Name and title of senior manager	**Salary (bands of £5,000) £'000**	**Taxable Expense payments taxable to the nearest £100**	**Performance pay and bonuses (bands of £5,000) £'000**	**Long-term performance pay and bonuses (bands of £5,000) £'000**	**All pension-related benefits (bands of £2,500) £'000**	**Other (totalled to the nearest £5,000) £'000**	**Total (a to e) (bands of £5,000) £'000**
Dr Ashley Shaw, Medical Director	90-95	0	0	0	0	195-200	290-295
Claire Stoneham, Director of Strategy and Major Projects	160-165	700	0	0	45-47.5	0-5	205-210
David Wherrett, Director of Workforce	175-180	0	0	0	0	0	175-180
Dr Susan Broster, Director of Innovation, Digital and Improvement	60-65	0	0	0	0	160-165	220-225
Ian Walker, Director of Corporate Affairs	155-160	700	0	0	0	0-5	155-160

Lorraine Szeremeta, Chief Nurse	180-185	0	0	0	0	0	180-185
Mike Keech, Chief Finance Officer	185-190	1,800	0	0	47.5-50	0-5	235-240
Nicola Ayton, Chief Operating Officer	205-210	0	0	0	27.5-30	0	235-240
Nicholas Kirby, Director of Strategy and Major Projects	25-30	0	0	0	105-107.5	0	135-140
Roland Sinker, Chief Executive	310-315	5,400	0	0	0	0	315-320
Dr Michael More, Chair	60-65	0	0	0	0	0	60-65
Ian Jacobs, NED	15-20	0	0	0	0	0	15-20
Adrian Chamberlain, NED	0-5	0	0	0	0	0	0-5
Alison Layne-Smith NED	15-20	0	0	0	0	0	15-20
Dr Annette Doherty, NED	15-20	0	0	0	0	0	15-20
Daniel Abrams, NED	15-20	0	0	0	0	0	15-20
Professor Patrick Maxwell, NED**	0	0	0	0	0	0	0
Professor Sharon Peacock, NED	15-20	0	0	0	0	0	15-20
Rohan Sivanandan, NED	15-20	0	0	0	0	0	15-20
Dr James Morrow, NED	0-5	0	0	0	0	0	0-5

*Other remuneration for two Directors, relates to their pay in respect of clinical duties.

** Prof Patrick Maxwell is the Regius Professor of Physic of the University of Cambridge. He is employed and paid by the University of Cambridge. The Trust paid £15,126 in 2023/24 to the University of Cambridge in recognition of his time spent at Board meetings.

Statement of directors' and governors' expenses

Directors and governors are reimbursed for expenses incurred on Trust business in accordance with agreed Trust policies. Where applicable, these are subject to income tax and national insurance in accordance with HMRC legislation and guidance.

Table 18: Governors' expenses

	Mileage (Car/Cycle)	Rail/bus Travel	Taxis	Hotel Accom.	Meals/ Subsistence and parking	Conference fees	Other	Total 2024/25	Total 2023/24
Frank Allan	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
John Allen	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Jane Biddle	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Josiane Chuisseu	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
John Clarkson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Rachel Cubberley	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Chris Cumberland	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Sarah Dixon	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Gemma Downham	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Elisa Ferraro	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Ruth Greene	£0.00	£0.00	£36.35	£0.00	£0.00	£0.00	£0.00	£36.35	£11.85
Elizabeth Howe	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Vernon Johnson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Melissa Lee	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Stephen Legood	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Julia Loudon	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Mahad Nur	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Helena Rubinstein	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Daniel Trajkovski	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00

Gill Shelton	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Howard Sherriff	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Robin Stevens	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Peter St George-Hyslop	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Neil Stutchbury	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Carina Tyrrell	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Susan van de Ven	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Rachel Wade	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Will Watson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Stephen Webb	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Adele White	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Chris White	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Karen Woodey	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00

Table 19: Directors' expenses

	Travel Home to Trust	Mileage business	Rail travel	Taxi	Hotels	Meals and Parking	Other	**Total 2024/25**	**Total 2023/24**
Daniel Abrams	£123.36	£50.4	£0.00	£0.00	£0.00	£0.00	£0.00	£173.76	£231.52
Nicola Ayton	£0.00	£0.00	£40.10	£111.80	£0.00	£0.00	£0.00	£151.90	£0.00
Susan Broster	£0.00	£0.00	£0.00	£38.03	£0.00	£0.00	£0.00	£38.03	£0.00
Annette Doherty	£156.67	£70.10	£16.30	£0.00	£0.00	£107.00	£17.00	£367.07	£1044.88
Ian Jacobs	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Michael Keech	£0.00	£0.00	£136.10	£0.00	£0.00	£13.60	£11.00	£160.70	£279.71
Ali Layne-Smith	£56.69	£143.26	£490.00	£41.60	£487.66	£236.58	£142.70	£1598.49	£1651.41
Patrick Maxwell	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00

	Travel Home to Trust	Mileage business	Rail travel	Taxi	Hotels	Meals and Parking	Other	**Total 2024/25**	**Total 2023/24**
Professor Andrew McCaskie	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Michael More	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£66.55
Sally Morgan	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
James Morrow	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Sharon Peacock	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Ashley Shaw	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£232.47
Claire Stoneham	£0.00	£0.00	£30.00	£0.00	£0.00	£0.00	£0.00	£30.00	£67.80
Roland Sinker	£0.00	£0.00	£113.75	£150.44	£0.00	£69.80	£0.00	£333.99	£427.23
Rohan Sivanandan	£0.00	£0.00	£296.30	£157.6	£431.1	£60.68	£23.20	£969.08	£662.85
Lorraine Szeremeta	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Ian Walker	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
David Wherrett	£0.00	£4.65	£0.00	£31.64	£0.00	£0.00	£4.00	£40.29	£53.47

Table 20: Pension benefit 2024/25

Name and title	Real increase / (decrease) in pension at pension age	Real increase / (decrease) in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2025	Lump sum at pension age related to accrued pension at 31 March 2025	Cash equivalent transfer value at 1 April 2024	Real increase / (decrease) in cash equivalent transfer value after deductions	Cash equivalent transfer value at 31 March 2025	Employers contribution to stakeholder pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
Dr Ashley Shaw, Medical Director	5-7.5	10-12.5	55-60	145-150	1040	124	1256	25
Claire Stoneham, Director of strategy and Major Projects	2.5-5	0	15-20	0	143	21	194	24
Roland Sinker, Chief Executive	60-62.5	0	60-65	0	0	989	1029	46
Ian Walker, Director of Corporate Affairs	2.5-5	0	40-45	90-95	795	32	900	23

Lorraine Szeremeta, Chief Nurse	2.5-5	0-2.5	75-80	190-195	1452	68	1641	27
Mike Keech, Chief Finance Officer	2.5-5	0	25-30	0	256	26	325	30
Nicola Ayton, Deputy Chief Executive	2.5-5	0	35-40	0	345	32	429	34
Dr Sue Broster Director of Innovation, Digital and Improvement	7.5-10	15-17.5	50-55	125-130	903	178	1161	23

**Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2025. HM Treasury published updated guidance on 6 January 2025; this guidance will be used in the calculation of 2024/25 CETV figures.*

**David Wherrett has chosen to opt out of the pension scheme for the 24/25 financial year.*

Table 21: Pension benefit 2023/24

Name and title	Real increase / (decrease) in pension at pension age	Real increase / (decrease) in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2024	Lump sum at pension age related to accrued pension at 31 March 2024	Cash equivalent transfer value at 1 April 2023	Real increase / (decrease) in cash equivalent transfer value after deductions	Cash equivalent transfer value at 31 March 2024	Employers contribution to stakeholder pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
Dr Ashley Shaw Medical Director	0	7.5-10	45-50	130-135	846	88	1040	22
Claire Stoneham Director of strategy and Major Projects	2.5-5	0	10-15	0	75	40	143	22
David Wherrett Director of Workforce	0	0	0	0	1494	0	0	0
Dr Ewen Cameron Director of Improvement and Transformation	0	0	0	0	913	0	0	0

Ian Walker Director of Corporate Affairs	0	35-37.5	35-40	85-90	631	80	795	22
Lorraine Szeremeta Chief Nurse	0	40-42.5	65-70	175-180	1090	227	1452	26
Mike Keech Chief Finance Officer	2.5-5	0	20-25	0	151	65	256	26
Nicola Ayton Chief Operating Officer	2.5-5	0	25-30	0	212	85	345	29
Nicholas Kirby Director of Strategy and Major Projects	2.5-5	12.5-15	25-30	75-80	0	4.01	556	24
Dr Sue Broster Director of Innovation, Digital and Improvement	0	35-37.5	35-40	100-105	696	109.55	903	19

**Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2024. HM Treasury published updated guidance on 27 April 2024; this guidance will be used in the calculation of 2023/24 CETV figures.*
**Roland Sinker and David Wherrett have chosen to opt out of the pension scheme for the 23/24 financial year.*

These pension disclosures relate to directors who were members of the NHS Pension Scheme during the financial year. The figures represent estimates by the NHS Pensions Agency of the theoretical value of each director's pension "fund" at the start and end of the financial year. The difference between these two values is taken to represent the director's pension benefits for the year. Any benefits earned in this way remain in the pension scheme until the director retires in accordance with the rules of the NHS Pension Scheme. These rules are the same for both directors and staff.

Roland Sinker
Chief Executive
27 June 2025

3.23 Staff report

Staff numbers

The staff report provides information about the workforce at Cambridge University Hospitals (CUH) during the 2024/25 financial year.

As of 31 March 2025, the Trust had 18 directors (ten male and eight female) and employed 13,785 people (3,742 male and 10,043 female). This includes people employed on both substantive and fixed term contracts.

The table below provides the gender balance of senior management and their direct reports:

Table 22: Gender balance of senior management and their direct reports

Type	Female		Male		Total
Senior Management	8	44.4%	10	55.6%	18
Direct reports	45	58.4%	32	41.6%	77
Total	53	55.8%	42	44.2%	95

The table below provides information relating to staff groups in whole time equivalents (WTE).

Table 23: Staff numbers – *Subject to Audit*

Average number of employees (WTE basis)	2024/25 Total Number	2024/25 Permanent Number	2024/25 Other Number	2023/24 Total Number	2023/24 Permanent Number	2023/24 Other Number
Medical and dental	2,067	1,941	126	1,961	1,820	142
Ambulance staff	0	0	0	0	0	0
Administration and estates	2,959	2,815	143	2,839	2,669	170
Healthcare assistants and other support staff	1,681	1,330	351	1,560	1,206	354
Nursing, midwifery and health visiting staff	4,290	3,886	404	4,024	3,572	452
Scientific, therapeutic and technical staff	1,229	1,178	51	1,201	1,146	55
Healthcare science staff	1,054	1,054	0	1,005	1,004	1
Social care staff	0	0	0	0	0	0
Total average numbers	**13,280**	**12,205**	**1,075**	**12,590**	**11,417**	**1,174**

Analysis of staff costs - *Subject to Audit*

The tables below sets out an analysis of staff costs during 2025/24 and 2024/23.

Table 24: Staff costs during 2024/25

Employee expenses	Year ended 31 March 2024 Total £000	Year ended 31 March 2024 Permanent	Year ended 31 March 2024 Other £000
Salaries and wages	689,448	682,258	7,190
Social security costs	74,767	74,767	-
Apprenticeship Levy	3,363	3,363	-
Pension cost – defined contribution plans employers	77,779	77,779	

contributions to NHS pensions			-
Pension cost - employer contributions paid by NHSE on providers behalf (6.3%)	50,838	50,838	-
Temporary staff – agency/contract staff	5,456	-	5,456
Total gross staff costs	**901,651**	**889,005**	**12,646**
Included within:			
Staff and executive directors costs	900,131	887,485	12,646
Redundancy	681	681	-
Early Retirements	839	839	-
Special Payments	-	-	-
Total employee benefits	901,651	889,005	12,646

Table 25: Staff costs during 2023/24

Employee expenses	**Year ended 31 March 2024 Total £000**	**Year ended 31 March 2024 Permanent**	**Year ended 31 March 2024 Other £000**
Salaries and wages	615,645	608,537	7,108
Social security costs	67,890	67,890	-
Apprenticeship Levy	3,072	3,072	-
Pension cost – defined contribution plans employers contributions to NHS pensions	68,512	68,512	-
Pension cost - employer contributions paid by NHSE on providers behalf (6.3%)	29,867	29,867	-

Temporary staff – agency/contract staff	8,638	-	8,638
Total gross staff costs	**793,624**	**777,878**	**15,746**
Included within:			
Staff and executive directors costs	792,809	777,063	15,746
Redundancy	186	186	-
Early Retirements	629	629	-
Special Payments	-	-	-
Total employee benefits	793,624	777,878	15,746

Expenditure on consultancy

Information regarding expenditure on consultancy can be found in the annual accounts.

Information about staff sickness

The information in the table below is compiled on a calendar year basis according to national requirements. It accounts for days lost due to sickness absence.

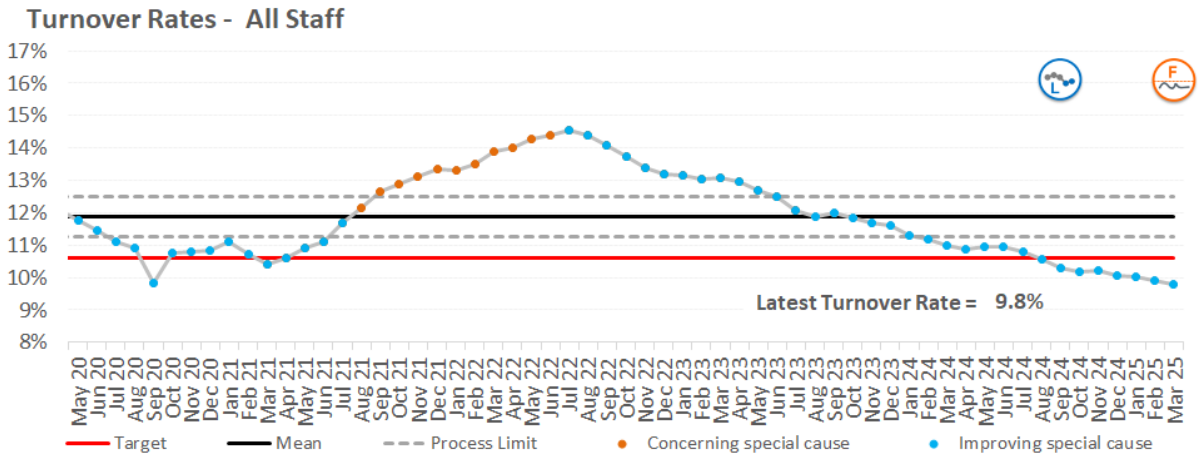
Table 26: Staff sickness

	Year ended 31 March 2025	Year ended 31 March 2024
Total Days lost (WTE)	114,422*	109,043
Total staff years	12,328*	11,575
Average working days lost (per WTE)	9.3*	9.4

*Due to a change in NHSE reporting requirements the figures to 31 March 2025 are provided by NHSE and are to 31 December 2024 and are for the calendar year. Figures to 31 March 2024 are internally reported and reflect the financial year.

Staff turnover

The Trust has continued to see an improvement in staff turnover rates during 2024/25. In March 2024 turnover was 11% and in March 2025 it had reduced to 9.8%. There has been a steady decrease since July 2022.



Our role as a local employer

We believe we can have a positive impact on our communities that extends beyond the health and care services we deliver. We consider we have a role to play to develop pathways into employment and training for disadvantaged groups. We offer a range of programmes: work experience, industry placements and work shadowing. We are committed to promoting social mobility; this is about creating a stronger, fairer society in which people from all backgrounds can realise their potential.

We have a range of learning and development opportunities for staff which include apprenticeships to degree level and pathways to professionally registered professions for new applicants and existing employees. We value the diversity of our workforce and the strength this brings to the communities we serve.

Consulting staff and representatives on matters of concern and the performance of the organisation

The Trust works in partnership with staff side representatives through a number of mechanisms on matters of concern to staff and the performance of the organisation. In addition, the Trust follows a communication strategy to update and consult employees with relevant information. The following points provide examples of some of the actions taken by the Trust to keep staff updated and provide opportunities for staff to raise their views and concerns.

- CUH Bulletin is a daily corporate email update sent to all employees email addresses on topical issues, events and any other information that CUH employees need to be aware of.
- CUH weekly is a virtual weekly meeting which provides an opportunity for staff to hear the latest developments within the Trust and speak with the chief executive and the senior leadership team about progress on

key issues. It is an open invitation meeting to all staff to participate in the virtual forum.

- Management Staff Forum (MSF) is the formal body for Trust-wide consultation which meets every six weeks. The MSF is made up of two groups consisting of senior management and staff side representatives. These two groups come together in the spirit of partnership working to consider all matters regarding the CUH workforce for the benefit of both staff and patients.
- Weekly media update which is a summary of articles mentioning Cambridge University Hospitals in the media.
- The Trust's internal intranet site provides relevant information, news and a repository of information that has been communicated across the Trust. via internal communications channels.

