Tees, Esk and Wear Valleys
NHS Foundation Trust

SPECIAL MEETING OF THE BOARD OF DIRECTORS

25 June 2025
at 2.00 pm

Via MS Teams

AGENDA

Standard Items (2.00 pm – 2.03 pm)

1.	Welcome and introduction (verbal)	Chair	2.00 pm
2.	Apologies for absence (verbal)	Co Sec	
3.	Declarations of interest (verbal)	All	

BAF Risk 4 Quality of Care
BAF Risk 7: Cyber Security and Protection
BAF Risk 12 Financial Sustainability

4.	Report of the Chair of Audit & Risk Committee (verbal)	Cmt Chair (JM)	2.03 pm
	For approval*:		
	a. The Annual Report and Accounts 2024/25	Int CEO DoFE&F	2.10pm
	b. The Quality Account 2024/25	CN	2.30pm
	c. Registration of Conflicts of Interest	Co Sec	2.50pm

	Exclusion of the public: The Chair to move: *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:* *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office holder or applicant to become an office-holder under, the Trust.* *Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.*	Chair	-

	Information which, if published would, or be likely to, inhibit – *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*		

4	d. Data security and Protection Toolkit	CIO	3.00pm

* papers will be circulated following consideration by Audit and Risk Committee

Bev Reilly
Interim Chair
19 June 2025

Contact: Karen Christon, Deputy Company Secretary
Tel: 01325 552307
Email: karen.christon@nhs.net

For information: Controls Assurance Definitions	
Substantial Assurance	Compliance with the control framework taking place. The control is being consistently applied. No remedial action required.
Good Assurance	A high level of compliance with the control framework taking place. The control is generally being applied consistently. Limited remedial action is required.
Reasonable Assurance	Compliance with the control framework taking place. The control is not being applied in a consistent manner. Some moderate remedial action is required.
Limited Assurance	Compliance with the control framework not taking place. The control is not being applied. Immediate and fundamental remedial action required.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Meeting of:	**Board of Directors**
Date:	**25 June 2025**
Title:	**Annual Report and Accounts 2024/25**
Sponsor(s):	**Beverley Murphy, Acting Interim Chief Executive** **Liz Romaniak, Director of Finance and Estates/Facilities Management** **Phil Bellas, Company Secretary**
Author(s):	**Phil Bellas, Company Secretary**

Report for:				
	Assurance	✓	***Decision***	✓
	Consultation		***Information***	✓

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
11	Governance & Assurance	The Trust has a minimal appetite for regulatory risks and has recognised that, whilst exposure will remain above tolerance, urgent action needs to be taken to strengthen controls.

Executive Summary:

Purpose:

The purpose of this report is to seek the Board's approval of the Annual Report and Accounts 2024/25 as recommended by the Audit and Risk Committee.

Proposal:

Subject to any further matters being raised by the External Auditors:

(1) To approve the Annual Report and Accounts 2024/25.
(2) To approve the Letter of Representation.
(3) To authorise the signing off of the Annual Report and Accounts, the Letter of Representation and any associated certificates and documents required by NHS England.
(4) To authorise the submission of the Annual Report and Accounts 2024/25 to NHS England and Parliament

Overview:

The Trust is required, under schedule 7 of the National Health Service Act 2006, to prepare accounts and annual reports in such form as directed by NHS England (and in the former case subject to the approval of the Secretary of State).

For the year ended 31 March 2025, the form of the documents is set out in the "NHS Foundation Trust Annual Reporting Manual 2024/25" (published by NHS England) and the "Department of Health and Social Care Group Accounting Manual 2024/25" (DHSC

GAM 2024/25).

Attached to this report are:

(1) The draft Annual Report and Accounts 2024/25.

The Board is asked to note that:

(a) It has been prepared on a group basis as the income and expenditure of the Trust's main subsidiary, Positive Independent Proactive Support Ltd, are now classed as material.

(b) At its meeting held on 21 June 2025, the Audit and Risk Committee received the Audit Completion Report from the Trust's External Auditors, Forvis Mazars.

The External Auditors have indicated that they will be issuing an unqualified opinion on the Annual Report and Accounts; however, in accordance with usual practice, the audit is continuing.

A supplementary letter to the Audit Completion Report is expected to be received from the External Auditors which will be circulated to Board Members under separate cover.

(c) The External Auditors have advised that, whilst they anticipate reporting to the National Audit Office (NAO) that the Trust's consolidation data is consistent with the financial statements, they will not be able to formally conclude the audit and issue the audit certificate. This is due to the NAO having indicated that it might select a further sample of trusts where additional work will be required to be undertaken by the auditor. Assurance has been provided that this should not delay the submission and laying of the Annual Report and Accounts.

(2) The draft Letter of Representation which is in the standard form.

Prior Consideration and Feedback

The Audit and Risk Committee follows a standard process for its oversight of the preparation of the Annual Report and Accounts and the progress of the annual audit.

At its meeting held on 21 June 2025, the Committee:

(1) Received the Audit Completion Report from the Trust's External Auditors for the year ended 31st March 2025.

(2) Determined that:

(a) The Annual Report and Accounts 2024/25, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy; and

(b) The Accounts give a true and fair view of Trust's income and expenditure, cash flows and financial state at the end of the financial period.

(3) Made a recommendation to the Board to approve and submit

the Annual Report and Accounts 2024/25.

Implications: Failure to approve and submit the Annual Report and Accounts is likely to raise governance concerns about the Trust by NHS England.

Recommendations: The Board, on the recommendation of the Audit and Risk Committee and subject to any further matters being raised by the External Auditors, is asked:

(1) To approve the Annual Report and Annual Accounts 2024/25 (attached)

(2) To approve the Letter of Representation (attached).

(3) To authorise the signing off of:

- The Annual Report
- The Performance Report
- The Accountability Report
- The Remuneration Report
- The Annual Governance Statement
- The Statement on the Accounting Officer's Responsibilities
- The Foreword to the Accounts
- The Statement of the Financial Position
- The Letter of Representation
- Any certificates relating to the above as required by NHS England.

(4) To authorise the submission of the signed Annual Report and Accounts, and related documentation, to NHS England and Parliament.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Annual Report and Accounts

1 April 2024 – 31 March 2025

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Tees, Esk and Wear Valleys 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

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Foreword by the chair and chief executive

Throughout 2024-25 we saw further change across health and social care. However, what really stands out is that despite challenges and some uncertainties, our colleagues continue to make a positive difference to people's lives. And they do this every single day. Patient care is at the heart of everything we do and it's important that we acknowledge the hard work of our colleagues, partners and everyone involved with our trust. Thank you.