Health and safety

Our five year health and safety strategy ‘*‘Safer culture, safer systems, safer workforce” sets the* direction for effective health and safety management at CUH. It supports the Trust's aim and objectives as laid out in our corporate strategy and our associated workforce strategy and also supports and contributes to the provision and delivery of our values of *Together – safe, kind and excellent*.

A Health and Safety annual report is produced each year and provides a review of the work that has been carried out on the management of H&S at CUH over the last 12 months. Key work undertaken by the H&S team this year includes:

- Development of a new corporate health and safety risk register that sets out the key health and safety risks for the organisation that require H&S Committee oversight due to their Trust wide nature and/ or potentially high impact on the organisation.
- Working with Risk Owners/ Risk Leads to ensure there is appropriate management of each risk on the H&S risk register and/ or escalation as appropriate.
- Investigating significant H&S incidents, identifying failures and key areas of learning and providing assurance that actions identified are completed.
- Investigating 33 incidents that required reporting to the HSE under the RIDDOR regulations. Ensuring that actions are identified, completed and any learning is shared.
- Auditing and inspecting 50 departments against a number of key standards as part of the Trust's rolling H&S department audit and inspection programme. This involves providing reports to local managers highlighting areas of good practice and areas in need of improvement.
- Carrying out the three-yearly managing health and safety self-assessment. Identifying areas of good practice and areas in need of improvement, providing individual action plans for each division, and monitoring completion of actions.

- Undertaking a Trust wide Health and Safety Survey as part of the National Quarterly Pulse Survey in Quarter 4 and analysing results by different demographics including protected characteristics and making suggestions for improvement.
- Supporting managers and teams in the development of health and safety risk assessments, ensuring that these are suitable and sufficient as required by legislation.
- Ensuring all health and safety training remains current and relevant.

Occupational health and wellbeing

Occupational Health and Wellbeing is the Trust's in-house service. It provides a full range of staff physical and psychological health and wellbeing services to CUH staff and external customers in the local area. The service works closely with local public health and wellbeing services to provide staff with access to a range of support and guidance on workplace health protection.

A specialist multi-disciplinary clinical service is provided, supporting the culture of workforce health in CUH. The service continues to meet the SEQOHS (Safe Effective Quality Occupational Health Service) accreditation quality standards.

Services include management and self-referrals, pre-employment screening, immunisations, health surveillance, workplace adjustments, physiotherapy, return to work guidance, mental health support and health promotion.

There are a range of key workstreams undertaken by Occupational Health and Wellbeing in the last 12 months. These include:

- Delivering the annual influenza flu vaccination programme for CUH staff, vaccinating 59.3%% of those eligible, CUH ended the programme as the best performing Trust in the East of England.
- Providing catch up immunisation programmes including, measles, pertussis and BCG for certain staff groups.
- Mpox Preparedness - OH have delivered pre-exposure 1st vaccines to a number of staff in infectious diseases in the last quarter of 2024. Further roll out will commence once further vaccine supplies become available.
- Contact tracing exercises in the event of infectious exposures. In the last 12 months there have been an increase in the number of contract tracing exercises in response to VZV/shingles, measles, and TB exposures.
- Winter wellbeing campaign offering tips, resources and interactive sessions on sleep, nutrition, exercise, smoking cessation and menopause.
- In-house mental health specialist nurse rapid referral mental health clinics.

- Annual respiratory, hand, noise and vibration health surveillance and assessment activity has been completed for those staff groups that require it e.g carpenters and incinerator staff.
- Occupational Health & Recruitment have successfully rolled out an online health screening pre-employment process to support all non-medical recruitment. This has improved time to recruit and candidate experience.

Recruitment and retention offers

There are a range of benefits on offer, which are designed to support recruitment and retention of the workforce. Offers include:

- Work/life balance schemes to offer opportunities for part time hours and flexible working including remote working.
- Comprehensive childcare facilities (two on-site nurseries and access to a local discounted holiday play scheme).
- NHS pension scheme.
- A range of on-site facilities – leisure and social centre (Frank Lee Centre) and improved staff spaces to enable staff to eat and or take a break.
- A range of leadership and employee development opportunities along with continuous professional development.
- A comprehensive financial wellbeing offer, which includes financial education, benefits advice, ability to track earnings.
- NHS England approved on boarding programme for international nurses through the Pastoral Support Award.
- Purple Passport to support those with a disability.
- We provide reasonable adjustments at interview for those that require it
- Increased numbers of Volunteers supporting Wards and patients.

Staff experience and engagement

Staff survey

CUH undertakes quarterly staff surveys, alongside the NHS national staff survey, to help understand what it feels like to work at CUH and to take action to make improvements based on the feedback received from staff.

The Trust has a number of listeners, who work alongside the Freedom to Speak Up Guardian, across our divisions and corporate functions to support staff to raise concerns.

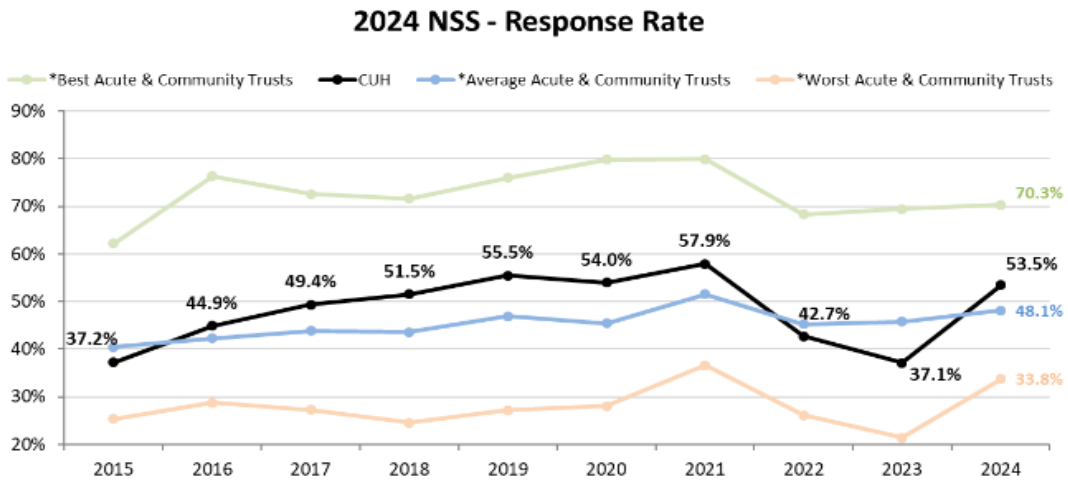
NHS staff survey

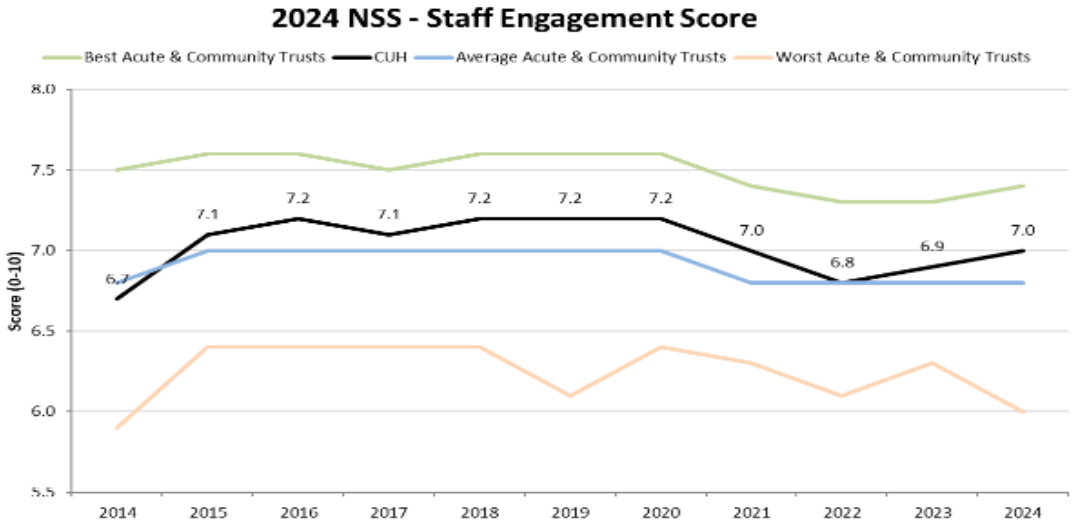
The annual staff survey for NHS trusts provides an opportunity for organisations to survey their staff in a consistent and systematic way. Gathering feedback from staff and considering their views enables the co-creation of better ways of working, which are vital for improving the employee experience, and contributes to service improvements. The Picker Institute undertakes the survey and trust data is benchmarked alongside 126 Acute, and Acute and Community Trusts. CUH also benchmark against the Shelford Group NHS Trusts.

2024/25 staff survey results

From 2021/22 the survey questions align to the seven elements of the NHS ‘People Promise’ and retain the two previous themes of engagement and morale. These replaced the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The CUH response rate increased from 37% in 2023 to 54% in 2024, marking a 17% improvement. This positive shift highlights the effectiveness of staff engagement within the trust.





Scores for CUH for each indicator together with the benchmarking for both the Shelford Group trusts and the NHS Acute and Acute and Community trusts are presented below.

Table 27: NHS Staff Survey results

Indicators	2024/25			2023/24			2022/23		
('People Promise' elements and themes)	Trust score	Shelford Group score	Acute and Community Trusts Avg Score	Trust score	Shelford Group score	Acute and Community Trusts Avg Score	Trust score	Shelford Group score	Acute and Community Trusts Avg Score
People Promise:									
We are compassionate and inclusive	7.4	7.3	7.2	7.2	7.2	7.2	7.2	7.2	7.2
We are recognised and rewarded	6.0	5.9	5.9	5.9	5.9	5.9	5.7	5.7	5.7
We each have a voice that counts	6.7	6.7	6.7	6.6	6.6	6.7	6.6	6.6	6.6
We are safe and healthy	6.2	6.1	6.0	-		-	5.8	5.9	5.9
We are always learning	6.0	5.8	5.6	5.8	5.6	5.6	5.4	5.4	5.4
We work flexibly	6.6	6.2	6.2	6.4	6	6.2	6.2	6	6
We are a team	6.8	6.7	6.7	6.7	6.7	6.8	6.6	6.6	6.6
Staff engagement	7.0	6.9	6.8	6.9	6.9	6.9	6.8	6.8	6.8
Morale	6.0	5.9	5.9	5.8	5.8	5.9	5.6	5.7	5.7

In 2024, the CUH staff engagement score saw a further increase of 0.1 to a position of 7.0, now placing CUH above the average of the Shelford Group and NHS Acute Trusts. An improvement in advocacy was also noted from 2023 to 2024 with the results in relation to staff recommending the organisation as a place to work increasing from 65% to 70% and as a place of treatment from 76% to 77%.

The results for CUH see a good improvement in all the nine people promise themes.

When comparing these results to the Shelford Group, CUH score second highest for the themes of *we are compassionate and inclusive*, *we work flexibly*, *we are always learning and we are recognised and rewarded, we are safe and healthy.* The small increase in engagement score translates to CUH moving up from fifth to fourth place when compared Shelford Group Trusts. For the remaining themes CUH rank third and fourth against this group of University Teaching Hospital Trusts.

Future priorities and targets

The improvements in 2024 are promising, and reflect the ongoing improving trajectory seen last year. Improvements reflect ongoing activities that have been delivered through the Trust workforce commitments – which includes the following themes: Good Work, Resourced, Inclusion, Ambition, Relationships. Whilst we have seen marked improvements in the experience of working in CUH from staff from an ethnic minority background or those with a disability, further improvements are required to address inequity highlighted in the results.

An immediate priority is in building capability and confidence of managers in using the staff survey within teams and services. As well as identifying teams who require targeted interventions.

Divisional and Trust level plans will be agreed and actions monitored through the usual governance structures.

Equality, diversity and inclusion

Equality, diversity and inclusion are key principles in how we work together at CUH and are integral to how we improve patient care, support our staff and build for the future in a way that is kind, safe and excellent.

As a responsible employer and provider of healthcare services, we recognise, value and support the diverse range of staff we employ and the patients we care for. Inclusion is one of the workforce commitments, which form the Trust's workforce strategy. We actively seek to drive out inequality, recognising that we are stronger as an organisation that values difference and inclusion. We do not tolerate any form of discrimination, harassment bullying or victimisation.

We would like every individual to feel safe and included at CUH, that they belong and can be themselves at work. And we expect that every individual plays their part in creating that culture for their colleagues, treating others with kindness and respect and supporting each other.

The Trust adheres to the requirements of the Equality Act 2010, the public sector equality duty and the NHS constitution. The Trust has an ongoing process to review equality activities, to understand our progress and to inform a long term strategy.

Inclusion Workforce objectives for 2024/25

- Protecting our staff against harassment, discrimination & victimisation
- Building thriving staff networks
- To become an antiracist organisation, implementing the Workforce Race Equality Standard (WRES) action plan
- To implement our Workforce disability equality standard (WDES) action plan
- Career progression for all

Equality Impact Assessments

The Trust has an equality impact assessment procedure and process in place which reviews all EIAs that are required for implementing a new or changes to a service, including implementing workforce changes and policy changes. All policies are equality impact assessed to ensure that no one impacted by a policy receives unjustifiably less favourable treatment on the grounds of protected characteristics such as age, disability, gender reassignment,

marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender, and sexual orientation.

EDI staff networks

The Trust engages with the following EDI staff networks to coproduce action plans:

- **Race Equality And Cultural Heritage (REACH) staff network** to support race equality and inclusion.
- **The Purple Network** is for staff with hidden or visible disabilities, physical, or mental health conditions or who are neuro-divergent and for allies to work together to promote inclusion for everyone at CUH.
- **The Open Minds Network** is for staff who are committed to changing the way we all think and act about mental health in the workplace and create a safe space for staff to share ideas on how to achieve this.
- **LGBT+ staff network** is a group for CUH staff members who are part of the LGBT+ community and allies who wish to support promoting equality and championing LGBT+ staff inclusion.

The networks support both our workforce EDI objectives and contribute to service equality objectives for patient experience. There is governance for the staff networks through an oversight group to support the development of the network business plans and ensure alignment with the workforce strategy. In addition to the staff networks there are a number of peer support groups.

Workforce Race Equality Standard (WRES)

Our latest (10th) Workforce Race Equality Standard WRES data report and action plan, which is coproduced with REACH Network staff, was approved by the Board in October and is published on the Trust public website here Workforce Race Equality Standard (WRES) | CUH

The WRES action plan was refreshed in 2023 to align with our commitments as signatories of the Unison Antiracism charter and with the NHS EDI improvement plan 6 high impact actions.

Key actions in 2024/25 included:

- A second series of successful Career coaching conversations and career development workshops have been run to support career progression of Black and minority ethnic staff organised by Cultural Ambassadors in conjunction with the REACH network committee and Culture Leadership and Learning.

- The REACH network has organised monthly Welcome meals events to welcome newly re recruited international staff. These meals were sponsored by UNISON.

- A second cohort of the Reverse Mentoring (RM) programme for executives and senior leaders in the divisional triumvirates (Divisional Directors, ADOs and Divisional Heads of Nursing).

- Cultural Ambassadors (CA's) continue to be involved in pre-action reviews in the disciplinary process. They support the employee relations team and Medical Staffing team when allegations are made against black and minority ethnic staff before formal disciplinary investigations proceed. CAs are being used to support BME staff as mentors and increasingly involved to support BME colleagues in other formal people management processes, for example performance management and sickness absence.

- Joint Employee Relations/CA and EDI quarterly meetings in place to review cases in which CAs are involved and to share learning to enable auditing and scrutinising regularly all formal people management cases such as performance and sickness management where BME staff are also involved.

Ethnicity Pay gap report 2024

In addition to the publishing of the gender pay gap, CUH has published an Ethnicity pay gap report for the third time. This includes some intersectional analysis between gender and ethnicity. The ethnicity pay gap report can be found on the Trust website here.

Workforce Disability Equality Standard (WDES)

The Trust's Workforce Disability Equality Standard (WDES) action plan, co-created with staff who have disabilities is approved by the Trust Board and published on the Trust's website here.

The Trust is a 'Disability Confident' Level 3 (Leader) employer and is a signatory of the 'Mindful Employer Charter' for 'Employers who are Positive about Mental Health' as well as a signatory of the MIND Mental Health at Work Commitment.

The 6th WDES data set was submitted in May 2024.

Actions in 2024/25 have included:

- Continued success of the centralised Workplace Adjustments Service led by the Occupational Health and Wellbeing team, which was fully launched in May 2023. This service enables funding from central budgets for physical equipment/adaptations. Neuro-divergent colleagues can also

use this service to request a workplace needs assessment to be carried out by Lexxic. This is not a diagnostic service but will identify any adjustments that would improve an individual's working life.

- The Purple Passport, our workplace adjustments passport promoted, audited and being reviewed to be holistic include adjustments to meet religious spiritual needs and needs of carers.

- The recruitment and selection procedure includes a requirement to include Diversity Inclusion Panellists (that includes Disabled staff) for recruitment of all posts of Band 8a and above to bring diversity into recruitment panels as part of our de-biasing recruitment programme of work.

- From January 2024 CUH have been running 'Supporting Neurodiversity in the Workplace' training. The current format is classroom based and is for anyone in the workplace who wishes to increase their knowledge of how to support others with neurodiversity or suspected neurodiversity. This course aims to identify different types of neurodiversity and how to make needed adjustments to help improve the experience of CUH staff. It is particularly relevant for managers and educators and has been under enough demand that more sessions than planned have been scheduled throughout the year with webinars proposed to cater to those unable to attend in person. This training is now under review in a collaboration between Culture, Leadership and Learning and the Occupational Health team.

- Accessibility of training is being reviewed by Culture, Leadership and Learning, having contracted with EDI consultancy *Included*. This review will not only include a diagnostic of who accesses our learning but how and why it is accessed.

LGBT+

CUH were Gold sponsors of Cambridge Pride 2024 with the LGBT+ staff network and EDI team taking part, alongside patient/service colleagues, ACT and CUH Arts staff. We submitted data for Stonewall WEI Index 2024 and results of these have informed the LGBT+ action plan.

Disability Pay gap report 2024

In addition to the publishing of the gender and ethnicity pay gap reports, CUH has published a Disability pay gap report. The disability pay gap report can be found on the Trust website here.

Gender Pay gap

Gender pay gap reporting legislation requires organisations to publish figures relating to their gender pay gap on an annual basis, and against a prescribed methodology which looks at mean and median gender pay gaps. The gender pay gap is different to equal pay, which is a legal requirement. The gender pay gap is the percentage difference between average (mean and median) hourly earnings for men and women. The Trust is committed to addressing any gender pay gaps within the organisation. The trust report is published on the trust website, which can be found here.

Further information on Trust's gender pay gap, including the distribution of men and women in each pay quartile, is available online at the government gender pay gap service available here.

All our equality monitoring information reports are on the public website here. This includes the Equality Delivery System, the Public Sector Equality Duty monitoring, Workforce Disability Equality Standard and Workforce Rate Equality Standard Reporting.

Counter fraud

CUH has taken all reasonable steps to comply with the requirements set out in the code of conduct for NHS managers, and has a named individual nominated to provide the lead local counter fraud specialist function, who is an accredited counter fraud specialist. When that specialist is absent, arrangements have been made to ensure that specialist assistance is available.

Under the NHS Standard Contract for 2024-2025, all organisations providing NHS services (providers) must put in place and maintain appropriate anti-crime arrangements. CUH fully complies with this requirement.

Standards of business conduct and the Bribery Act

The Bribery Act 2010 has been in force since July 2011. This act creates the offences of offering, promising or giving a bribe, requesting, agreeing to receive or accepting a bribe, bribing a foreign public official and the corporate offence of failing to prevent bribery. We have a clear policy, which includes our zero-tolerance approach to bribery. Our stance is equally strong and clear in relation to those associated with or contracting with the Trust, and we avoid doing business with any individuals and organisations who fail to demonstrate their commitment to operate fairly, openly and honestly. Doing business transparently and preventing bribery is important in safeguarding the proper use of public money and resources, and a clear stance also provides patients, other customers, potential contractors and business partners as well as our governors and members with confidence that we will act in a transparent and fair way. This in turn protects our trusted position within our community and our reputation as a leading national and international centre for specialist treatment, education and research.

CUH has in place a number of procedures for the prevention of bribery, including a clear raising concerns policy and procedure, and a local counter-fraud specialist. In addition, a publicly-available register of interests for directors, governors and staff is kept as well as a hospitality register. All staff have a role to play, but individuals with specific responsibility for implementing bribery-prevention procedures include the Board of Directors, the Trust Secretary, and Trust managers, both clinical and non-clinical.

The Trust works closely with colleagues both within and outside the NHS to support a concerted effort to promote fair, honest and open operations and to prevent bribery, for the ultimate benefit of the patients and public we serve.

Relevant Union Officials

Table 28 - What was the total number of your employees who were relevant union officials during the relevant period?

What was the total number of your employees who were relevant union officials during the relevant period? Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
26	24.15

Table 29 - Percentage of time spent on facility time: How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	3
1-50%	22
51-99%	1
100%	0

Table 30 - Percentage of pay bill spent on facility time: the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Total cost of facility time	£62,288
Total pay bill	£ 792,809,000
Percentage of the total pay bill spent on facility time, calculated as:	0.00785 %

(total cost of facility time ÷ total pay bill) x 100	

Table 31 - Paid trade union activities - As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	5.86%

Off-payroll engagements

Table 32: Highly-paid off-payroll worker engagements as at 31 March 2025 earning £245 per day or greater

Number of existing engagements as of 31 March 2025	
Of which :	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 33: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2025	
Of which:	
Not subject to off-payroll legislation	0
Subject to off-payroll legislation and determined as in-scope of IR35	0
Subject to off-payroll legislation and determined as out-of-scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0

Of which: number of engagements that saw a change to IR35 status following review	0

Table 34: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

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.	18

Exit packages – subject to audit

Exit packages are accounted for in full in the year of departure.

Table 35: Exit packages

Reporting of other compensation schemes - exit packages 2024/25 Exit package cost band (including any special payment element)	**Number of compulsory redundancies Number**	**Cost of compulsory redundancies £000s**	**Number of other departures agreed Number**	**Cost of other departures agreed £000s**	**Total number of exit packages Number**	**Total cost of exit packages £000s**	**Number of departures where special payments have been made Number**	**Cost of special payment element included in exit packages £000s**
<£10,000	2	16	24	85	26	101	0	0
£10,001 - £25,000	3	60	7	106	10	166	0	0
£25,001 - 50,000	6	244	0	0	6	244	0	0
£50,001 - £100,000	1	54	0	0	1	54	0	0
£100,001 - £150,000	1	116	0	0	1	116	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	13	490	31	191	44	681	0	0

Table 36: Exit packages

Reporting of other compensation schemes - exit packages 2023/24 Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £000s	Number of other departures agreed Number	Cost of other departures agreed £000s	Total number of exit packages Number	Total cost of exit packages £000s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £000s
<£10,000	0	0	0	0	0	0	0	0
£10,001 - £25,000	0	0	0	0	0	0	0	0
£25,001 - 50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	1	67	0	0	1	67	0	0
£100,001 - £150,000	1	119	0	0	1	119	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	2	186	0	0	2	186	0	0

Exit packages: other (non-compulsory) departure payments – 2024/25	2024/25 Payments agreed Number	2024/25 Total value of agreements £000	2023/24 Payments agreed Number	2023/24 Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0

Contractual payments in lieu of notice	0	0	0	0
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	0	0	0	0
of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

3.24 Code of governance

The Trust has applied the principles of the 'Code of Governance for NHS Provider Trusts' which came into effect on 1 April 2023.

The Trust has reviewed compliance with the Code of Governance for NHS Provider Trusts'. As a result of this review, we consider that CUH complies with the main and supporting principles of the code of governance. This includes the issue of whether or not all of the NEDs are independent in accordance with code provision B1.1. The Board of Directors has determined that all of the NEDs are independent in character and judgement. This includes the appointed representative of University of Cambridge, Professor Patrick Maxwell, the Regius Professor of Physic, notwithstanding the Trust's relationship during this reporting period with the University of Cambridge, School of Clinical Medicine and with Cambridge University Health Partners (CUHP).

In relation to the more detailed provisions of the code of governance, CUH is compliant with the provisions with the following exceptions:

B.1.3. During the reporting period, the Director of People and Business Development of Cambridgeshire and Peterborough NHS Foundation Trust was a partnership governor on the CUH Council of Governors.

The representative of Cambridgeshire and Peterborough NHS Foundation Trust is a partnership governor appointed to reflect the views of a key partner organisation.

3.25 NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

Segmentation

As of 31 March 2025 the Trust is in segment 2 - Targeted support: support needs identified in finance and use of resources and operational performance.

This segmentation information is the Trust's position as at 31 March 2025.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website.

3.26 Well Led

In 2023/24 the Trust commissioned an external review against the CQC's Well-Led domain and approved an action plan to address the recommendations. Progress against this has been reported to the Board of Directors during 2024/25.

Specifically further work was undertaken during 2024/25 to review and enhance the Trust's Accountability Framework. The Board of Directors receives regular updates on the actions taken to improve oversight of

performance and to strengthen a culture of performance and accountability at CUH.

In the most recent Care Quality Commission inspection published in February 2019, the Trust was rated as 'Outstanding' in the 'Well-led' domain.

3.27 Statement of the Chief Executive's responsibilities as the Accounting Officer of Cambridge University Hospitals NHS Foundation Trust

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

NHS England has given Accounts Directions which require Cambridge University Hospitals NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Cambridge University Hospitals 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.

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 him 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.

Signed

Roland Sinker
Chief Executive
27 June 2025

3.28 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 Cambridge University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Cambridge University Hospitals NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

The system of internal control integrates a number of individual controls as described in other sections of this statement, and other key policies and procedures such as the Standing Orders, identification of matters reserved to the Board, Standing Financial Instructions and Scheme of Delegation used to govern the Trust's activities, together with checks and balances provided by Board oversight, and internal and external audit reviews.

Capacity to handle risk

The Board of Directors sets the policy framework and provides leadership for the management of risk within the Trust. The Chief Nurse is the Executive Director lead for risk management.

The Board Assurance Framework (BAF) identifies the principal risks to the achievement of the Trust's strategic objectives, together with key controls and assurances and any gaps in those controls and assurances. The Corporate Risk Register (CRR) includes operational risks escalated by clinical divisions and corporate directorates.

Operational responsibility for risk management sits within the clinical divisions and corporate directorates. Each clinical division and corporate directorate is required to have processes in place by which risks are identified, evaluated and managed at a local level, and escalated as required in accordance with the Trust's policy framework.

The principles of risk management are included as part of the mandatory corporate induction programme and guidance and training are provided to staff through the annual refresher programme, risk management training, Trust-wide policies and procedures and feedback from audits, inspections and incidents.

The Trust also learns from good practice through a range of mechanisms including those detailed above together with clinical supervision and reflective practice, individual and peer reviews, after action reviews, performance management, continuing professional development programmes, clinical audit and application of evidence-based practice.

The risk and control framework

The Risk Management Strategy and Policy sets out the approach to managing risk within the organisation. The latest version of the Strategy and Policy was reviewed and approved by the Board of Directors in January 2025. It defines the roles, responsibilities and reporting lines in relation to risk management as well as the overall governance structure underpinning this at both Board and divisional/directorate level. It details the Trust's approach to identification, assessment, management, monitoring and escalation of risk and a statement of the Board's risk appetite.

As noted above, the BAF sets out the principal risks to the achievement of the Trust's strategic objectives. The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The BAF describes controls in place to manage each of the risks and explains how the Board is assured that those controls are in place and operating effectively. The BAF also identifies any gaps in control or

assurance and the actions being taken to address these within specified timeframes.

The Risk Oversight Committee meets monthly and reviews the BAF and the CRR. It is chaired by the Chief Executive and membership includes all members of the Management Executive. The BAF and the CRR are received by the Board of Directors four times a year, detailing movements in risk and mitigating actions being taken with the aim of reducing the risk towards its target level. In addition, entries on the BAF and CRR are received and considered at each meeting of the relevant Board assurance committees to which they are assigned.

At an operational level, responsibility rests with each Divisional Director, supported by the Divisional Director of Operations and Divisional Head of Nursing, for clinical divisions; and with each Executive Director for the corporate directorates. Divisional 'red-rated' risks are reviewed at divisional Performance Review Meetings with members of the Executive Team.

The above meetings and associated processes are intended to facilitate a seamless risk management system from Board to ward.

The Board of Directors has previously agreed the principles regarding the level of risk which the Trust is prepared to seek, accept or tolerate in pursuit of its agreed objectives. These principles are focused on quality, finance and value for money, innovation, commercial opportunities, compliance and regulatory framework, reputation and workforce. The Board of Directors has reviewed the principles and the organisational risk appetite during the financial year.

The 2024/25 internal audit report on the BAF and risk management provides an overall assessment of 'Significant assurance with minor improvement opportunities'. The recommendations of the report have been accepted by the Executive Team and will be actioned during 2025/26.

As at 31 March 2025, the Trust identified through the BAF the most significant risks to the achievement of its strategic objectives as being:

- Due to physical capacity constraints and sub-optimal patient flow, the Trust is not able to deliver timely and responsive urgent and emergency care services, sustainably increase activity levels to reduce waiting lists, while at the same time managing future surges in seasonal viruses and providing decant capacity to address fire safety and backlog maintenance, which adversely impacts on patient outcomes and experience.
- There is a risk that the Trust, as part of the Cambridgeshire and Peterborough ICS, is unable to deliver the scale of financial

improvement required in order to achieve a breakeven or better financial performance within the funding allocation that has been set for the next three years, leading to regulatory action and/or impacting on the ability of the Trust to invest in its strategic priorities and provide high quality services for patients.

- A failure to sufficiently prioritise and address estate infrastructure and safety system risks and their ongoing maintenance impacts on patient and staff safety, continuity of clinical service delivery, regulatory compliance and reputation.
- As a result of incomplete fire compartmentation, there is a risk of fire causing harm to patients and staff and impacting on continuity of clinical service delivery.
- There is a risk that the Trust does not reduce inequality of opportunity and discrimination both within its workforce and in the provision of its services, caused by a failure to develop and implement a robust Equality, Diversity and Inclusion Strategy, which leads to poor staff and patient experience and sub-optimal patient outcomes.
- The Trust does not prioritise and deploy to best effect the limited resources available for IT investment to support staff to deliver improved patient care and experience.
- The construction and transformation programmes for the Cambridge Cancer Research Hospitals and the Cambridge Children's Hospital experience delays resulting in the need to maintain poor quality facilities for an extended period of time, adverse financial implications and a failure to realise the clinical, operational and wider benefits.
- Addenbrooke's 3 proposals beyond the CCH and CCRH are not developed or approved in a timely way resulting in the need to maintain poor quality facilities for an extended period of time and a failure to realise the clinical, operational and wider benefits of future schemes.
- As a result of a failure to deliver the CUH Green Plan, the Trust does not enhance environmental sustainability and reduce its direct carbon emissions by 10% by 2025 (as a key step towards the national commitment to halve carbon emissions before 2032 and deliver net zero carbon by 2045) nor develop and deliver a credible adaptation plan, which impacts on organisational reputation and regulatory compliance and increases the susceptibility of our services to the effects of climate change.
- There is a risk that partnership working across the Cambridgeshire and Peterborough Integrated Care System (ICS) and the Cambridgeshire South Care Partnership does not deliver interventions and changes in models of care at the scale and pace required to manage demand resulting in a failure to sustain and improve services for patients.
- The Trust does not meet required CQC regulations and continuously improve the quality, safety and experience of all its

services which adversely impacts on patient outcomes and experience and on organisational reputation.

- The Trust does not work effectively with regional partners (particularly regarding specialised services) resulting in a failure to sustain and improve services for regional patients and regulatory intervention and/or the recurrence of a financial deficit.
- The Trust and our industry and research partners – convened through Cambridge University Health Partners (CUHP) – fail to capitalise on opportunities to improve care for more patients now, generate new treatments for tomorrow and power economic growth in life sciences in Cambridge and across the region.

The Trust has identified the controls in place to manage these risks and the sources of assurance that the controls are effective. It has also identified any gaps in control or assurance and the associated actions being taken to address these gaps. The Board of Directors and Board assurance committees regularly seek assurance on the effectiveness of the controls and progress being made to address gaps in control and assurance to reduce the level of risk, where this is within the Trust's ability to do so.

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS*27 guidance.

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

The 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.

In order to be assured that staffing processes are safe, sustainable and effective, the Board of Directors receive a monthly nurse staffing report, aa quarterly report from our Guardian of Safe Working. The Board also

receives a more detailed report twice a year, most recently in November 2024 and June 2025 which covers nurse and midwifery staffing capacity and compliance with the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) standards and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) standards.

Quality governance

The Board of Directors has a collective responsibility for providing high quality care to the Trust's patients and has put in place a quality governance framework to ensure that quality is an integral part of the Trust's activities. The quality governance framework is kept under regular review, having due regard to the Well-Led Framework and best practice from other organisations. The Care Quality Commission (CQC) undertook a Well-Led review of the Trust in November 2018 and rated the Well-Led domain as 'Outstanding'.

The Quality Committee, in conjunction with the Performance Committee, provides assurance to the Board on the quality of patient care and compliance with national and local standards, with reference to the monthly Integrated Performance Report and other relevant reports and data. It reviews the Trust's clinical audit programme, compliance with the requirements of the Care Quality Commission, and Trust preparedness for regulatory inspections.