Over the last 12 months we have continued Our Journey to Change. There have been many examples of real and meaningful improvements, and the impact that they have on the quality and the safety of the care we provide.

In our Trust we have reduced the number of agency staff, increased the number of lived experience roles in our trust, reduced the number of vacancies, took part in major research studies, worked with partners to open wellbeing hubs, launched a new community 10k running event – and so much more.

Our transformation work continues across both our inpatient and community services. Reflecting on our inpatient transformation so far, there has been a clear focus on culture of care and work to further reduce restrictive interventions. This work also has also included changes to our urgent care. In the last 12 months we have switched our crisis service over to NHS 111 (select the mental health option) and worked with partners to introduce Right Care, Right Person, which aims to give people in our communities the most appropriate support to meet their needs when in a crisis.

In February, the Care Quality Commission (CQC) published its report into our mental health crisis services and health-based places of safety. We were rated 'good' which means we retained our previous rating and that the service is performing well and meeting the CQC's expectations. These services support some of our most vulnerable patients, so maintaining our 'good' rating is incredibly important.

There has also been a huge emphasis on mental health community transformation, and the role our organisation plays in this. Earlier this year the Hartlepool Hub was mentioned as an example of best practice at a Parliamentary Health Select Committee. We are incredibly proud of this partnership work and the positive impact it continues to have. There are many, many other examples of this across our communities.

However, we are not complacent. As we continue our journey to improvement, we know there is more to do. As we look ahead and await the publication of the NHS 10 year plan, that will set out how we create a truly modern health service designed to meet the changing needs of our population, we will focus on the three shifts that the government, health service and experts agree need to happen. This includes:

- Moving care from hospitals to communities

- Making better use of technology
- Focussing on preventing sickness, not just treating it.

The work we have done during 2024-25 fundamentally supports these shifts. Importantly they are also the focus of our own future plans, and the next chapter of Our Journey to Change. This will ensure that we continually improve and that we provide safe, effective and kind care to people across the communities we serve.

Bev Reilly	Beverley Murphy
Interim Chair	Acting Interim Chief Executive
25 June 2025	25 June 2025

This annual report, including the annual accounts, has been prepared under a direction issued by NHS England under the National Health Service Act 2006.

The performance report

Overview of performance

Purpose

This report has been prepared on a 'group' basis and will refer to Tees, Esk and Wear Valleys NHS Foundation Trust Group as 'TEWV or 'the Group'.

The TEWV 'group' includes Positive Independent Proactive Support Ltd (PIPS), a wholly owned subsidiary company.

Sections of this report that are relevant to the NHS services provided by Tees, Esk and Wear Valleys NHS Foundation Trust will be referred to as 'the Trust'.

Sections of this report that are relevant to services provided by Positive Independent Support Ltd will be referred to as "the Subsidiary" or "the Company".

The purpose of the performance report is to provide an overview of our purpose, our strategic direction – including our vision, mission and strategic goals – the key risks to achieving them and information on how we have performed during the year.

Statement on Performance

We have made good progress during 2024-25 on the delivery of Our Journey to Change. The achievements are mentioned throughout this annual report.

There have been specific examples of external acknowledgement of our improvements. In February, the Care Quality Commission (CQC) published its report into our mental health crisis services and health-based places of safety. The Trust was rated 'good' which means we retained our previous rating and that the service is performing well and meeting the CQC's expectations.

We have 30 key performance measures that make up our Trust integrated performance dashboard. Each of our care groups also have an integrated performance dashboard following the same format. The measures are grouped under the domains of quality, people, finance and activity. We also have a set of national quality requirements, and a number of ambitions agreed with our local commissioners which feature in both the Trust and care group integrated performance reports.

The Trust has achieved across a range of areas including patient experience, carer experience, inpatients reporting that they feel safe in our care and children and young people showing measurable improvement following treatment. We have also achieved the standards we set ourselves for measures which monitor staff retention, mandatory and statutory training and appraisals.

The Trust's overall performance continues to be impacted by national pressures throughout the NHS, and locally with high demand and staffing levels. Concerns remain that at times, patients are not being assessedor treated in as timely a manner as we would like. However, we are committed to improving the quality of our services and the health and wellbeing of our patients and colleagues, and considerable work is being done to improve our performance in those areas.

Beverley Murphy
Acting Interim Chief Executive 25 June 2025

Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) Group at a glance

The TEWV Group comprises Tees Esk and Wear Valleys NHS Foundation Trust, which is the mental health and learning disability NHS Foundation Trust for County Durham and Darlington, Teesside, North Yorkshire and York, and Positive Independent Proactive Support Ltd which provides support for people with learning disabilities and autism who have complex needs.

We serve a population of two million people and are geographically one of the largest NHS Foundation Trusts in England. We also provide mental health care in prisons located in the North East, Cumbria and parts of Lancashire.

From education and prevention, to crisis and specialist care - our talented and compassionate teams work in partnership with our patients, communities and partners to help the people of our region feel safe, understood, believed in and cared for.

Patients and carers have a say in how they are supported and treated, because we know how important it is to listen and treat people as individuals. Our patients, their families and carers work together with us towards better mental health.

The Trust operates across two care group boards – one covering Durham, Tees Valley and Forensic services and one for North Yorkshire, York and Selby.

Across our care group boards, we deliver care under six clinical directorates:

- Adult mental health services
- Mental health services for older people
- Children and young people's mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

Our Trust was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust. In 2008 our Trust became the first mental health Foundation Trust in the North and since then, it has expanded both geographically and in the number and type of services provided.

As a Foundation Trust we are accountable to local people through our Council of Governors and are regulated by NHS England and the Care Quality Commission.

Positive Independent Proactive Support Ltd was established and incorporated as a wholly owned subsidiary in 2014. Wholly owned subsidiary companies are an organisational and governance form that NHS Foundation Trusts can legally establish to manage parts of their organisation. Wholly owned subsidiary companies are separate legal entities. PIPS is part of the "TEWV Group", supporting the delivery of Our Journey to Change, with the Trust holding 100% of the Company's shares.

The Group also includes:

- The Trust's charity in which the Trust is the sole Corporate Trustee. Funds held are used for any charitable purpose relating to the general or specific purposes of the Trust or purposes relating to the NHS.
- TEWV Estates and Facilities Management Ltd, a dormant wholly owned subsidiary.

Neither of these are consolidated into the accounts as they are not material to the performance of the Group.

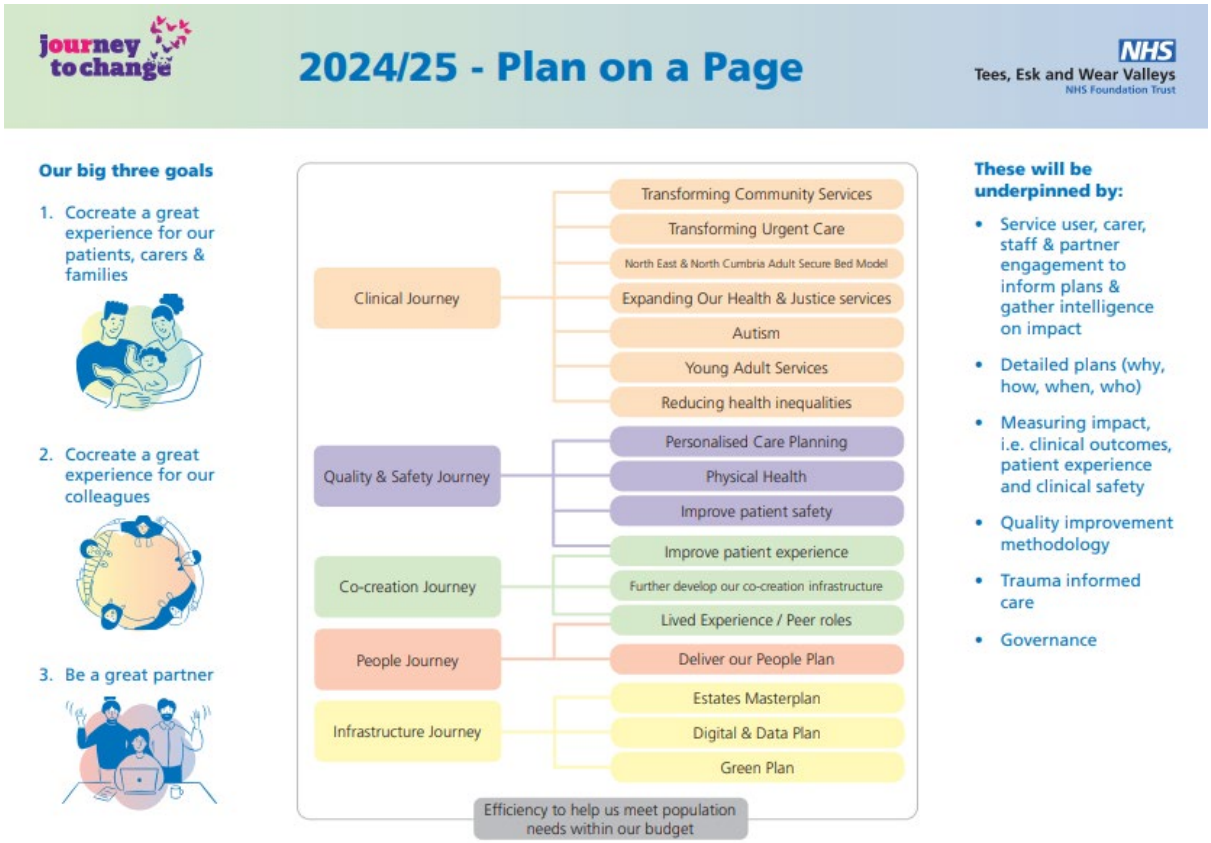
Our Group has around 8,500 staff and an annual income of over £550 million.

Structure, Objectives and Strategies

During 2024/25 we continued to focus on delivering the mission, vision, values, and goals agreed with stakeholders during 2020 – which are included in Our Journey to Change - our strategic framework launched in 2021.

This work was based around five supporting strategies, known as our 'strategic journeys'. Agreed by the Board of Directors on 30 March 2023, these focussed on 1) clinical, 2) quality and safety, 3) co-creation, 4) people and 5) infrastructure.

Each set out a clear vision and principles for the future, and areas of focus. The strategies also drove our delivery planning process during the year and the new Our Journey to Change delivery plan shows the actions we will take across 17 priority areas, linked to the five journeys.



In our 2024/25 business plan 61% of the actions contained were successfully completed, with a further 17% on track for delivery during 2025/26 as planned. Most of the remaining actions, that have been delayed, are now in 25/26 delivery plans.

During 2024-25 the Trust developed a revised and updated next chapter of Our Journey to Change to take account of changes in the national policy environment and the progress the Trust has made. We held a “big conversation” to engage with colleagues, patients, partners and our communities. The Board considered the views of a lived experience strategic reference group and the trust’s leadership network groups. This was approved by the Board of Directors on 10 April 2025, just after the end of the period covered by this annual report.

The next chapter of Our Journey to Change gives more emphasis to the clinical effectiveness (rather than just experience) in goal 1 and to challenge, innovation and celebration of good practice in goal 2. Goal 3 now recognises our role in reducing health inequalities and as a major employee in the areas we serve. Rather than the previous five strategic journeys we will now focus directly on nine strategic objectives. This new version of Our Journey to Change will drive our planning work during the next 12 months and be fully reflected in our plans for 2026/27.

	Our Journey to Change: The Next Chapter
Mission	We support people to lead their best possible lives.

Vision	We provide consistently good healthcare which helps our communities become healthier and safer
Goal 1	**We will co-create high quality care. Therefore, people who use our services and their carers will experience:**
Goal 1 Objectives	• *A timely response with help when you need it* • *Consistently patient-centred care, with positive outcomes* • *Involvement in planning and personalising care and opportunities to help improve services*
Goal 2	**We will be a great employer. Our colleagues will:**
Goal 2 objectives	• *Feel pride in what we do and the impact of our work* • *Be supported and empowered to do our job well* • *Feel safe to challenge, innovate and celebrate*
Goal 3	**We will be a trusted partner. Our partners will experience us working with them to:**
Goal 3 Objective3	• *Deliver integrated services and improve population wellbeing* • *Reduce health inequalities* • *Offer training, job and career opportunities*
Value 1	**RESPECT**
	• Inclusive
	• Considerate
	• Open and honest
Value 2	**COMPASSION**
	• Kind
	• Fair
	• Listening and acting
Value 3	**RESPONSIBILITY**

	• Accountable
	• Reliable and productive
	• Challenging and improving

Notwithstanding this revision to our strategic framework, our Group's business model continues to focus on providing secondary level community and inpatient mental health, learning disability and autism-related care. We also continue to support prevention and early intervention activity, as this is important to maximise wellbeing and reduce the demand for our services.