The Committee also oversees the implementation of the Trust's Quality Plan and its ongoing development. This includes a focus on clinical quality improvement to ensure that the Trust learns, shares and takes appropriate action in respect of safety reporting, and prospective and proactive patient safety risk detection; information and experience from outside the Trust; external reviews of Trust activity; and the results of clinical audit. It also oversees the development of and agrees priorities for the Trust's annual Quality Account.

The Trust transitioned to the new Patient Safety Incident Response Framework (PSIRF) on 1 January 2024. This framework encourages organisations to focus on and address areas of patient safety risks relevant to the Trust and population, rather than focus entirely on a predetermined list of reportable incidents being investigated as serious incidents (SI) under the 2015 Serious Incident Framework.

The Trust agreed five priority areas for the PSIRF focus and made progress with these in the last year. Significant incidents, including Never events and any other identified safety risks are reported to the Executive Directors, the Trust Lead commissioners and the Care Quality Commission (CQC) where required. Incidents are reviewed at the Safety Event Review Forum (SERF) and progress with safety actions and

improvements are tracked through the Safety Improvement Group (SIG). Summaries of patient safety incidents and themes are included in the monthly Integrated Performance Report and in the Patient Safety Report received by Quality Committee.

In addition, the Trust utilises a range of methods and learning responses to review and learn from patient safety incidents. Examples include After-Action Reviews (AAR), Multidisciplinary Round Tables, Thematic reviews or in-depth Patent Safety Incident Investigations (PSIIs). Outputs from these reviews are shared at the SIG and the Trust is working towards strengthening its improvement efforts following these investigations.

For rapid learning, the After Action Review (AAR) methodology is used as a method to reflect on what happened in an incident.

In addition to the above, the Management Executive has a standing item at its weekly meeting on quality issues and risks, affecting both patients and staff, to ensure that appropriate and timely action has been taken in response to any issues and risks which have arisen in the past week.

Information governance

The Trust has in place an Information Governance policy which sets out the Trust's commitment to ensuring that information is efficiently and effectively handled, managed and safeguarded. The policy establishes a robust information governance framework which includes up to date policies, procedures and accountabilities. Managers within the Trust are responsible for ensuring that the policy and its supporting standards and guidelines are built into divisional and directorate processes and that there is ongoing compliance.

The Trust complies with the requirements of the NHS Digital Data Security and Protection Toolkit for the management and control of risks to information. The current level (2023/24) of compliance with the Toolkit is 'approaching standards' and a plan is in place to meet the requirement that 95% of staff have completed their information governance training (currently 87%) and a programme of work is in place to meet the standards for 2024/25, with an agreed action plan in place.

The Trust has clear lines of responsibility and accountability for data security and protection, with effective lines of reporting to the CUH Digital Board. The next Toolkit submission for 2024/25 is due at the end of June 2025.

The Director of Innovation, Digital and Improvement is the Trust's Senior Information Risk Owner (SIRO), reporting to the Board of Directors. Senior managers across the Trust are information asset owners, accountable for a particular group of information assets under the Information Governance

policy and management framework. The Information Security and Governance Programme Board reports to the Digital Board.

During 2024/25 the Trust reported seven incidents relating to information governance, including data loss or confidentiality breach, which were classified as reportable Information Governance Incidents. These cases have been reported to the Information Commissioner's Office (ICO) and have been fully investigated.

Additionally, on 29 March 2024 the ICO informed the Trust that no action would be taken in relation to the data breaches reported in November 2023. To ensure that the Trust continues to learn from incidents, an internal audit review of the Trust's Freedom of Information process was commissioned. The findings of the review were presented to the Audit Committee in February 2025, with a number of recommendations arising that will be monitored and reviewed through the Digital Board and the Audit Committee.

Risks to foundation trust governance

The Board of Directors is responsible for setting the vision and values and the strategic objectives of the Trust. After more than two years of intense pressure due to Covid, the Trust's strategy was refreshed looking forward to 2025. A refresh of the current strategy is due for completion in autumn 2025 and will reflect the need for the healthcare of the future to be delivered differently in order to be sustainable.

The Audit Committee is the Board committee with primary responsibility for overseeing the Trust's governance and assurance processes and, in particular, for independently reviewing the effectiveness of the system of internal control and risk management, and ensuring that all significant risks are properly considered and communicated to the Board.

The Performance Committee, the Quality Committee and the Workforce and Education Committee provide independent and objective oversight and assurance to the Board of Directors on the Trust's performance in relation to operational standards, quality, finance and workforce. In addition, the Addenbrooke's Futures Board Committee provides assurance to the Board of Directors on the progress of the hospitals redevelopment programme and key issues and risks.

As set out in the Trust's Accountability Framework, the clinical divisions are held to account and escalate issues as required through monthly Performance Review meetings with the Executive Team. Each division provides a balanced scorecard of performance information which is included in the monthly Integrated Performance Report.

Involvement of stakeholders in risk

The Trust endorses three principles which underpin the quality framework:

- Quality is at the heart of all that the Trust does.
- There is an open and transparent culture to facilitate a learning organisation.
- The organisation will work collaboratively with stakeholders to ensure the quality and safety of services and demonstrate commitment to continual improvement.

Further information regarding patient and public engagement in the Trust is included in the Annual Report.

The Trust informs and engages with its commissioners throughout the year in relation to risk through regular meetings to review contract/clinical quality matters and to engage with them on the development of the Trust's Quality Account.

The Trust is engaged with partner organisations in the local health and care system in discussing quality and risk issues impacting on patients, in particular through the Cambridgeshire and Peterborough Integrated Care System.

The Trust engages with public stakeholders and the local Healthwatch in discussions including consideration of risks which impact on them. Governors are involved in discussions about risks which impact on patients and members through regular meetings including of the Council of Governors and supporting meetings. They are also involved in the development of the Trust's strategy and operational plans, specifically through the Governor Strategy Group.

CQC registration

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

An announced focussed CQC inspection was conducted in May 2023 of the Rosie Hospital as part of a wider national programme of inspections of maternity. The final report has been received by CUH and was published on the CQC website on 1 September 2023.

Whilst there is no impact on the Trust Overall rating of 'Good', the core service rating for Maternity (Safe) declined from 'Good' to 'Requires Improvement', with findings that mirrored the themes outlined by the CQC summarising their progress so far nationally – there were no 'outlier' non-conformities compared to other Trusts inspected. As part of the inspection, the well led domain was rated as 'Good'.

The Trust was inspected by the CQC in November 2018 and the inspection report was published in February 2019. The CQC inspected four core services and undertook a Trust-wide Well-Led review, together with a Use of Resources assessment by NHS Improvement. The Trust continued to be rated as 'Good' overall for Quality, with both the Caring and Well-Led domains being rated as 'Outstanding'. The Trust was rated as 'Requires Improvement' for the Responsive domain and for Use of Resources. The Trust continues to monitor the action plan in place to address the 'Should Dos' identified in the CQC inspection.

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

The Cambridgeshire and Peterborough system plan, incorporating the Trust's operational and financial plans for 2024/25, was submitted to NHS England in April 2025.

The key elements of the operational and financial plan have been monitored by the Management Executive and the Performance Committee has sought assurance on behalf of the Board of Directors on the delivery of the plan.

The objectives set out in the Trust's Internal Audit Plan include ensuring the economical, effective and efficient use of resources and this consideration is applied across all audits. The findings of internal audit reports are reported to the Audit Committee. Non-financial audits relating to quality are considered by the Quality Committee.

The process to ensure that resources are used economically, efficiently and effectively across clinical services include divisional Performance Review meetings, the clinical audit programme and the regular monitoring of clinical indicators covering quality and safety.

Data quality and governance

The assessment of performance data, including quality metrics, is an integral part of the Trust's performance management system. The Trust produces a monthly Integrated Performance Report which includes operational, quality, workforce and financial data and this has been subject to continued review during 2024/25. In addition to an ongoing programme of internal review and audit of data quality, in accordance with the Trust's Data Governance policy, data quality is subject to periodic audit by the Trust's internal auditors.

During 2024/25 the Performance Committee and Board of Directors received progress relating to the refresh of the Trust's Accountability Framework, which seeks to address the key findings of the Deloitte Well-Led External Governance Review, undertaken between October 2023 and

January 2024. The initial priority was enhancing the Executive Quality and Performance Meetings within divisions through improvements in the access and visibility of data and a shared understanding of the issues in order to ensure that the right conversations are being had and there is greater local ownership and accountability for performance.

LUNA National is a data quality and waiting list assurance platform, designed in partnership with NHS England, which provides real-time oversight of key data quality and waiting list indicators across every hospital in England.

The metrics provide a confidence level for the Trust's data quality within the RTT waiting list, with the confidence level for CUH assessed as 99.58%.

We have also developed our own internal data quality model within our RTT waiting list to highlight potential pathways aligned to the LUNA data quality metrics. This helps focus the validation efforts of our pathway trackers.

As part of our internal audit plan, we are audited on various elements of our internal data quality metric. The most recent audit of our waiting list management systems and processes in 2022/23 was rated as 'significant assurance with minor improvement opportunities.'

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 results of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee, other Board assurance committees and the Internal Auditors and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by the work through the year of the Board of Directors and of Board committees, as described in the risk and control framework section above. I have also been informed by the work of the internal auditors during the year, working to a risk-based plan agreed by

the Audit Committee, and the action plans resulting to address areas for improvement.

The Head of Internal Audit opinion for 2024/25 has concluded that significant assurance with minor improvement opportunities can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The result of the external auditors' work on the annual accounts and annual report are also a key assurance. Other external assurance is provided by CQC insight reports, the outcomes of the clinical audit programme and the results of reviews and inspections by external organisations.

The Audit Committee has reviewed the overall framework for internal control, and has recommended this statement to the Board of Directors.

Significant internal control issues

The Board of Directors has identified the following significant internal control issues for the Trust:

- In February 2025, the Trust announced that it would be carrying out a retrospective external review into the practice of an orthopaedic surgeon who specialises in paediatric surgery. This followed the conclusion of an initial external review, received January 2025, which identified that the outcomes of treatment provided to nine patients were below the standard the Trust would expect, and that they and their families were entitled to expect from us.

  As a precautionary measure in 2024, the Trust restricted the individual surgeon's clinical practice. Following the outcome of this initial review, the surgeon was suspended.

  The external clinical review of the surgeon's practice is being undertaken by a panel of expert clinicians and chaired by Andrew Kennedy KC. The expert clinical panel will review the care of around 700 patients who have undergone planned surgical procedures during the time the surgeon has been employed by CUH.

  The Trust has contacted patients and families to confirm that they are in scope of this review and to outline the support we will provide to them as the review progresses. We have put in place a dedicated Patient and Family Liaison Team who will be the primary point of contact for patients and their families for the duration of the review.

While we anticipate that the process of reviewing all the patients will take at least a year, we will be contacting patients and families during this time once the review of their care is complete to inform them of the outcome and to confirm whether further clinical assessment and treatment are needed.

While the individual surgeon specialises in paediatric surgery, it is normal practice for all orthopaedic consultants to carry out emergency orthopaedic procedures on both adults and paediatric patients. Therefore, as part of this retrospective review, the expert clinical panel will also review an initial 100 adults and paediatric orthopaedic trauma cases to determine whether there are any concerns about the emergency treatment provided by this surgeon.

While it will take time to review the cases fully, the Trust is committed to doing this in a thorough, open and transparent way.

In addition, the Trust has commissioned Verita to undertake an independent investigation into what was known when and whether there were opportunities to have identified these issues sooner. This includes investigating whether an external clinical review in 2016 was acted upon appropriately and, if not, why.

This independent investigation is due to be completed by the end of July 2025 and we will publish and implement the findings.

The terms of reference for the external clinical review and the independent investigation have been published.

A dedicated governance structure has been put in place to oversee this significant control issue, with regular reporting to the Board of Directors and the Quality Committee. External stakeholders, including representatives of NHS England and the Care Quality Commission, are represented on the Oversight Board.

- There continues to be concerns regarding the performance of the Addenbrooke's Treatment Centre Private Finance Initiative (PFI) contract and the associated risks (as reflected in the Trust's Corporate Risk Register). The Trust continues to work with an advisory in order to mitigate operational risks and review and consider options relating to the PFI contract. The Trust's Performance Committee has continued to exercise oversight on this issue and the latest published accounts of Key Health Services (Addenbrookes) Ltd acknowledges the existence of material uncertainties relating to going concern.

- Despite positive performance across a number of elective care metrics, in 2024/25 the Trust failed to comply with the nationally mandated 4-

hour target for urgent and emergency care. The Trust achieved a score of 71.4% against the national stretch target of 78%. Despite not achieving the target, significant progress was made in the ability of the Trust to deploy its resources more effectively and maintain more consistent performance against the 4-hour target throughout the year, particularly during a challenging winter period.

Conclusion

My review has established that Cambridge University Hospitals NHS Foundation Trust has a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives. I am satisfied that the significant internal control issues that have been identified in this review have appropriate action plans to help mitigate the associated risks and are subject to appropriate review, monitoring and escalation both internally and externally.

Roland Sinker
Chief Executive
27 June 2025

3.29 Sustainability and climate change report

Introduction

This report describes the commitment, approach, and performance of Cambridge University Hospitals NHS Foundation Trust (CUH) in its ongoing response to the environmental sustainability agenda during 2024/25. It specifically covers the challenge of tackling the climate emergency through CUH's three-phase Green Plan programme, of which Phase 1 is now complete. The report is divided into two sections:

Section 1 outlines the Trust's commitment, approach, and governance.

Section 2 provides a summary of performance, achievements and next steps under the Green Plan headings of: i.) cutting carbon, ii.) working on waste, and iii.) better together.

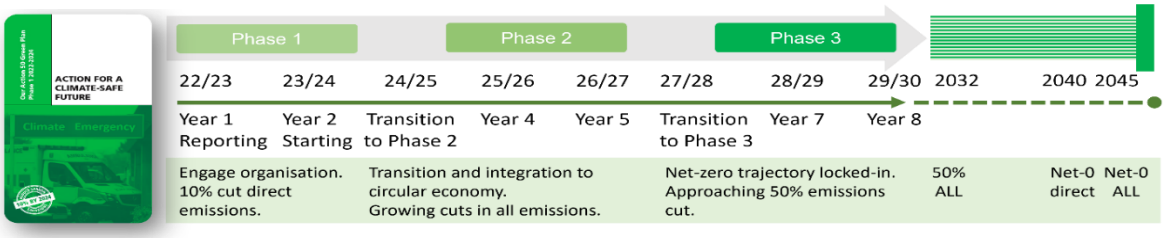
Section 1

Our commitment

Since the publication of its Long Term Plan (2019) and *Delivering a "Net Zero" NHS* (2020), the NHS has injected real urgency into action to realise its well-established direct commitments to tackling climate change (responding to the Government's national declaration of a "climate emergency"). In 2022 a net-zero NHS by 2045 was embedded in legislation by the Health and Care Act. As NHS trusts across the country conclude their first phase Green Plans, statutory guidance for the next round of plans was released in February 2025.

The content of these directives and guidance has been encompassed within CUH's *Action 50 Green Plan: Phase 1, 2022-24* (hereafter referred to as A50GP) and the drafting of the next phase as Green Plan 2 (2025-27). Both have built on our experience and achievement to date in delivering against the parameters of environmental sustainability.

Figure 1: the CUH Green Planning timeline



The A50GP aimed to reduce direct carbon emissions by 10% by the end of 2024/25 as the initial step in halving direct carbon emissions by 2032 (both from a 2019/20 baseline) and then reaching net-zero by 2045 (re. Figure 1), whilst engaging and influencing CUH's supply and disposal chains to avoid indirect emissions, pollution and waste of resources.

All actions contribute to the core NHS agendas of ill-health prevention, future-proofing operations, and adding value to patient care.

Progress is regionally and nationally checked through quarterly returns and a comprehensive internal governance regime.