As our Trust is funded by block contracts, supporting demand reduction activity is rational for us as it will help us to provide a higher quality, more quickly accessed set of services for those patients with the highest-level needs.

We continue to be a significant provider of criminal justice pathway related services through our work to support prisons and courts. We also manage many low and medium secure forensic beds. We continue to work with NHS England and Cumbria, Northumberland, Tyne and Wear Foundation Trust as partners to develop a North East North Cumbria secure service model for the future.

Positive Independent Proactive Support Ltd - Strategy and Business Model

During 2012 and 2013 and in response to the Winterbourne View scandal and subsequent national Transforming Care learning disability policy, the Trust considered how to address the situation where many people with learning disabilities were not able to leave hospital because local social care providers could not provide a suitable care service for learning disabled people with complex needs.

The Trust assessed that it could address this market failure by setting up a subsidiary focussed on providing a high level of care to complex patients. It also believed that a subsidiary company would keep this work within the "NHS family" and ensure that the culture of the new organisation was patient focused and able to see its clients as individual people with their own wants and needs. It was decided to call the subsidiary "Positive Individual Proactive Support." Following careful consideration of the PIPS business case and working within the foundation trust regulatory regime of that period, PIPS was established. It's managing director moved from TEWV to manage the new service.

PIPS still fits well into the Trust's strategic framework. It's mission: "To provide high quality support to people who have the most complex needs, who require the expertise to understand their needs, patience and understanding of a staff team who see the person at the centre of all they do and help the person lead an interesting

and productive life" and its day to day work with learning disabled clients fits well with TEWV's Our Journey to Change's strategic objectives and values.

PIPS clearly delivers on TEWV's 3 lived experience goal objectives

- *A timely response with help when you need it*
- *Consistently patient-centred care, with positive outcomes*
- *Involvement in planning and personalising care and opportunities to help improve services*

It also supports delivery of our 3 Partnership goal strategic objectives

- *Deliver integrated services and improve population wellbeing*
- *Reduce health inequalities*
- *Offer training, job and career opportunities*

PIPS is a local business with established links within the community and a good understanding of the environment in which we operate.

Strategic Risks

The principal risks we face in delivering Our Journey to Change are described in the Board Assurance Framework (BAF) together with relevant controls, assurances on the operation of the controls, gaps in control and assurance and mitigations.

The risks have been reviewed during 2024/25 taking into account the development of our refreshed mission, vision and strategic goals and changes in the external environment.

Information on the strategic risks is provided in the Annual Governance Statement later in the Annual Report.

Going Concern

For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

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

Performance analysis - how we performed in 2024/25

How we measure our performance

The Trust's integrated performance approach (IPA) enables us to have better oversight, monitor and report key measures that demonstrate the delivery of the quality of services we provide. Our integrated performance report (IPR) comprises an integrated performance dashboard (IPD) which contains a set of measures agreed by the Board of Directors and are aligned to one of our three strategic goals and, where appropriate, support the monitoring of the Board Assurance Framework risks. The IPR also includes our performance against national and local quality requirements and our waiting times. The IPR is discussed and approved each month by the executive directors group and bi-monthly, is reported to the Board of Directors to provide assurance that the Trust is continuing to deliver operationally. The report is also made available to our patients and carers, commissioners and wider public.

The Trust level IPR is supported by two care group IPRs which are reported monthly into executive directors group. Oversight of these reports are maintained by the care group boards, comprising corporate and clinical senior managers aligned to each respective care group and the reports are shared monthly with our local place-based commissioners. We also have a range of waiting time reports, which provide oversight on the number of patients waiting and the length of time waited, supporting clinical services in monitoring and managing risk from a patient safety and quality perspective.

The IPRs are underpinned by statistical process control (SPC) charts which helps us understand variation and in doing so guides us when to act for those measures that are reporting a concern. The report describes what the current underlying issues are, including triangulation with other key measures and data, and the actions being undertaken to support improved performance. We utilise several improvement tools to support improvement, depending on whether short, medium or longer-term actions are needed, all of which are managed through an appropriate governance route. If executive directors group or the Board of Directors identify any areas which could impact the Trust and operational delivery, then this would be escalated through the risk management processes.

We continue to develop our integrated performance approach and during 2024/25 we launched two committee level dashboards that underpin the Trust IPD providing oversight and assurance through the Board sub-committees. Our people and culture dashboard was launched in April 2024 and the quality dashboard in January 2025,

reporting key priorities identified by the respective committees. Work has now commenced to develop a mental health legislation dashboard and specialty, ward and team level dashboards which will be completed in 2025/26.

We believe that whilst a performance dashboard is critical in monitoring performance, it is only one part of an overarching performance management framework that supports delivery of high-quality care.

Culture

In our Trust we align our understanding of our people risks and the evidence base around culture to develop a comprehensive approach to nurturing our workplace culture. This underpins Our Journey to Change and our three strategic goals.

We regularly monitor indicators of culture across the organisation, for example our intention to leave process, which helps us identify and address emerging challenges before they escalate; leavers and movers rates; sickness; engagement with change. Equally important is our commitment to ensuring people have and use their freedom to speak up, providing every team member a secure platform to share their ideas and concerns without hesitation. Additionally, we gather insights from both the national staff survey and national quarterly pulse survey. Both these measures give the executive directors group (EDG) and other leaders a rich, immersive snapshot of daily experiences to continuously refine our practices and to develop an inclusive culture. Together, these measures enable us to uphold the highest standards of care by nurturing a supportive, transparent, and resilient workforce.

Underpinning all of this work is a requirement to have an effective and compassionate collective leadership group in parts of the organisation. This year we formally launched our leadership and management academy to ensure that all leaders and managers in the trust are equipped with the foundations to carry out their role and that their learning in turn contributes to our strategic change and the development of other colleagues for the benefit of the communities we serve.

Health and Wellbeing

The staff survey results provide us with valuable insights relating to being safe and healthy show that when compared with other Trusts, our overall score of 6.34 is slightly below the average of 6.39.

Element	2021	2022	2023	2024
People promise “we are safe and healthy”	6.16	6.21	6.37	6.34

Sub score Health and safety climate	5.52	5.51	5.78	5.78
Burnout	5.04	5.12	5.24	5.22
Negative experiences	7.91	7.99	8.08	8.01

Key progress in the past year includes

- Achieved Gold Better Health at Work Award and working towards continuing excellence accreditation in late 2025
- Developed manager's training for health and wellbeing conversations and sickness absence and attendance
- Increased our thriving network of Health and Wellbeing champions to more than 350.
- Reviewed and agreed metrics to be reported to measure outcomes for Employee Psychology and mindfulness services
- Reviewed the Employee Staff Support service and agreed service metrics.
- Surveyed staff about violence and aggression and establishing an operational group to meet National Violence Reduction and Prevention standards. Signed up to the NHS England Sexual Safety charter. Published toolkits to support this development
- Worked with Trust programme managers for preventing suicide to input into the National suicide prevention framework

Analysis and explanation of financial and operational performance

The Trust's key performance measures for 2024/25 are contained in the integrated performance dashboard shown in the following pages.

Our overall performance continues to be impacted by national pressures throughout the NHS, and locally within our services in respect of high demand and staffing levels, and we remain concerned that at times, we are not assessing or treating our patients in as timely a manner as we would like. We are committed to improving the quality of our services and the health and wellbeing of our patients and colleagues, and considerable work is being done to improve our performance in those areas.

Our quality measures

OUR QUALITY MEASURES	Variation	Assurance	Standard	Actual	Commentary
01)Percentage of Patients surveyed reporting their recent experience as very good or good			92.00%	93.03%	**Achieved**
02) Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	H		75.00%	76.11%	**Achieved and demonstrates improvement**
03) Percentage of inpatients reporting that they feel safe whilst in our care			75.00%	80.66%	**Achieved**
04) Percentage of CYP showing measurable improvement following treatment - patient reported	L	F	35.00%	22.25%	**Requires Improvement**
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported		F	55.00%	45.49%	**Requires Improvement**
06) Percentage of CYP showing measurable improvement following treatment - clinician reported	H	F	50.00%	53.44%	**Achieved and demonstrates improvement**
07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	H	F	30.00%	24.39%	**Not achieved but demonstrates improvement**
08) Bed Occupancy (AMH & MHSOP A & T Wards)	H	F	85%	100.49%	**Requires Improvement**
09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	L	N/A		100	**Demonstrates improvement**
10) The number of Patient Safety Incident Investigations reported on STEIS	L	N/A		25	**Demonstrates improvement**
11) The number of Incidents of moderate harm or severe harm	L	N/A		372	**Demonstrates improvement**
12) The number of Restrictive Interventions Used		N/A		10691	**No significant change**
13) The number of Medication Errors with a severity of moderate harm and above		N/A		4	**No significant change**
14) The number of unexpected Inpatient unnatural deaths reported on STEIS		N/A		8	**No significant change**
15) The number of uses of the Mental Health Act		N/A		4152	**No significant change**

Achievements We have achieved the standards we set ourselves for the following measures:

- ✓ Percentage of patients surveyed reporting their recent experience as very good or good
- ✓ Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for
- ✓ Percentage of inpatients reporting that they feel safe whilst in our care
- ✓ Percentage of children and young people (CYP) showing measurable improvement following treatment - clinician reported

Areas for improvement:

- **Outcomes** We are concerned that a significant number of our patients in adult, older people and children and young people's services do not show the level of measurable improvement following treatment that we would want. However, detailed analysis shows a significant improvement in the number of outcomes we are collecting for patients coming into our services which will not be visible until the point of discharge. We have developed a clinical outcomes improvement plan which includes raising awareness amongst staff and managers, reinforcing the importance of capturing clinical outcomes and why it is essential to high quality patient care.

- **Bed pressures** Whilst we have seen a reduction in the number of patients being placed in beds external to our Trust and have no active out of area placements at the end of the financial year, pressures on our inpatient services continue and our bed occupancy remains high, with a greater number of patients on our adult and older people wards remaining in beds longer than we would want. There are several mitigating actions in place to support improvement in addition to the work of our urgent care programme board, including the pilot of a digital tool (Optica) to support inpatient flow. We have sustained improvement in our crisis line call pick-up rates and have developed a process to respond to patients who abandon calls; agreed investment for safe havens in Durham and Tees Valley and a 24/7 alternative to the crisis pilot in York is scheduled for implementation in June 2025. We are also working with both Integrated Care Boards and local authority authorities to maintain oversight of patients clinically ready for discharge and improve processes aiming to have a positive impact on patient care through the provision of appropriate support.

Our people measures

OUR PEOPLE MEASURES	Variation	Assurance	Standard	Actual	Commentary
16) Percentage of staff recommending the Trust as a place to work	N/A		60.00%	55.34%	Requires Improvement
17) Percentage of staff feeling they are able to make improvements happen in their area of work	N/A		65.00%	59.20%	Requires Improvement
18) Staff Leaver Rate	L	F	11.00%	10.40%	Achieved and demonstrates improvement
19) Percentage Sickness Absence Rate		?	5.50%	6.14%	Requires Improvement
20) Percentage compliance with ALL mandatory and statutory training	H	?	85.00%	88.37%	Achieved and demonstrates improvement
21) Percentage of staff in post with a current appraisal	H	?	85.00%	87.24%	Achieved and demonstrates improvement

Achievements: We have achieved the standards we set ourselves for the following measures:

✓ Staff leaver rate

✓ Percentage compliance with all mandatory and statutory training
✓ Percentage of staff in post with a current appraisal

Areas for improvement:

- **Staff survey** Following release of the annual staff survey results, all services are developing team-level improvement plans which will be presented at the Trust leadership events in June. The development of these plans will be supported by organisational development colleagues and our people partners.

- **Staff sickness** We value our staff's health and wellbeing and are concerned that our sickness levels remain above the standard we have set ourselves. The human resources operational team continues to support the management of both short- and long-term sickness and sickness clinics are established in all areas experiencing high absence, and support, training and guidance is available for all managers.