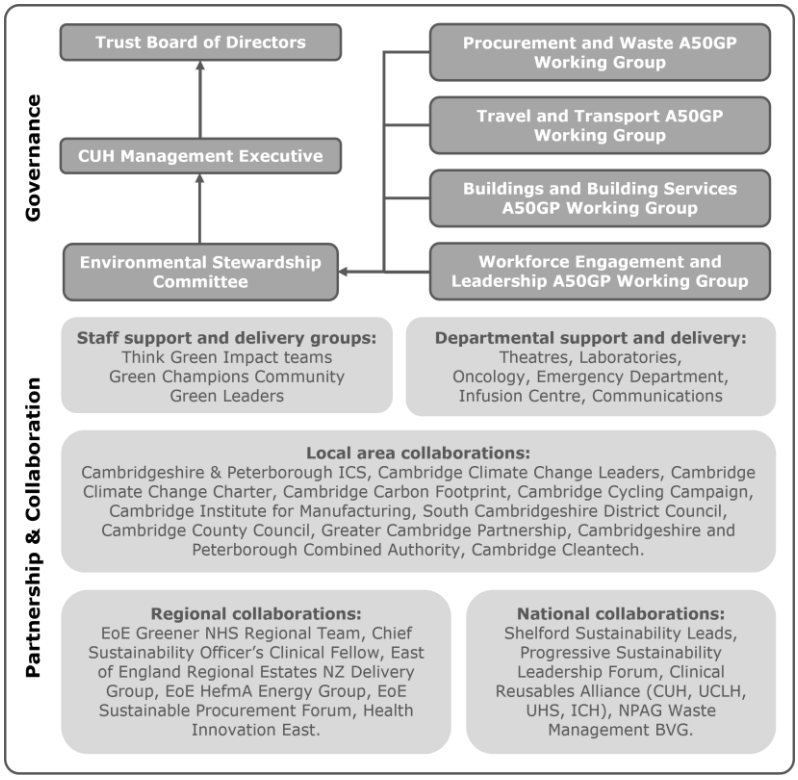
The first phase of CUH's Green Plan programme has been all about securing traction for the imperatives of rapidly accelerating carbon reduction and the interlinked essential outcomes of improved: waste management, pollution control, climate resilience, community health and overall value in delivery. This has been successful. Objectives have been met and exceeded. However, the real proof of achievement is in how well this leads into the comprehensive transition to genuinely integrated sustainable consumption.

Our approach

Carbon emissions are deeply embedded in everything the Trust consumes – from goods, materials, equipment, food and pharmaceuticals to energy, water and business miles. Some of these can be responded to directly (e.g.

improving energy efficiencies and switching to renewable sources), and others only indirectly (e.g. delivering in line with circular economy principles and collaborating with suppliers to support this). What, how and how much CUH consumes involves everyone. Working closely with all staff, patients, visitors, suppliers, and contractors is therefore essential. The significant number of moving parts within the Trust's supply, use, and disposal chains mean that the A50GP has needed to work on more than just changing some individual choices – it needs to reframe the decisions about what and how we consume as a whole system.

Figure 2: A50GP governance, partnership and



CUH's Green Plan programme formalises this reframing and the actions we are, and will be taking to establish a new 'story' for consumption: moving away from today's high-carbon/high-waste approach that is dominated by take-make-use-throwaway (referred to as the fossil-fuelled 'linear economy') and towards a net-zero/zero-waste approach that is dominated by high-efficiency renewable energy, reuse, repair and recycling - referred to as the renewably-powered 'circular economy'.

The progressive transition to a high-efficiency, very low waste, non-fossil-fuelled, renewably-powered circular economy is the Trust's active vision of a sustainable future. All the subsequent actions are incontrovertibly tied to ill-health prevention and growing system resilience in the short, medium, and longer term whilst improving the value of healthcare for patients.

Our governance, partnerships and collaborations

The delivery of CUH's A50GP has been provided with a strong governance model including support, escalation, and assurance. The Plan's fifty actions are split between a set of Working Groups that are scheduled to meet every two-months to check progress and help overcome barriers as they

arise. Should issues persist they are escalated to the Environmental Stewardship Committee which is scheduled to meet every six months. This committee subsequently reports progress to the CUH Management Executive which in turn provides an annual review to the Trust's Board of Directors.

The Plan's delivery and governance was subject to a full review by the Trust's internal auditors. The final report (April 2024) was positive, providing "significant assurance with minor improvement opportunities".

The Trust also carries formal risks within its assurance framework that cover an Energy and Sustainability Carbon Commitment (672), and Impact of Climate Change Upon Delivery of Services at CUH (CR59).

Alongside this formal structure is an established network of partnership and collaboration which helps to add important experience, value, reach and enhancement opportunities to Green Plan actions and its working model.

Section 2

Performance and achievements

2024-25 is the last full delivery year for the A50GP before the Trust enters Phase 2 (2025-27) of its Green Plan programme. Most actions have now completed their Phase 1 delivery. A relatively small proportion of these are standalone, most are subject to continuous development and rolling delivery to secure fully embedded and growing carbon reductions. A small cohort of actions have struggled to gain traction and are currently under review, and subject to a restructuring, that will be taken into Phase 2.

The A50GP set a very specific carbon reduction target: to cut the Trust's direct carbon emissions by 10% by the end of 2024/25 from a 2019/20 baseline. This calculated baseline was set at 32,000 tCO_2e, the target reduction is therefore by 3,200 tCO_2e. By the end of 2024/25 the reduction achieved was 4,174 tCO_2e, a 13% reduction.

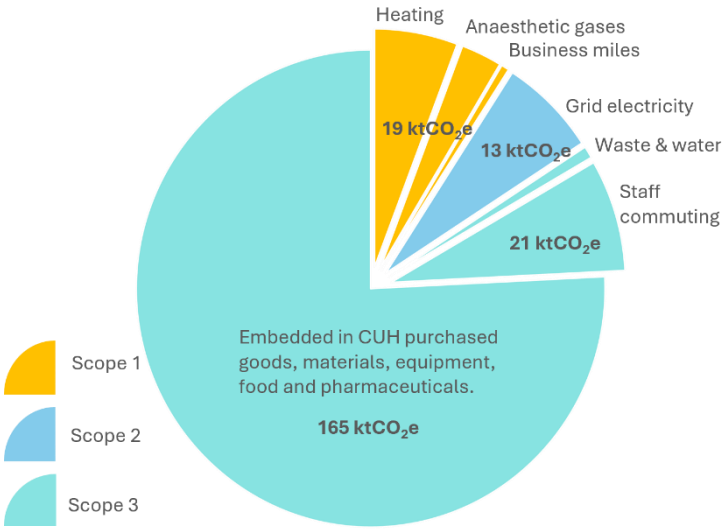
The following sub-sections are aligned with the three themes under which the A50GP's actions were developed: i.) 'cutting carbon', ii.) 'working on waste', and iii.) 'better together'.

i.) Cutting carbon

An important note on NHS carbon footprints

For the Trust to understand its progress in cutting carbon emissions it needs to have a calculated baseline figure from a particular point in time. In line with NHS guidance this baseline period is set at 2019/20 and the calculation is laid out in the A50GP. These numbers are important as they provide something against which to measure progress. At the same time however, because of the nature of CUH's site and the method of calculation they are, at most, good estimates and, at least, purely indicative of relative values. For this section, covering CUH's most directly controllable emissions (Scopes 1 and 2) the figures are good estimates based on readings from meters and gauges. They remain estimates, however, as operationally some datasets were not available for recording (typically transport and some clinical emissions) or sufficient sub-metering was not in place (typically for utilities in embedded partner building space). Having said this, the baselines are good and meaningful blends of hard figures and estimates from proxy data. These datasets are considerably more dependable than those of indirect Scope 3 emissions (embedded through the supply chain in purchased items). Calculations here are very loosely based on the relationship between emissions and spending by a high-level categorisation of purchase types. This is recognised nationally as a flawed methodology but is currently the only practical means available. Scope 3 emission figures must therefore be treated with much caution and always seen as only indicative.

Figure 3: CUH estimated/indicative baseline carbon emissions 2019/20



The other important variable in a baseline calculation is the variation in emission factors over time. These are externally set and periodically adjusted on the availability of new or updated information from activity within the supply and disposal chains. This means that the quantified elements that make up CUH's carbon footprint are liable to change year-on-year without the organisation taking any action at all.

Both issues (estimated consumption and variable emission factors) make looking at progress against an annual recalculation of all emissions problematic. To overcome this, the following sections express performance in reducing direct carbon emissions through assessment from the ground up.

Cutting CUH's directly controllable carbon emissions

When we talk about ‘cutting carbon’ in this section, we are talking about emissions that:

- CUH can most directly control (Scopes 1 and 2);
- are practically measurable (meters and gauges), and;
- are predominantly associated with CUH’s building services, transport, and some first-hand clinical processes.

Cutting carbon here is primarily about:

1. Reducing building energy consumption by taking out any waste or losses (e.g. through insulation and system controls) and using the most efficient technologies (e.g. LED lighting, heat-pumps, etc.). This is sometimes referred to as minimising energy use intensity – typically, getting the use as low as possible for each square meter of a property. This reduction in consumption not only cuts carbon but also cuts costs and often has benefits for both patient and staff local environments.
2. Switching to renewable sources of energy for buildings and campus services – typically solar photovoltaic (PV) panels either on-site, or locally connected via a ‘private wire’.
3. Finding and providing alternatives to the lone-driver use of petrol/diesel cars and switching to electric vehicles (EVs).
4. Driving down direct clinical emissions that have high global warming potentials (e.g. nitrous oxide and desflurane related to anaesthesia).

Green Plan delivery and progress in cutting direct carbon emissions.

The following list of graphic boxes illustrates the cumulative carbon reduction and associated savings from CUH’s Phase 1 Green Plan actions to the end of 2024/25

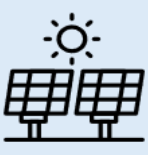
Boiler House
Operational improvements and upgrades. Savings/yr: 1,733 MWh gas = 320tCO_2e, £86k (+£50k UK ETS).

LED lighting
Upgrading from fluorescent. Savings/yr: 223MWh electricity; 49tCO_2e, £56k.

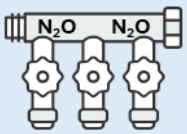
Thermostatic valves
Controlling radiator temperatures. Savings/yr: 87MWh gas; 16tCO_2e, £4.5k.

Building Mgt. System
Reviewing occupancy schedules. Savings/yr: 95MWh electricity; 21tCO_2e, £25k.

Switch-off campaign
PCs out of hours (if sustained). Savings/yr: 274MWh electricity; 55tCO_2e, £74k.



On-site solar panels
Cambridge Movement Surgical Hub. Savings/yr: 50MWh grid electricity; 10tCO_2e, £13k.



Nitrous oxide distribution
From network to mobile cylinders. Savings/yr: 4355k ltrs N_2O; 2,434tCO_2e, £26k.

Entonox distribution
Remedial work to network. Savings/yr: 1142k ltrs; 638tCO_2e, £17k.

Desflurane
Removed from formulary. Savings/yr: 160 ltrs; 580tCO_2e, £53k.

Electric vehicle charging
Start of fleet electrification. Savings/yr: 2,250ltrs petrol; 6.6tCO_2e, £1.5k.

Manual aircon scheduling
Resetting occupancy controls. Savings/yr: 49MWh electricity; 10tCO_2e, £12k.

Theatre occupancy sensors
Occupancy control. Savings/yr: 168MWh electricity; 34tCO_2e, £42k.

Many of these first phase immediate and shorter-term deliverables will go on to be sustained and extended (e.g. LED lighting and the automation of building services). These are joined by several long-term schemes at various stages of development.

Heat decarbonisation is now a growing reality through the Frank Lee Centre and Residencies project alongside new builds such as the Cambridge Movement Surgical Hub and 'U' ward block. Linked to this, and technology-driven increases in electricity demand, the sourcing of renewable energy supplies is a similarly long-term programme. With on-site electric vehicle charging infrastructure now in place, the progressive switch to electrifying all CUH fleet vehicles is under way.

Green Plan 1 (A50GP) 2022-24: long-term project enabling and delivery work.

Private-wire Solar PV
Babraham Park & Ride. Savings/yr.: 2000MWh grid electricity, 400tCO_2e, £25k.

Greyfleet to EV pool cars. Major £ and CO_2e reduction in 200k business miles. Subject to travel expense policy

Heat Decarbonisation.
Frank Lee & Residencies £7.3m govt. grant. Savings/yr : 3,700MWh gas, 600tCO_2e, £ subject to electric/gas differential

Cambridge Cancer Research & Children's hospitals. Savings/yr: major, but subject to RIBA4 deign efficacy.

ii.) Working on waste

What do we mean by ‘waste’?

We use the term ‘waste’, in this section, to refer to the left-over goods, materials and equipment from all the activities CUH undertakes in the provision, operation and administration of its healthcare services as a major acute teaching hospital.

By ‘working on’ waste, we mean acting not only to minimise the amount that is thrown away (through reuse, repair and refill), and thereby cut costs, but also to ensure that as much as possible of what is no longer wanted is made available for reprocessing back into the supply chain.

This is how CUH can most directly reduce the carbon emissions tied into the numerous supply chain elements of all the goods, products, and devices it consumes.

The Trust is therefore working on waste to ensure it is acting as an environmentally responsible consumer through:

- Connecting supply, to use and to disposal to secure circularity.
- Reducing pollution and the loss of natural resources.
- Holding carbon in the supply chain and so avoiding the need for it to be re-emitted.

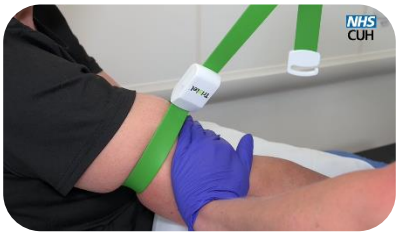
Reducing waste to cut carbon, pollution and the loss of natural resources is primarily about:

1. Collaboratively working with our supply and disposal partners to retain maximum value from everything CUH purchases.
2. Putting in place the necessary reuse, repair, return and recycling infrastructure to make this happen.
3. Recognising that in delivering the above, the Trust is building its resilience to the supply chain shocks that are to be expected from the global impacts of climate change and wider environmental crisis.

CUH has continued to make good progress in embedding such parameters in all tender exercises (following Procurement Policy Note 06/20 and the NHS Net Zero Supplier Roadmap) whilst also working on catalogue purchase options where there is genuine room for manoeuvre.

Alongside this, local teams across the Trust have been using circular economy principles (reduce, reuse, repair etc.) to develop and deliver significantly more sustainable patterns of consumption.

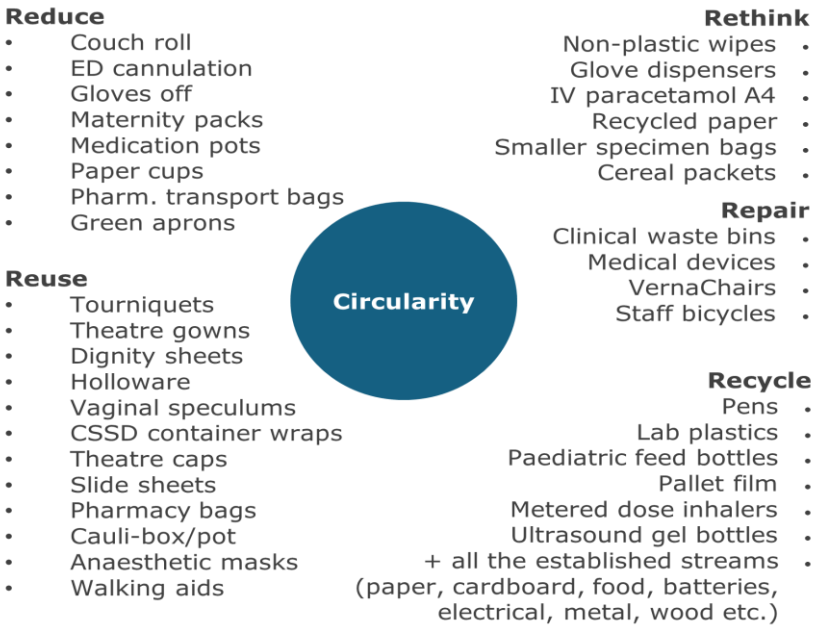
This is a complex area that requires multi-disciplinary teams and clinical leadership. Figure 4 lists items in which real circular economy characteristics have either been embedded, are under development, or are in the pipeline. Once lifecycle thinking has been introduced, and the transition has been made, the returns and benefits are significant. For example:



- Piloting the switch from single-use to reusable venous tourniquets has meant that, over the next 12 months, the 15 teams involved will avoid the use and disposal of over 125,000 single-use tourniquets – generating a financial saving of approximately £6,000 (plus an improvement in patient experience).
- Switching to reusable instruments in rationalised maternity packs is now saving an estimated 600kg of waste, with all the 'embedded' carbon emissions and pollution, per year (300kg of this being single-use stainless steel); plus saving £600 per year in utilities and waste management and £9,600 in staff costs within the CUH Central Sterilisation Services Department.

- Changing from single patient use flat disposable slide sheets to reusable tubular versions (better for patients and staff) has taken over 21,000 of the single-use items out of the supply and disposal chain and saving approximately £14,000 per year.

Figure 4: items developed and/or delivered in the transition to circular economy



iii.) Better together

What do we mean by 'together'

The Trust has learnt, from over ten years of working on environmental sustainability, that full and lasting success only comes from committed collaboration with all stakeholders. Like the Trust's Together: Safe, Kind and Excellent values, environmental sustainability really is for everyone. In the pressured and complex environment of a major acute teaching hospital it needs to include:

- Participative engagement allowing everybody to contribute.
- 'Joining the dots' across all aspects of an item's lifecycle and costs.
- Establishing clear environmental sustainability responsibilities and development opportunities for all CUH staff.

Most actions under this theme do not deliver carbon or circular economy savings in themselves but, rather, through engagement and enablement they are the essential tools for: initially providing traction, and then creating the space for the transition and transformation to a renewably-powered circular economy way of working at CUH.