Of note: Whilst we continue to achieve the standard for compliance with **mandatory and statutory training**; we are concerned that there are a significant number of face-to-face training competencies that have not been completed. We have held focused discussions with executive directors group on the lowest levels of compliance and have undertaken a quality improvement review of our processes. An action plan has been developed to rationalise the training portfolio, which includes reducing the duration and frequency of some competencies and the removal of others.

Our activity measures

OUR ACTIVITY MEASURES	Variation	Assurance	Standard	Actual	Commentary
22) Number of new unique patients referred		N/A		98861	**No significant change**
23) Unique Caseload (snapshot)		N/A		64721	**Not a concern**

Our finance measures

OUR FINANCE MEASURES	Plan	Actual	Commentary
24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit	£0	£617,000	**Achieved**
25a) Financial Plan: Agency expenditure compared to agency target	£12,146,000	£11,555,000	**Achieved**

25b) Agency price cap compliance	67%	61%	**Requires Improvement**
26) Use of Resources Rating - overall score	2	2	**Achieved**
27) CRES Performance – Recurrent	£15,722,681	£14,129,074	**Achieved (overall)**
28) CRES Performance – Non-Recurrent	£6,055,000	£7,746,376	
29) Capital Expenditure (Capital Allocation)	£11,138,000	£11,077,000	**Not a concern**
30) Cash balances (actual compared to plan)	£44,379,000	£51,368,000	**Achieved**

Achievements: We have achieved our plans for the following measures:

- ✓ Financial plan: SOCI - final accounts – surplus
- ✓ Financial plan: agency expenditure compared to agency target
- ✓ Use of resources rating - overall score
- ✓ Cash releasing efficiency savings (CRES) performance – overall total
- ✓ Cash balances (actual compared to plan)

Areas for improvement:

- **Agency price cap compliance** – Most price cap breaches during 2024/25 have related to medical locum or prison mental health nursing cover for hard to fill vacancies. Actions to focus on medic recruitment and retention, including through international recruitment, have helped to reduce the number and value of breaches and related annualised premia costs. Actions to raise the profile of recruitment into vacancies in prisons have similarly helped to reduce the number of breaches from shifts covered by agency. The annualised premia, based on in-month breaches, has reduced from £3.59m in March 2024 to £2.16m in March 2025. Restrictions on who can fill the post means we will continue to see some breaches until we have completed recruitment. We have seen workforce increase over the year, to 132 whole time equivalents (WTE) over plan. Work to decrease agency spend has been successful, with a 36.6% (43.7 WTE) reduction from April 24, bank has increased 7.65% (28.97 WTE) and substantive staff 0.8% (64.38 WTE) over the same period. There is a risk that successful reduction of bank and agency in 2025/26 will be achieved through increased substantive headcount, reducing the savings that can be achieved.

Of note: cash releasing efficiency savings recurrent - We had an efficiency programme of £21.78m in 2024/25 and delivered marginally more than this (£21.88m). Recurrent efficiencies delivered were £1.6m lower than planned. Additional schemes to address unidentified cash releasing efficiency savings were largely non recurrent, and when recurrent schemes were not delivering, they were largely replaced with non-recurrent schemes. Key schemes that did not deliver were the benefits from international recruitment; LED lighting savings; and pay reductions related to roadmaps for staffing change.

PIPS Performance

The performance of the subsidiary is monitored by its Board of Directors which reports to the Group's Resources and Planning Committee.

Group Performance

PIPS is included within the financial performance for the Group. All profits generated are retained and reinvested in the company.

The company did not issue any dividend payment in 2024/25. The annual accounts for PIPs will not be formally approved until September 2025.

To ensure consistency within this Annual Report and the Accounts, the following provides an overview of the consolidated Group position:

Measure Name	Trust	PIPS	Total
24) Financial Plan: SOCI - Final Accounts – Surplus	£37,000	£580,000	£617,000
25a) Financial Plan: Agency expenditure compared to agency target	£10,479,000	£1,076,000	£11,555,000
25b) Agency price cap compliance	61%	n/a	61%
26) Use of Resources Rating - overall score	2	n/a	2
27) CRES Performance – Recurrent	£14,129,000	n/a	£14,129,000
28) CRES Performance – Non-Recurrent	£7,746,000	n/a	£7,746,000

(Note: the use of "n/a" in the above table signifies that the metric only refers to the Trust and not to the subsidiary)

Performance against key quality requirements (Trust)

Achievements: There were eight national quality requirements for delivery during 2024/25, of which we achieved the following for all areas* (*unless otherwise stated):

- ✓ Percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care.
- ✓ Percentage of service users referred to an NHS Talking Therapies programme who wait six weeks or less from referral to entering a course of NHS Talking Therapies treatment
- ✓ Percentage of service users referred to an NHS Talking Therapies programme who wait 18 weeks or less from referral to entering a course of NHS Talking Therapies treatment
- ✓ Percentage of service sers experiencing a first episode of psychosis or at risk mental state (ARMS) who wait less than two weeks to start a NICE-recommended package of care within the exception of York where we have shown significant improvement in March.

Areas for improvement:

We did not achieve the national targets for the following measures:

Child eating disorders

- Percentage of service users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)
- Percentage of service users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months) except for Tees Valley

Whilst we failed to achieve the national waiting times standard (95%) for routine and urgent referrals to child eating disorder services, the main reasons for this were patient choice, patients required requiring hospital admission, patients being uncontactable, physical tests not being arranged by primary care in a timely manner.

There are two further national quality requirements included within the 2024/25 mental health contract, which were:

- Number of episodes of mixed sex accommodation – sleeping
- Duty of candour (failure to notify)

These were consistently achieved for the 2024/25 financial year.

Local quality requirements

Achievements: We delivered the following local quality requirements which had been agreed with local health commissioners:

- ✓ Talking Therapies: Percentage of people who have waited more than 90 days between first and second appointments for North Yorkshire
- ✓ Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness for Tees Valley, North Yorkshire and York
- ✓ Talking Therapies: Reliable improvement rate for those completing a course of treatment for North Yorkshire and York
- ✓ Number of CYP aged 0-17 supported through NHS funded mental health with at

least one contact for County Durham and Tees Valley
- ✓ Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses for Tees Valley
- ✓ Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)
- ✓ Number of women accessing specialist community PMH services for County Durham and Tees Valley

Areas for Improvement

We did not achieve the locally agreed targets for the following measures:

Talking Therapies:
- Percentage of people who have waited more than 90 days between first and second appointments for County Durham, Tees Valley and York
- Reliable recovery rate for those completing a course of treatment and meeting caseness for County Durham
- Reliable improvement rate for those completing a course of treatment for County Durham and Tees Valley

Action: A Trust-wide task and finish group was established to support improvements within Talking Therapies and data has been sourced and triangulated to understand the different services and is being used to inform the development of a Trust-wide action plan.