2023-24 delivery and progress in being better together

i.) Engagement for a climate safe-future

- CUH Green Champions' Community (340+ members)
- Cambridgeshire & Peterborough ICS, East of England Greener NHS
- Cambridge Biomedical Campus Sustainability Group
- Founding member for the Circular Economy Healthcare Alliance.
- Shelford Group: Sustainability Working Group

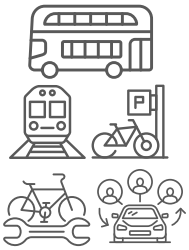
- CUH Facebook: 500+ followers, 4,000+ reactions, >60,000 reach.
- Instagram
- MS Teams channel
- Newsletters and video clips.
- Press releases

- Repair cafes
- Swishes (clothes swap)
- Plant swaps
- Climate cafes
- Conferences and presentations

ii.) Facilitating participation in a climate-safe future

- > 50 teams taking part in CUH's Think Green Impact programme (60 awards).
- CUH Green Leaders.
- 5 staff joined IDN Sustainability apprenticeships.
- Annual Green Champions award,

- Connect intranet resources
- E-learning modules
- New starter induction
- ADR objectives
- Waste and energy 'tours'



- Cycle Repair Hub
- Cycle checks/marling
- Bus service promotions
- E-bike/scooter hire
- Sustainable travel routes
- Cambridge South station
- Kinto car-sharing

Looking ahead

The conclusion of the Trust's first Green Plan (2022-24) and drafting of its second (2025-27) is a watershed moment in securing a sustainable future for the organisation. The three main reasons for this are:

1. A dangerously changed climate is now almost certainly our shared destiny. The key questions are, how dangerous? and how does the Trust, manage, minimise and reverse the impacts of this danger on the wellbeing of its patients and staff?
2. CUH's Green Plan 1 has met its carbon reduction targets and developed crucial enabling work. However, pushing the reduction in direct carbon emissions to 50% by 2032 will require an exceptional commitment to expanding and developing the programme into a comprehensive transition.
3. The use of circular economy principles to determine what, how and how much CUH consumes sits at the heart of being a responsible consumer in a climate emergency. With so much of the organisation's environmental impact embedded within its supply chain, some of the most material actions it can take are:
    - to work with suppliers that share, and will collaborate with us to achieve, the NHS carbon reduction trajectory,
    - to avoid unnecessary and wasteful embedded emissions by retaining the most value possible in what the Trust purchases, and

- to establish both of these elements as standard purchasing and contract management practices as an urgent necessity.

Our Action 50 Green Plan (Phase 1: 2022-24) has demonstrated that having a map of how the world needs to be (renewably-powered circular economy) is important. But, using it on a terrain where the ground has been worn, shaped and structured from years of working with another map (fossil-fuelled linear economy) is exceptionally challenging. The way forward is often blocked, easily frustrated and frequently blurred.

Delivering Green Plan 2 will be about sustaining a Trust-wide commitment to the new renewably-powered circular economy map, as the new norm, to progressively reshape our on-the-ground infrastructure, processes and behaviours.

3.30 Other issues

The activities and policies of the CUH in the areas of social, environmental, community and human rights are outlined earlier in this chapter and specifically the equality and diversity report and sustainability and climate change report.

Roland Sinker
Chief Executive
27 June 2025

Cambridge University Hospitals NHS
NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust
Accounts
Year Ended 31 March 2025

Presented to Parliament pursuant to Schedule 7, paragraphs 24 and 25 of the National Health Service Act 2006.

Independent auditor's report to the Council of Governors of Cambridge University Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Cambridge University Hospitals NHS Foundation Trust ('the Trust') for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including material accounting policy information.

The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2024/25 as contained in the Department of Health and Social Care Group Accounting Manual 2024/25, 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 as at 31 March 2025 and of the Trust'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 2024/25; 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 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 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 Chief Executive Responsibilities as the Accounting Officer, 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 2024/25 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 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, we considered that non-compliance with the following laws and regulations might have a material effect on the financial statements: National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), Mental Health Capacity Act, Mental Health Act, Access to Health Records Act, Children's Act and Health and Safety Act.

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:

• inquiring with management and the Audit Committee, as to whether the Trust 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;

• communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and

• considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

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), Mental Health Capacity Act, Mental Health Act, Access to Health Records Act, Children's Act and Health and Safety Act and we considered the extent to which non-compliance might have a material effect on the financial statements.

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 incorrect recognition of accrued variable income, manipulating expenditure accruals, prepayments to defer expenditure to the following year, posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

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

• making enquiries of management, Head of 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;

• addressing the risks of fraud through management override of controls by performing journal entry testing;

• addressing the risk of fraud in revenue recognition by performing appropriate sample testing of revenue; and

• addressing the risk of fraud through expenditure recognition by testing a sample of non-pay expenditure.

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

We are also required to conclude on whether the 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 2025.

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 by Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024.

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 2024/25; 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 2024/25; 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 Cambridge University Hospitals NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the NAO that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.

Suresh Patel, Key Audit Partner

For and on behalf of Forvis Mazars LLP (Local Auditor)

30, Old Bailey,

London

EC4M 7AU

30 June 2025

FOREWORD TO THE ACCOUNTS

Cambridge University Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust ("the Trust") acts as an acute hospital and the main teaching hospital for the University of Cambridge. The Trust serves the local Cambridge area and also provides specialist services to the wider population throughout the East of England and beyond. The Trust hosts a number of clinical networks and the Cambridge Biomedical Research Centre.

These accounts for the year ended 31 March 2025 have been prepared by Cambridge University Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Signed

Roland Sinker
Chief Executive

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2025

	Note	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Operating income from patient care activities	2.1	1,391,144	1,250,030
Other operating income	2.3	236,043	198,599
Total operating income from continuing operations		1,627,187	1,448,629
Operating expenses of continuing operations	3	(1,634,047)	(1,490,567)
Operating (deficit)		(6,860)	(41,938)
Finance Income and costs			
Finance income	6.1	5,832	9,405
Finance expense	6.2	(10,683)	(9,667)
PDC dividend charge		(3,244)	(1,991)
Net finance costs		(8,095)	(2,253)
Other gains/(losses)	6.3	469	(163)
(Deficit) for the year		(14,486)	(44,354)
Other comprehensive income/(expenditure)			
Will not be reclassified to income and expenditure:			
Impairment charged to the revaluation reserve	6.4	(5,065)	(11,605)
Revaluations charged to revaluation reserve		-	1,614
Total comprehensive (expense) for the year		(19,551)	(54,345)
Allocation of (losses) for the year:			
(Deficit) for the year attributable to:			
Trust		(14,486)	(44,354)
Total comprehensive (expense) for the year attributable to:			
Trust		(19,551)	(54,345)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2025

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	7	17,822	15,628
Property, plant and equipment	8.1	477,193	460,766
Right of Use Assets	8.2	62,784	61,001
Receivables	10	1,906	1,864
Total non-current assets		559,705	539,259
Current assets			
Inventories	9	15,258	14,782
Trade and other receivables	10	114,555	72,879
Cash and cash equivalents	11	100,656	139,583
Asset Held for Sale		22	22
Total current assets		230,491	227,266
Current liabilities			
Trade and other payables	12.1	(213,243)	(212,143)
Borrowings	13	(16,072)	(15,842)
Provisions	14	(19,763)	(8,600)
Other liabilities	12.2	(94,882)	(84,740)
Total current liabilities		(343,960)	(321,325)
Total assets less current liabilities		446,236	445,200
Non-current liabilities			
Borrowings	13	(130,401)	(153,475)
Provisions	14	(5,741)	(9,099)
Total non-current liabilities		(136,142)	(162,574)
Total assets employed		310,094	282,626
Taxpayers' equity			
Public dividend capital		676,298	629,279
Revaluation reserve		32,006	37,162
Income and expenditure reserve		(398,210)	(383,815)
Total taxpayers' equity		310,094	282,626

These financial statements including the notes were approved by the Board and signed on 27 June 2025 on its behalf by:

Baroness Sally Morgan
Chairman

Mr Roland Sinker
Chief Executive

Mr Mike Keech
Chief Finance Officer

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR YEAR ENDED 31 MARCH 2025

	Total £000	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' equity at 01 April 2024	282,626	629,279	37,162	(383,815)
(Deficit) for the year	(14,486)	-	-	(14,486)
Transfers between reserves	-		(91)	91
Impairments charged to the revaluation reserve	(5,065)	-	(5,065)	-
Revaluations	-	-	-	-
Public dividend capital received	47,019	47,019	-	-
Taxpayers' equity at 31 March 2025	310,094	676,298	32,006	(398,210)

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR YEAR ENDED 31 MARCH 2024

	Total £000	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' equity at 01 April 2023	358,912	615,959	47,026	(304,073)
Implementation of IFSR16 measurement principles to PFI liability on 1 April 2023	(35,261)			(35,261)
(Deficit) for the year	(44,354)	-	-	(44,354)
Transfers between reserves	-		127	(127)
Impairments charged to the revaluation reserve	(11,605)	-	(11,605)	-
Revaluations	1,614	-	1,614	-
Public dividend capital received	13,320	13,320	-	-
Taxpayers' equity at 31 March 2024	282,626	629,279	37,162	(383,815)

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2025

	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Cash flows from operating activities		
Operating (deficit) from continuing operations	(6,860)	(41,938)
Non-cash income and expense		
Depreciation and amortisation	38,860	35,285
Impairments	27,358	47,527
Income recognised in respect of capital donations (cash and non-cash)	(16,751)	(5,435)
(Increase)/decrease in receivables	(43,632)	(2,226)
(Increase)/decrease in inventories	(476)	(1,389)
(Decrease)/increase in trade and other payables	(5,880)	(30,918)
Increase in other liabilities	10,142	(7,205)
Increase/(decrease) in provisions	7,768	(5,271)
Other movements in operating cash flows	1	5
Net cash generated from / (used in) operations	10,530	(11,565)
Cash flows from investing activities		
Interest received	5,832	9,405
Purchase of intangible assets	(7,539)	(1,058)
Purchase of property, plant and equipment and investment property	(65,949)	(78,909)
Sales of property, plant and equipment and investment property	144	168
Receipt of cash donations to purchase capital assets	4,295	5,435
Net cash (used in) investing activities	(63,217)	(64,959)
Cash flows from financing activities		
Public dividend capital received	47,019	13,320
Movement in loans from the Department of Health and Social Care	(6,398)	(6,398)
Capital element of lease liability repayments	(15,142)	(3,804)
Capital element of PFI, LIFT and other service concession payments	(4,135)	(3,167)
Interest on loans	(1,459)	(1,678)
Interest element of lease liability repayments	(862)	(610)
Interest element of PFI, LIFT and other service concession obligations	(3,964)	(4,130)
PDC dividend (paid)/refunded	(1,299)	(3,812)
Net cash generated from financing activities	13,760	(10,279)
(Decrease)/increase in cash and cash equivalents	(38,927)	(86,803)
Cash and cash equivalents at 1 April	139,583	226,386
Cash and cash equivalents at 31 March	100,656	139,583
Cash at commercial banks and in hand	2,790	6,030
Cash with the Government Banking Service	97,866	133,553
Total cash and cash equivalents as in SoCF	100,656	139,583

The Foundation Trust held £nil cash at bank and in hand at 31 March 2025 (year ended 31 March 2024, £0.1k) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

NOTES TO THE ACCOUNTS

IFRS Accounting Policies

1 Accounting policies and other information

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

1.1 Accounting convention

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

1.2 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.

1.3 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 services provided is recognised when (or as) performance obligations are satisfied, by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation. 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.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for healthcare services. A performance obligation relating to delivery of a spell of healthcare is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

The Trust does not currently accrue for incomplete spells due to the decision to stop this process as a result of the Covid-19 pandemic and the transfer to fixed/variable funding from 2020/21. Where contract

challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

For 2024/25, the National Payment System is the funding regime. This contains a mixture of fixed and variable elements and is a continuation of previous years. The fixed elements of the Aligned Payment Incentive are predominately emergency care, and the variable elements are largely made up of planned admitted patient care, outpatient first attendances, nuclear medicine and diagnostics and excluded from tariff drugs and devices. The value of the fixed elements is determined through the contract setting process and the variable elements are calculated nationally by NHSE using Trust supplied activity data through SUS. Aligned Payment Incentive (API) contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2024-25 NHS Payment Scheme documentation: https://www.england.nhs.uk/pay-syst/nhs-payment-scheme.

All patient activity is run through a national grouper and through our software to be priced. The income software splits activity between fixed and variable and, for the fixed elements, the commissioner bills are adjusted back to align with the agreed fixed values in the contract. The key areas that are variable are planned admitted patient care, outpatient first attendances, diagnostics, nuclear medicine, chemotherapy (all of which form part of the elective recovery fund (ERF) variable payment mechanism) and excluded from tariff drugs and devices. Whilst LVAs (low value associate commissioners) make a nationally determined fixed payment for the year, devolved administrations pay for services on a variable basis for each patient treatment/activity undertaken (i.e. under a PbR basis).

Although CQUIN schemes are included in contracts with NHS commissioners of healthcare services there are no financial adjustments associated with the delivery of these schemes. Prior to the Covid-19 pandemic CQUIN schemes were accounted for as variable income with their own distinct performance obligations where specific quality improvement criteria had to be met to recognise that income. In 2024/25, CQUIN 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. Payment under this scheme is now included in fixed payments from commissioners based on assumed delivery.

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.

1.4 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.

Apprenticeship service income

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

1.5 Expenditure on employee benefits

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

Pension costs - NHS Pension Scheme

Employer pension costs are recognised as expenditure in the Statement of Comprehensive Income in the period in which the service is received from employees. 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, general practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.
The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers. The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.
The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that, they have been received. It 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.

1.7 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 will be supplied to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably and is above £5K

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 cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Subsequently, land and buildings (exclude leasehold improvements) are measured at the current value in existing use and all other Property, plant and equipment assets are held at their current value in existing use.

Specialised buildings are valued at depreciated replacement cost on a modern equivalent asset (alternative site) basis. Land and non-specialised buildings are valued at market value for existing use. All assets held for their service potential and which are in use are measured at their current value in existing use. Valuations are carried out by professionally qualified District Valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

Valuation guidance issued by the Royal Institution of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust. The land and buildings valuation was undertaken as at the prospective valuation date of 31 March 2025, applying the modern equivalent assets valuation (alternative site) basis which is consistent with IAS (International Accounting Standard) 16.

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, borrowing costs. Assets are revalued and depreciation commences when they 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, less any residual value, on a straight-line basis over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Freehold land is considered to have an infinite life and is not depreciated. Properties not yet in use are held as assets under construction and are not depreciated.

Buildings, installations and fittings are depreciated on their current value for existing use over the estimated remaining life of the asset as assessed by professional valuers.

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 is shown in the table below:

Land	Infinite
Buildings	2 – 60 years
Plant and Machinery	5 – 15 years
Information Technology	5 – 12 years
Furniture and fittings	7 – 10 years
Transport Equipment	7 years

Revaluation gains and losses

Revaluations of land and buildings are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

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 DHSC 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

- the impairment charged to operating expenses; and
- 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, government grant and other 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.

Private Finance Initiative (PFI) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the payment for the repayment of the liability including finance costs, the charges for services and 'lifecycle replacement' of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

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

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The

element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities in 2023/24

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

1.8 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, it is recognised as an operating expense in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

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

Measurement

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

Subsequently intangible assets are measured at cost as proxy for depreciated replacement cost. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

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 estimated life of purchased computer software is between 2 and 12 years.

1.9 Inventories

Inventories comprise mainly consumable medical products.

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost formula for drugs and the first in first out cost formula for all other

inventories. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Cash and cash equivalents

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

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

1.11 Financial assets & financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provision 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. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

Amortised cost financial assets are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

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

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

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

Expected credit losses are estimated via a provision matrix that assigns differing percentages and timings in terms of categories of debt. These are based on an assessment of past performance, current/future market and general economic conditions and any other considerations relevant to specific categories of debtor.

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

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

De-recognition

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

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

1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as lessee

Initial recognition and measurement

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

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as lessor

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.

1.13 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.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.40% in real terms (2023-24: 2.45%). All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

A nominal medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

A nominal long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

A nominal very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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 is not recognised in the Trust's accounts.

1.14 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.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual 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 in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (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.

1.15 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 assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Climate Change Levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.17 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.

1.18 Key sources of estimation uncertainty

The most significant estimate within the accounts is the value of land and buildings. The land and buildings have been valued by the District Valuer on a modern equivalent asset (alternative site) basis as at 31 March 2025. The District Valuer is independent of the Trust and is certified by the Royal Institution of Chartered Surveyors. The valuer has extensive knowledge of the physical estate and market factors. The valuation methodology is set out in the RICS guidance, the Treasury FReM, Treasury Guidance on asset valuations and the IFRS (IAS16) guidance. The value does not take into account potential future changes in market value which cannot be predicted with any certainty. The carrying amount of land and buildings as at 31 March 2025 is summarised in the Note 8 'Property, Plant, and Equipment' to the Statement of Financial Position.