Access to services:
- Number of children and young people aged 0-17 supported through NHS funded mental health with at least one contact for North Yorkshire and York. ***Action:*** In-depth analysis concluded that whilst there is no evidence that the service is receiving less referrals or delivering less contacts, there is evidence that there has been a significant increase in re-referrals of the same patient and a demand on the services to treat those patients. This correlates with an increase in the average number of contacts per patient. Further analysis of re-referrals is being undertaken to better understand the reasons.

- Access to transformed community mental health services for adults and older adults with severe mental illnesses for County Durham, North Yorkshire and York. ***Action:*** In-depth analysis (similar to what was undertaken for children and young people access) is being undertaken to help services understand and identify possible improvement actions.

- Number of women accessing specialist community perinatal mental health services for North Yorkshire and York. ***Action:*** A recovery plan is in place for the teams covering those areas with several key mitigating actions established to support improvement.

Children and young people paired outcomes:
- Percentage of children and young people closed referrals, with at least two contacts, with paired outcome scores within reporting period. ***Action:*** We have developed a clinical outcomes improvement plan which includes raising awareness amongst staff and managers, reinforcing the importance of capturing

clinical outcomes and why it is essential to high quality patient care.

Summary of financial performance

In 2024-25 the Group worked with its Integrated Care System partners to initially develop, and then coordinate delivery of, organisation and system-level financial plans for revenue and capital that were within agreed national envelopes and aimed to ensure that investment in healthcare was optimised.

The 2024-25 financial plan was agreed by the Board of Directors as part of the Group's Integrated Business Planning cycle and underpinned the achievement of the Trust's strategic objectives.

Our financial objectives, both planned and achieved, are shown in the following table:

Objectives	Outcomes
Delivering a £0.00m adjusted financial surplus (before impairments, depreciation on peppercorn right of use (RoU) assets and technical adjustments on PFI accounting).	Adjusted financial surplus of £0.62m achieved.
Delivery of £21.78m Cash Releasing Efficiency Savings (CRES).	Delivery of £21.88m CRES, inclusive of non-recurrent recovery actions.
Managing our capital plan priorities and leased asset obligations* to within a Trust capital allocation of £11.14m and supporting wider management of the Integrated Care System (ICS) capital pressures within the system envelope.	Capital expenditure of £11.08m including leased asset obligations of £3.62m generated £0.06m under spending against allocated capital resources and supported management by the wider ICS of partner provider pressures.
Achieving an end of year cash balance of £44.38m.	Cash balances were £51.37m.

*following the adoption of IFRS 16 in 2023/24, amendments to ROU lease assets result in a charge against capital allocation.

Revenue position

The Group planned to breakeven (£0.00m surplus) in the 2024-25 financial year and realised an end of year surplus (excluding impairments, depreciation on peppercorn

ROU assets and technical adjustments on PFI accounting) of £0.62m, which was better than planned.

Cash releasing efficiency savings (CRES) delivery

CRES achieved by 31 March 2025 were £21.88m and very marginally better than planned, with non-recurrent delivery better than planned by £1.69m. Overall, £14.13m was delivered recurrently in-year, and £7.75m was delivered on a non-recurrent basis as we continued recovery work to deliver recurrent schemes and to confirm full year effects of schemes commencing part way through the financial year. By 31 March 2025 recurrent CRES schemes had been delivered in full, the delay in implementation meant additional non recurrent schemes were required to support delivery in year.

Our Trust is making good progress with future year plans and has executive leads responsible for facilitating the planning and delivery of identified schemes.

Capital investment

Our Trust has worked within its agreed regional share of nationally allocated ICS capital to prioritise improvements to our environments and infrastructure and ensure that appropriate equipment and technology is available for patient care and to support colleagues.

Over the last twelve months and, working with partners to manage the impacts of increasingly constrained national allocations and funding allocated via the North East and North Cumbria ICS capital envelope, we have invested cash balances with the aim of providing the safest environments and best supporting infrastructure possible.

Our Trust worked flexibly throughout the year to support variances within planned schemes across the North East and North Cumbria ICS, ensuring the system delivered against its plan.

During 2024-25, our Trust invested £11.21m in capital assets, and £3.75m in property lease additions and inflationary increases. We were successful in bidding for £2.96m of central cash backed capital funding which was used on IT infrastructure, energy efficiency schemes and a community hub development in Harrogate.

Cash balances

The Group’s cash balances were planned to reduce from £59.93m to £44.38m. Plans reflected ongoing capital commitments and the breakeven revenue position. Actual cash balances were £51.37m, which was £6.99m higher than planned due to working capital variations and capital funding receipts.

Asset valuation

Our Trust's land and buildings (including right of use assets) were subject to a market price revaluation exercise, which resulted in impairments* as follows:

	2024-25		
	£m		
	Realised in surplus	**Realised in reserves**	**Total**
Impairments	22.57	0.72	**23.29**
Reversal of impairments	(2.16)	0	**(2.16)**
Total loss (gain) realised	**20.41**	**0.72**	**21.13**

**An impairment is a reduction in the recorded value of an asset, as determined by an independent expert valuer.*

When recorded as 'realised in surplus' (meaning in our Trust's overall Statement of Comprehensive Income position), net impairment losses are recognised as a charge to expenditure.

Whilst charged to expenditure, impairments are excluded by NHS England from the assessment of Trust's performance against plan.

Working capital

The Trust retained strong liquidity despite a decrease from 13.9 to 10.8 days, principally due to planned expenditure on capital projects, which exceeded internally generated cash balances from depreciation charged to expenditure.

Going concern

For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

After making enquiries, the directors have a reasonable expectation that the services provided by Tees, Esk and Wear Valleys NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Board of 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.