1.19 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 2024/25:

IFRS 17 Insurance Contracts
The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in

2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements

The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. 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.

2. Operating income

IFRS 8 requires the disclosure of results of significant operating segments; the Trust considers that it only has one operating segment, healthcare.

2.1 Income from patient care (by nature)

Income from activities	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Acute services		
Aligned payment & incentive (API) income - Variable (based on activity)	256,454	225,602
Aligned payment & incentive (API) income - Fixed (not variable based on activity)	857,291	782,993
High cost drugs income from commissioners	200,613	190,271
Other NHS clinical income	5,336	5,109
All other services		
Private patient income	8,765	8,813
Additional pension contribution central funding	50,838	29,867
Agenda for change pay offer central funding	2,889	617
Other clinical income	8,958	6,758
Total income from patient care activities	1,391,144	1,250,030

In line with the DHSC GAM additional guidance and the detailed guidance provided by NHS England, providers' accounts are required to account for the additional expenditure arising from the 9.4% (PY: 6.3%) pension contributions paid by NHS England and related income on a gross basis.

2.2 Income from patient care (by source)

	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Income from activities		
NHS England	403,541	647,651
Integrated Care Boards	964,555	581,573
NHS Foundation Trusts	3	8
NHS Trusts	-	9
Department of Health and Social Care	40	110
NHS other (including Public Health England)	5,290	5,109
Non NHS: private patients	8,765	8,813
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	1,943	1,311
Injury cost recovery scheme	7,007	5,446
Total income from activities related to continuing operations	1,391,144	1,250,030

During FY2024/25, income from commissioner requested services totalled £1,373m (PY: £1,234m) and non-commissioner requested services totalled £17.7m (PY: £15.6m). In the 2024/25 financial year NHSE have devolved areas of specialised services to the NHS ICB commissioners for payment purposes. This has led to a transfer of income recognition from NHSE to the ICBs.

2.3 Other operating income

	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Other operating income		
Research and development (IFRS 15)	39,804	42,268
Education and training (excluding notional apprenticeship levy income)	53,823	48,001
Non-patient care services to other bodies	82,585	64,183
Other (recognised in accordance with IFRS 15)	37,748	32,863
Education and training - notional income from apprenticeship fund	2,852	2,980
Cash donations for the purchase of capital assets - received from other bodies	16,751	5,435
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	-	575
Rental revenue from operating leases	2,480	2,294
Total other operating income related to continuing operations	236,043	198,599
Total operating income	1,627,187	1,448,629

2.4 Overseas visitors (relating to patients charged directly by the Foundation Trust)

	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Income recognised this year	1,943	1,311
Cash payments received in-year (relating to invoices raised in current and previous years)	415	638
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	1,053	553
Amounts written off in-year (relating to invoices raised in current and previous years)	-	-

3. Operating expenses (by type)

	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Purchase of healthcare from NHS and DHSC bodies	113	-
Purchase of healthcare from non-NHS and non-DHSC bodies	5,376	6,090
Staff and executive directors costs	900,131	792,809
Non-executive directors	147	110
Supplies and services – clinical (excluding drugs costs)	212,275	199,305
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	71	576
Supplies and services - general	21,485	21,083
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	225,344	206,343
Consultancy	380	316
Inventories written down (consumables donated from DHSC group bodies for COVID response)	-	19
Establishment	22,886	22,628
Premises - business rates collected by local authorities	4,540	4,793
Premises - other	94,396	88,512
Transport (business travel only)	754	753
Transport - other (including patient travel)	4,132	5,274
Depreciation	33,515	30,096
Amortisation	5,345	5,188
Impairments net of (reversals)	27,358	47,527
Increase in impairment of receivables	(2,128)	(207)
Provisions arising / released in year	8,286	(1,545)
Change in provisions discount rate	7	(106)
Audit services - statutory audit (net of VAT)	160	125
Internal audit	98	98
Clinical negligence - amounts payable to NHS Resolution (premium)	25,753	25,499
Legal fees	1,090	1,017
Insurance	1,277	838
Research and development	11	15
Education and training	3,014	3,246
Education and training - notional expenditure funded from apprenticeship fund	2,852	2,980
Operating lease expenditure	359	430
Lease expenditure - short term leases (<= 12 months)	117	343
Lease expenditure - irrecoverable VAT	987	748
Early retirements	839	629
Redundancy costs	681	186
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	3,314	2,746
Car parking and security	2,204	1,052
Hospitality	313	242
Other losses and special payments	470	307
Grossing up consortium arrangements	17,717	14,958
Other operating expenses	8,378	5,544
Total operating expenses of continuing operations	1,634,047	1,490,567

4. Staff

4.1 Employee expenses

	Year ended 31 March 2025 Total £000	Year ended 31 March 2025 Permanent £000	Year ended 31 March 2025 Other £000
Salaries and wages	689,448	682,258	7,190
Social security costs	74,767	74,767	-
Apprenticeship levy	3,363	3,363	-
Pension cost - employer contributions to NHS pension scheme	77,779	77,779	-
Pension cost - employer contributions paid by NHSE on provider's behalf (9.4%)	50,838	50,838	-
Temporary staff - agency/contract staff	5,456	-	5,456
Total gross staff costs	901,651	889,005	12,646
Staff and executive directors costs	900,131	887,485	12,646
Redundancy	681	681	-
Early retirements	839	839	-
Total employee benefits	901,651	889,005	12,646

	Year ended 31 March 2024 Total £000	Year ended 31 March 2024 Permanent £000	Year ended 31 March 2024 Other £000
Salaries and wages	615,645	608,537	7,108
Social security costs	67,890	67,890	-
Apprenticeship levy	3,072	3,072	-
Pension cost - employer contributions to NHS pension scheme	68,512	68,512	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	29,867	29,867	-
Temporary staff - agency/contract staff	8,638	-	8,638
Total gross staff costs	793,624	777,878	15,746
Staff and executive directors costs	792,809	777,063	15,746
Redundancy	186	186	-
Early retirements	629	629	-
Total employee benefits	793,624	777,878	15,746

The 'Permanent' staff cost above also includes internal bank staff cost of £72.1m (PY: £78.9m).
In line with the DHSC GAM additional guidance and the detailed guidance provided by NHS, providers' accounts are required to account for the additional expenditure arising from the 9.4% (PY: 6.3%) pension contributions paid by NHS England and related income on a gross basis.

However, the same as prior years, during 2024/25 the NHS Business Service Authority collected only 14.38% from employers. Central payments have been made by NHS England and the Department of Health and Social Care for their respective proportions of the outstanding 9.4% on local employers' behalf and expenditure has been uplifted to show these contributions to Trust expenses.

The pension cost (excluding additonal pension contribution paid by NHS England) for the 2025/26 financial year is estimated at £79.7m.

4.2 Early retirements due to ill health

	Year ended 31 March 2025 Number	Year ended 31 March 2024 Number
Number of early retirements on the grounds of ill-health	9	4
	£000	**£000**
Value of early retirements on the grounds of ill-health	839	629

5. Operating income and expenditure miscellaneous

5.1 Operating lease income and future receipts (trust as lessor)

	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Minimum lease receipts	2,479	2,294

5.2 Analysis of operating lease income, future minimum lease receipts due

	At 31/03/2025 £000	At 31/03/2024 £000
On land leases:		
- not later than one year;	1,269	1,175
- later than one year and not later than five years;	5,077	4,700
- later than five years.	12,322	12,745
Total lands leases	18,668	18,620
On building leases:		
- not later than one year;	1,168	1,083
- later than one year and not later than five years;	2,236	1,233
- later than five years.	2,363	2,597
Total building leases	5,767	4,913
Total leases	24,435	23,533

5.3 Limitation on auditor's liability

There is no specified limitation on the auditors liability in the current financial year (PY: Nil) .

5.4 Other audit remuneration

	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
All other non-audit services	-	-

6. Finance income and expense

6.1 Finance revenue

	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Interest on bank accounts	5,832	9,405

6.2 Finance expenditure

	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Interest on loans from the Department of Health and Social Care		
Capital loans	1,385	1,615
Finance costs on PFI and other service concession arrangements (excluding LIFT)		
Main finance costs	3,963	4,130
Finance costs on PFI from remeasurement of liability as a result of changes in RPI	4,436	3,102
Interest on lease obligations	862	610
Total interest expense	10,646	9,457
Unwinding of discount on provisions	37	210
Total finance expenditure	10,683	9,667

6.3 Gains/(losses) on disposal of assets

	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Gains on disposal of other property, plant and equipment-owned	144	168
Gains on disposal of other property, plant and equipment-leased	741	-
Losses on disposal of other property, plant and equipment-owned	(168)	(331)
Losses on disposal of other property, plant and equipment-leased	(248)	-
Total	469	(163)

6.4 Impairments of assets

	Year ended 31 March 2025 £000	Year ended 31 March 2024 £000
Changes in market price	27,358	47,527
Total impairments charged to operating deficit	27,358	47,527
Revaluations charged to the revaluation reserve	5,065	11,605
Total impairments	32,423	59,132

7. Intangible assets

7.1 Intangible assets for the year ended 31 March 2025

	Software £000
Gross cost at 1 April 2024	53,459
Additions - purchased	7,539
Reclassifications	-
Disposals	(262)
Gross cost at 31 March 2025	**60,736**
Amortisation at 1 April 2024	37,831
Provided during the year	5,345
Disposals	(262)
Amortisation at 31 March 2025	**42,914**
NBV total at 31 March 2025	**17,822**

7.2 Intangible assets for the year ended 31 March 2024

	Software £000
Gross cost at 1 April 2023	52,429
Additions - purchased	1,058
Reclassifications	2
Disposals	(30)
Gross cost at 31 March 2024	**53,459**
Amortisation at 1 April 2023	32,673
Provided during the year	5,188
Disposals	(30)
Amortisation at 31 March 2024	**37,831**
NBV total at 31 March 2024	**15,628**

Intangible assets represent a comprehensive electronic patient record system called e-Hospital and other IT software projects including digital innovation, Epic development, and data environment.

8. Property, plant and equipment

8.1 Property, plant and equipment for the year ended 31 March 2025

	Total £000	Land £000	Buildings £000	PFI asset £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000
Gross cost or valuation									
At 1 April 2024	546,977	40,000	247,804	62,751	33,441	140,508	360	18,343	3,770
Zero NBV assets at 1 April 2024	(14,683)	-	-	-	-	(11,571)	-	(3,112)	-
Additions - purchased	68,603	-	19,411	2,237	28,034	13,254	-	5,526	141
Additions - assets purchased from cash donations/grants	4,295	-	142	-	2,601	1,552	-	-	-
Impairments charged to revaluation reserves	(6,779)	-	-	(6,779)	-	-	-	-	-
Impairments charged to operating expenses	(34,642)	-	(28,191)	(6,451)	-	-	-	-	-
Reclassifications	-	-	1,828	-	(2,613)	-	-	785	
Disposals	(13,356)	-	-	-	-	(11,792)	(11)	(1,430)	(123)
At 31 March 2025	550,415	40,000	240,994	51,758	61,463	131,951	349	20,112	3,788
Depreciation									
At 1 April 2024	86,211	-	13,900	-	-	59,740	111	10,119	2,341
Zero NBV assets at 1 April 2024	(14,683)	-	-	-	-	(11,571)	-	(3,112)	-
Provided during the year	28,146	-	12,165	1,714	-	11,873	50	2,143	201
Impairments charged to revaluation reserves	(1,714)	-	-	(1,714)	-	-	-	-	-
Impairments charged to operating expenses	(11,550)	-	(11,550)	-	-	-	-	-	-
Disposals	(13,188)	-	-	-	-	(11,624)	(11)	(1,430)	(123)
At 31 March 2025	73,222	-	14,515	-	-	48,418	150	7,720	2,419
Net book value									
Owned	402,402	40,000	213,180	-	58,749	76,535	199	12,392	1,347
On-SoFP PFI contracts	51,758	-	-	51,758	-	-	-	-	-
Owned - equipment donated from DHSC, UKHSA and NHSE for COVID response	1,312	-	-	-	-	1,312	-	-	-
Government granted	3,893	-	-	-	2,601	1,292	-	-	-
Donated	17,828	-	13,299	-	113	4,394	-	-	22
At 31 March 2025	477,193	40,000	226,479	51,758	61,463	83,533	199	12,392	1,369

8. Property, plant and equipment

8.1 Property, plant and equipment for the year ended 31 March 2024

	Total £000	Land £000	Buildings £000	PFI asset £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000
Gross cost or valuation									
At 1 April 2023	569,354	43,550	230,466	60,235	84,394	127,536	364	18,482	4,327
Additions - purchased	51,119	-	16,160	2,592	12,679	17,425	-	1,654	609
Additions - assets purchased from cash donations/grants	5,435	-	2,152	-	-	3,258	-	-	25
Impairments charged to revaluation reserves	(11,605)	(3,550)	(7,979)	(76)	-	-	-	-	-
Impairments charged to operating expenses	(55,487)	-	(55,487)	-	-	-	-	-	-
Reclassifications	(2)	-	62,492	-	(63,632)	1,283	-	(447)	302
Transfers	(3,768)	-	-	-	-	(3,768)	-	-	-
Disposals	(8,069)	-	-	-	-	(5,226)	(4)	(1,346)	(1,493)
At 31 March 2024	546,977	40,000	247,804	62,751	33,441	140,508	360	18,343	3,770
Depreciation									
At 1 April 2023	82,182	-	13,343	-	-	55,513	65	9,563	3,698
Provided during the year	25,082	-	10,996	1,614	-	10,384	50	1,902	136
Impairments charged to operating expenses	(7,960)	-	(10,439)	-	-	2,479	-	-	-
Transfer	(3,746)					(3,746)	-	-	-
Revaluations	(1,614)	-	-	(1,614)	-	-	-	-	-
Disposals	(7,733)	-	-	-	-	(4,890)	(4)	(1,346)	(1,493)
At 31 March 2024	86,211	-	13,900	-	-	59,740	111	10,119	2,341
Net book value									
Owned	377,558	40,000	219,920	-	33,329	74,431	249	8,224	1,405
On-SoFP PFI contracts	62,751	-	-	62,751	-	-	-	-	-
Owned - equipment donated from DHSC, UKHSA and NHSE for COVID response	1,530	-	-	-	-	1,530	-	-	-
Government granted	1,425	-	-	-	-	1,425	-	-	-
Donated	17,502	-	13,984	-	112	3,382	-	-	24
At 31 March 2024	460,766	40,000	233,904	62,751	33,441	80,768	249	8,224	1,429

The brought forward cost and accumulative depreciation for plant and machinery and information technology which have become fully depreciated, have nil net book value, and are no longer in use have been removed in 2024/25 as current year adjustments due to immateriality. Buildings in the above tables includes leasehold improvements. Cumulative depreciation brought forward on land and buildings relates to leasehold improvements, which are not revalued on an annual basis.

8.2 Right of use assets for the year ended 31 March 2025

	Total	Land and Buildings	Plant & machinery	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Gross cost or valuation				
At 1 April 2024	70,271	65,438	4,833	2,448
Additions-lease liability	11,426	11,426	-	22
Impariment charged to I&E-Revaluation of existing lease	(4,266)	(4,266)		
Disposals/derecognition - lease termination	(1,267)	(317)	(950)	-
At 31 March 2025	**76,164**	**72,281**	**3,883**	**2,470**
Depreciation				
At 1 April 2024	9,270	6,469	2,801	929
Provided during the year - right of use asset	4,775	4,126	649	742
Provided during the year - peppercorn leased asset	594	594	-	-
Disposals/derecognition - lease termination	(1,259)	(317)	(942)	-
At 31 March 2025	**13,380**	**10,872**	**2,508**	**1,671**
Net book value				
At 31 March 2025	**62,784**	**61,409**	**1,375**	**799**

8.2 Right of use assets for the year ended 31 March 2024

	Total	Land and Buildings	Plant & machinery	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Gross cost or valuation				
At 1 April 2023	53,776	49,594	4,182	2,107
Additions-lease liability	16,495	15,844	651	341
At 31 March 2024	**70,271**	**65,438**	**4,833**	**2,448**
Depreciation				
At 1 April 2023	4,255	2,913	1,342	422
Provided during the year - right of use asset	4,725	3,347	1,378	507
Provided during the year - peppercorn leased asset	290	209	81	-
At 31 March 2024	**9,270**	**6,469**	**2,801**	**929**
Net book value				
At 31 March 2024	**61,001**	**58,969**	**2,032**	**1,519**

9. Inventory

9.1 Inventory movements for the year ended 31 March 2025

Carrying value	Total £000	Drugs £000	Consumables £000	Energy £000
At 1 April 2024	14,782	5,101	9,300	381
Additions	315,674	225,974	89,688	12
Additions (donated) - from DHSC	-	-	-	-
Inventories consumed (recognised in expenses)	(315,198)	(225,344)	(89,777)	(77)
Write-down of inventories recognised as an expense	-	-	-	-
At 31 March 2025	15,258	5,731	9,211	316

9.1 Inventory movements for the year ended 31 March 2024

Carrying value	Total £000	Drugs £000	Consumables £000	Energy £000
At 1 April 2023	13,393	4,624	8,398	371
Additions	295,246	206,820	88,396	30
Additions (donated) - from DHSC	575	-	575	-
Inventories consumed (recognised in expenses)	(294,413)	(206,343)	(88,050)	(20)
Write-down of inventories recognised as an expense	(19)	-	(19)	-
At 31 March 2024	14,782	5,101	9,300	381

10. Trade receivables

10.1 Trade receivables and other receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables (IFRS 15): invoiced	15,696	10,643
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	98,732	72,701
Allowance for impaired contract receivables / assets	(15,981)	(27,001)
Prepayments (non-PFI)	13,035	9,430
PDC dividend receivable	-	1,913
VAT receivable	2,607	4,883
Clinician pension tax provision reimbursement funding from NHSE	77	29
Other receivables	389	281
Total current receivables	114,555	72,879
Non-current		
Clinician pension tax provision reimbursement funding from NHSE	1,906	1,864
Total receivables	116,461	74,743

Prepayments and accrued income are neither past their due date nor impaired.

Other trade receivables become due immediately as we offer no credit terms.

In line with IFRS9, the Trust recognises impairment losses on other trade receivables when there is a breach of contract following a risk assessment based on future, present and historical information. This is deemed to have occurred if the outstanding receivable has not been settled within 3 months of the invoice date, if a medical insurance company has underpaid or any other relevant information that suggests an impairment.

10.2 Allowances for credit losses

	Contract receivables and contract assets 31 March 2025 £000	Contract receivables and contract assets 31 March 2024 £000
At 1 April	27,001	27,748
New allowances arising	3,775	7,826
Reversals of allowances (where receivable is collected in-year)	(5,903)	(8,034)
Utilisation of allowances (where receivable is written off)	(8,892)	(539)
At 31 March	15,981	27,001

11. Cash and cash equivalents

11.1 Cash and cash equivalents movements

	31 March 2025 £000	31 March 2024 £000
At 1 April	139,583	226,386
Net change in year	(38,927)	(86,803)
At 31 March	100,656	139,583

11.2 Breakdown of cash and cash equivalents

Total cash and cash equivalents balance at period end is broken down into:

	31 March 2025 £000	31 March 2024 £000
Cash at commercial banks and in hand	2,790	6,030
Cash with the Government Banking Service	97,866	133,553
Total cash and cash equivalents as in SoFP	100,656	139,583

12.1 Trade and other payables

Current	31 March 2025 £000	31 March 2024 £000
Trade payables	19,273	33,278
Capital payables (including capital accruals)	12,582	5,633
Accruals (revenue costs only)	140,376	133,521
Annual Leave Accruals	9,897	9,624
Social security costs	19,397	18,209
PDC dividend payable	32	-
Other payables	11,686	11,878
Total current trade and other payables	213,243	212,143

12.2 Other liabilities

	31 March 2025 £000	31 March 2024 £000
Deferred income: contract liability (IFRS 15)	67,141	51,297
Deferred income: other (non-IFRS 15)	11,889	13,375
Deferred grants	15,852	20,068
Total other liabilities	94,882	84,740

13. Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Normal Course of Business Capital loans from the Department of Health and Social Care	6,855	6,928
Lease liabilities	4,598	4,779
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	4,619	4,135
Total current borrowings	16,072	15,842
Non-current		
Normal Course of Business Capital loans from the Department of Health and Social Care	27,151	33,550
Lease liabilities	32,164	48,655
Obligations under PFI, LIFT or other service concession contracts	71,086	71,270
Total non-current borrowings	130,401	153,475
Total borrowings	146,473	169,317

13.1 Reconciliation of liabilities arising from financing activities

	DHSC loans 31 March 2025 £000	PFI, LIFT and other service concession obligations 31 March 2025 £000	Lease Liabilities 31 March 2025 £000	DHSC loans 31 March 2024 £000	PFI, LIFT and other service concession obligations 31 March 2024 £000	Lease Liabilities 31 March 2024 £000
Carrying value at 1 April	40,478	75,405	53,434	46,939	40,209	40,743
Cash movements:						
Financing cash flows - principal	(6,398)	(4,135)	(15,142)	(6,398)	(3,167)	(3,804)
Financing cash flows - interest (for liabilities measured at amortised cost)	(1,459)	(3,964)	(862)	(1,678)	(4,130)	(610)
Non-cash movements:						
Impact of implementing IFRS 16 PFI on 1 April 2023	-	-	-	-	35,261	-
Additions	-	-	11,426	-		16,495
Change in effective interest rate				-	-	-
Changes in fair values	-	-	(12,918)	-	-	-
Termination of lease	-	-	(38)	-	-	-
Carrying value at 31 March	**34,006**	**75,705**	**36,762**	**40,478**	**75,405**	**53,434**

13.2 Reconciliation of the carrying value of lease liabilities

	31 March 2025 £000	31 March 2024 £000
Carrying Value at 1 April	53,434	40,743
Lease additions	11,426	16,495
Interest charge arising in year	862	610
Remeasurement of existing lease	(12,918)	-
Termination of leases	(38)	-
Lease payments (cash outflows)	(16,004)	(4,414)
Carrying value at 31 March	**36,762**	**53,434**

13.3 Maturity analysis of future lease payments

	Total	Of which leased from Other NHS Bodies:	Total	Of which leased from Other NHS Bodies:
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
Undiscounted future lease payments payable in:	**£000**	**£000**	**£000**	**£000**
- not later than one year;	4,598	462	4,779	465
- later than one year and not later than five years;	14,362	728	14,202	929
- later than five years.	23,299	-	46,136	-
Total gross future lease payments	**42,259**	**1,190**	**65,117**	**1,394**
Finance charges allocated to future periods	(5,497)	(24)	(11,683)	(70)
Net lease liabilities at 31 March 2024	**36,762**	**1,166**	**53,434**	**1,324**
Of which:				
- Current	4,598	462	4,779	465
- Non-Current	32,164	704	48,655	859
	36,762	**1,166**	**53,434**	**1,324**

14. Provisions

14.1 Provisions for liabilities and charges

	31 March 2025	31 March 2024
Current	**£000**	**£000**
Pensions relating to other staff	66	62
Pensions Injury benefits	169	156
Legal claims	83	35
Clinician pension tax reimbursement	77	29
Redundancy	11,852	-
Other	7,516	8,318
Total current	19,763	8,600
Non-current		
Pensions relating to other staff	334	334
Pensions Injury benefits	1,461	1,425
Legal claims	47	47
Clinician pension tax reimbursement	1,906	1,864
Other	1,993	5,429
Total non-current	5,741	9,099
Total provisions	25,504	17,699

The provision for pension costs relates to additional pension liabilities arising from early retirements. Unless due to ill health, these are not funded by the NHS Pension Scheme. The full amount of such liabilities is charged to the Statement of Comprehensive Income at the time the Trust commits itself to the retirement.

14.2 Provisions for liabilities and charges analysis

	Total £000	Pensions - Early departure costs £000	Pensions - Injury benefits £000	Legal claims £000	Clinician pension tax reimbursement £000	Redundancy £000	Other £000
At 1 April 2024	17,699	396	1,581	82	1,893	-	13,747
Change in the discount rate	(11)	1	6		(18)	-	-
Arising during the year	19,358	26	169	90	57	11,852	7,164
Utilised during the year - cash	(661)	(52)	(132)	(31)	(46)	-	(400)
Reversed unused	(11,015)			(13)		-	(11,002)
Unwinding of discount	134	29	6	2	97	-	-
At 31 March 2025	25,504	400	1,630	130	1,983	11,852	9,509
Expected timing of cash flows:							
In one year or less	19,763	66	169	83	77	11,852	7,516
In more than one year but not more than five years	2,913	185	476	47	212		1,993
In more than five years	2,828	149	985	-	1,694		-
Total	25,504	400	1,630	130	1,983	11,852	9,509

14.3 Clinical negligence liabilities

	31 March 2025 £000	31 March 2024 £000
Amount included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Cambridge University Hospitals NHS Foundation Trust	305,207	296,016

15. Related party transactions

The Trust is a body corporate established by order of the Secretary of State for Health.

Government Departments and their agencies are considered by HM Treasury as being related parties.

The Department of Health and Social Care is regarded as a related party. During the year Cambridge University Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department including NHSE, Health Education England and NHS Resolution.

During the year, the following organisations have been identified as related parties with the Trust and the transactions with the Trust are material.

- University of Cambridge, which is a related party by virtue of the fact that Professor Patrick Maxwell is both a Non-Executive Director of the Trust and Regius Professor of Physic with the University.
- Cambridge University Health Partners (CUHP) is regarded as a related party by virtue of the fact that the Trust is one of the five partners and Mr Roland Sinker is a shared director.
- Cambridge Biomedical Campus Ltd is a related party due to the fact that Mr Mike Keech is a shared director.
- Addenbrookes Charitable Trust (ACT), Dr Michael More is both a former Non-Executive Director (Chairman) of the Trust (resigned on 31 December 2024) and a Trustee of ACT.
- St John's Ambulance (SJA), Dr Annette Doherty is both a Non-Executive Director of the Trust and a Trustee of SJA.
- Granta Medical Services Limited, Dr Thomas James Morrow is both a Non-Executive Director of the Trust and a director of Granta Medical Services Limited.

15 Related party transactions

15.1 Related party transactions

	Year ended 31 March 2025 Revenue £000	Year ended 31 March 2025 Expenditure £000
Department of Health and Social Care	37,759	-
University of Cambridge	14,830	36,862
Granta Medical Services Limited	-	107
Cambridge Biomedical Campus Ltd	82	500
Cambridge University Health Partners	22	728
St Johns Ambulance Services	-	2,085
Addenbrookes Charitable Trust	2,685	119
	55,378	40,401

	Year ended 31 March 2024 Revenue £000	Year ended 31 March 2024 Expenditure £000
Department of Health and Social Care	31,133	-
University of Cambridge	13,180	63,033
Cambridge University Health Partners	1,448	874
Addenbrookes Charitable Trust	3,945	9
St Johns Ambulance Services	-	1,930
Ove Arup & Partners Limited	-	586
Granta Medical Services Limited	-	143
Cambridge Biomedical Campus Ltd	55	565
	49,761	67,140

15.2 Related party balances

	31 March 2025 Receivables £000	31 March 2025 Payables £000
Department of Health and Social Care	1,919	1,181
University of Cambridge	9,709	19,785
Granta Medical Services Limited	-	3
Cambridge Biomedical Campus Ltd	219	-
Cambridge University Health Partners	372	420
St Johns Ambulance Services	-	173
Addenbrookes Charitable Trust	250	61
	12,469	21,623

	31 March 2024 Receivables £000	31 March 2024 Payables £000
Department of Health and Social Care	488	120
University of Cambridge	7,745	14,506
Cambridge University Health Partners	297	-
Addenbrookes Charitable Trust	1,168	28
St Johns Ambulance Services	-	35
Ove Arup & Partners Limited	-	63
Granta Medical Services Limited	-	29
Cambridge Biomedical Campus Ltd	245	500
	9,943	15,281

16. Contractual capital commitments

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	25,108	24,434
Total contractual capital commitments	25,108	24,434

The contractual capital commitments relate to the committed future spend on the Trust's current on-going capital projects.

17. Private Finance Initiative (PFI) scheme

The PFI scheme is to design, build, maintain and operate (through facilities management and related services) a 128 bed Elective Care, Genetics and Diabetes Centre at the Trust. The centre became operational in April 2007. The contract start date of the PFI scheme was 13 February 2007 and the end date is 12 February 2037.

The facilities within the centre include Diabetes Research Facilities which are utilised by the University of Cambridge. These facilities are funded by the University of Cambridge and the Medical Research Council and have no effect on the Trust's cost structures.

The contract requires the Trust to make a unitary payment that totals £13.6m annually. It is charged monthly and adjusted for any penalties relating to adverse performance against output measures describing all relevant aspects of the contract.

17. PFI

17.1 On-SoFP PFI obligations (finance lease element)

	31 March 2025 £000	31 March 2024 £000
Gross PFI liabilities of which liabilities are due		
In one year or less	8,366	8,099
In more than one year but not more than two years	7,886	8,090
In more than two years but not more than five years	24,544	23,383
In more than five years	61,283	67,238
Gross Liabilities	102,079	106,810
Finance charges allocated to future periods	(26,374)	(31,405)
Net Liabilities	75,705	75,405
Net PFI obligation of which liabilities are due		
In one year or less	4,619	4,135
In more than one year but not more than two years	4,382	4,343
In more than two years but not more than five years	15,494	13,490
In more than five years	51,210	53,437
Total	75,705	75,405

17.2 Total On-SoFP PFI commitments

	31 March 2025 £000	31 March 2024 £000
Total future payments committed in respect of PFI arrangements		
In one year or less	13,833	13,377
In more than one year but not more than two years	13,833	13,377
In more than two years but not more than five years	41,499	40,130
In more than five years	95,088	105,327
Total	164,253	172,211

Under IFRS the unitary charge is apportioned between the repayment of the liability, financing costs and the charges for services. The service charge is recognised in operating expenses under "Premises" and the finance costs are charged to finance costs in the Statement of Comprehensive Income.

The Trust has not entered into any 'off-Statement of Financial Position' arrangements.

17.3 Analysis of amounts payable

	31 March 2025 £000	31 March 2024 £000
Unitary payment payable to PFI operator consisting of:		
- Interest charge	3,964	4,130
- Repayment of finance lease liability	4,135	3,167
- Service element	3,314	2,746
- Capital lifecycle maintenance	2,237	2,592
Total amount paid to service concession operator	13,650	12,635

18. Financial instruments

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with ICBs and the way those NHS organisations 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. 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 and therefore has low exposure to currency rate fluctuations.

Credit risk

The Trust can borrow within affordable limits and NHS England will assess the affordability of material borrowing. The Trust can invest surplus funds in accordance with NHS England's guidance on Managing Operating Cash. This includes strict criteria on permitted institutions, including credit ratings from recognised agencies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to manage the risks facing the Trust in undertaking its activities. The Trust has low exposure to credit risk.

Liquidity risk

The Trust's net operating income is received under legally binding contracts with ICBs, which are financed from resources voted annually by Parliament. The Trust has financed capital expenditure from internally generated resources, and net borrowing within its affordable limits. The Trust is not, therefore, exposed to significant liquidity risks.

Market risk

The main potential market risk to the Trust is interest rate risk. The Trust's financial liabilities carry nil or fixed rates of interest. Cash balances are held in interest bearing accounts for which the interest rate is linked to bank base rates and changes are notified to the Trust in advance. The Trust is not, therefore, exposed to significant interest-rate risk.

18.1 Carrying value and fair value of financial assets

	31 March 2025 Financial assets at amortised cost £000	31 March 2024 Financial assets at amortised cost £000
Financial assets as per SoFP		
Receivables (excluding non financial assets) - with DHSC group bodies	76,630	56,741
Receivables (excluding non financial assets) - with other bodies	22,206	(117)
Cash and cash equivalents	100,656	139,583
Total	199,492	196,207

18.2 Carrying value and fair value of financial liabilities

	31 March 2025 Financial liabilities at amortised cost £000	31 March 2024 Financial liabilities at amortised cost £000
Financial liabilities per the SoFP		
DHSC loans	34,006	40,478
Obligations under leases	36,762	53,434
Obligations under PFI, LIFT and other service concession contracts	75,705	75,405
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	17,741	15,831
Trade and other payables (excluding non financial liabilities) - with other bodies	155,290	163,405
Total	319,504	348,553

18.3 Maturity of financial liabilities

	31 March 2025 £000	31 March 2024 £000
In one year or less	193,560	199,900
In more than one year but not more than two years	19,828	20,434
In more than two years but not more than five years	47,495	50,337
In more than five years	94,810	126,602
Total	355,693	397,273

The financial assets and financial liabilities the Trust held at 31st March 2025 are measured at their carrying amounts, which are considered to be reasonable approximation to their fair values. The maturity analysis of financial liabilities is required by IFRS7 to be an analysis of undiscounted future contractual cash flows, which therefore differ to the book value.

19. Losses and Special Payments

Losses and special payments (approved cases only)

	31 March 2025 Total number of cases Number	31 March 2025 Total value of cases £000's	31 March 2024 Total number of cases Number	31 March 2024 Total value of cases £000's
Losses of cash due to				
Theft, fraud etc.	4	-	1	-
Total losses	4	-	1	-
Special Payments, Ex gratia payments in respect of				
Loss of personal effects	72	54	79	30
Personal injury with advice	7	21	13	46
Total special payments	79	75	92	76
Total losses and special payments	83	75	93	76

20. Events after reporting period

There were no events to report after the period.