Environmental Matters

A summary of progress on delivery of the green plan

Our commitment

The Health and Care Act 2022 placed new duties on NHS bodies including foundation trusts to contribute towards statutory emissions and environmental targets. The NHS has set out statutory top-level targets for carbon emissions which the Trust has aligned themselves to:

- For the emissions we control directly (the NHS carbon footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 on 1990 levels.
- For the emissions we can influence (our NHS carbon footprint plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 on 1990 levels.

Our existing green plan ran from April 2022 to March 2025 and was formed around nine areas of focus in line with guidance from NHSE England. We are refreshing the green plan and the next version will set out the next three years in our journey towards achieving net zero by 2040 and review our progress so far. It will align with key requirements that have been developed by NHS England including the estates net zero delivery plan, net zero travel and transport strategy and net zero supplier roadmap. Progress in the nine focus areas is summarised below:

System leadership and workforce

A new energy and sustainability manager joined the trust in June 2024 with delivery of the green plan being a key focus of the role. Our Trust sustainability group was reconvened in August 2024 and meets quarterly to review and progress the green plan action plan. Progress is reported six monthly to the strategy and resources sub group with periodic assurance into the strategy and resources committee. Working groups have been set up with core membership from sustainability group members and wider trust staff. We are working with the communications team to establish a green plan staff volunteer network with a dedicated MS Teams channel, with monthly drop-in sessions in development. We continue to work closely with our regional partners to share good practice and enhance delivery of green plans across the NHS. Work to identify external funding opportunities for reducing building energy use has been a particular focus this year and we have been in a position to submit bids to a number of competitive funding schemes with some notable successes.

Sustainable models of care

We have worked with the University of York to develop and submit an outline proposal for National Institute of Health and Care Research (NIHR) funding for a project to identify which parts of the mental health care pathway have the highest

carbon footprint and to explore whether alternative approaches, such as more care in the community or better medicines management, can help to reduce emissions whilst maintaining standards of care. Discussions are in progress to integrate sustainable quality improvement (SusQI) elements into existing quality improvement programmes. Working group membership has been established with further input from across our care groups being a key aim of this workstream.

Digital transformation

A working group has been established and actions are progressing with a focus on digital and remote appointments and engaging staff and patients in digital care channels.

Travel and transport

A regional project funded by the North East Combined Authority (NECA) to provide a two year fully funded travel survey, scoping study and analysis for Lanchester Road Hospital is in progress. We are continuing to develop travel plans across our sites and are using the Modeshift platform as a tool to support this work. Knowledge sharing with our regional partner trusts is helping to standardise work in this area and engagement with local and combined authorities will be key to progressing further. Business mileage is monitored and progress towards decarbonising our fleet of vehicles is ongoing. This is supported by a network of 80 electric vehicle charging points across our Trust.

Estates and facilities

A successful bid was made to the NHS Energy Efficiency Fund (NEEF) for funding for LED lighting upgrades at Roseberry Park Hospital and a building management system (BMS) upgrade at Cross Lane Hospital. The project value was £350k with expected carbon savings of 80 tonnes CO_2e. Following the announcement of a Great British energy solar fund opportunity and submission of expression of interest for several solar projects for delivery in 2025/26, funding for Roseberry Park Hospital and Acklam Road Hospital totalling £1.2 million was confirmed in March 2025. This is expected to save 140 tonnes CO_2e each year. We will review opportunities for consultancy funding to support development of Heat Decarbonisation Plans for our sites. The previous low carbon skills fund (LCSF) bid in April 2024 met the required standard but allocation was random and we were not successful on that occasion. If bid criteria remain unchanged, the bid can be updated and submitted but this is subject to further funding being announced. We are continuing to engage with regional partners on potential for heat networks as part of future decarbonisation. Current networks under discussion are deep geothermal for Lanchester Road Hospital, hydrogen for Roseberry Park and a low carbon district heat network for Foss Park Hospital.

Data on food waste is being collected by hotel services in line with national guidance and reporting requirements and the waste manager has developed a food waste recycling scheme to meet the requirements of the new simpler recycling legislation which came into force for businesses on 1 April 2025. Work to move clinical waste for alternative treatment into the offensive waste stream where appropriate is ongoing with good progress towards national targets being made.

Biodiversity and green space working group membership has been established with estates officers and grounds and gardens staff engaged to provide baseline information on current processes. We aim to involve our clinical and allied health professional colleagues in this area and are looking at ways to capture all the initiatives currently taking place across different services. Wildflower areas at Lanchester Road Hospital, Cross Lane Hospital and Acklam Road Hospital are at the end of a three year cycle, with future plans for planting in development. Potential for a hedgerow planting programme on selected sites in Autumn 2025 is being reviewed and three sites will take part in a ‘no mow’ May initiative where some grassed areas are left uncut for the month of May to encourage plant life which is beneficial to pollinating insects. We will be working closely with our regional partner trusts in the coming year to share knowledge which will help us to develop a biodiversity and green space strategy.

Medicines

A working group has been established and action to date has been around developing high level areas of focus for future actions as part of the green plan refresh. We plan to integrate medicines waste into our main clinical waste management process.

Supply chain and procurement

All procurement activities over public contracts regulations (PCR) 2015 thresholds now include mandatory social value and net zero considerations which will help out Trust manage our Scope 3 emissions targets going forward: the largest part of our total overall carbon footprint. We are working with our external procurement partner to explore how they can support us in this area and improving data will be a key area of focus in the coming year.

Food and nutrition

A Trust-wide nutrition and hydration steering group is in development and a sustainability lead for the dietetic team has been appointed. Involvement from hotel services and catering teams will be ongoing and knowledge sharing in this area facilitated by NHS England is providing useful guidance and networking opportunities.

Adaptation

A working group is in place and adaptation is being incorporated into our Trust emergency preparedness, resilience and response (EPRR) framework in 2025. This workstream is led by the EPRR manager and close working with regional partners will ensure a consistent approach to developing climate change risk assessments and adaptation plans. Capturing data on climate-related risks and incidents will be a key area of focus for the coming year.

Taskforce on climate related financial disclosures (TCFD)

NHS England's NHS foundation trust reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability 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, risk management and metrics and targets pillars for 24/25. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

Governance
Describe the board's oversight of climate-related issues.
• Our Trust provides six-monthly updates on green plan, sustainability and net zero progress, which is issued to the Trust net zero lead, executive management group, and the Trust board of directors. • Our Trust is in the process of developing an EPRR risk register, which will include climate risks and impacts. The register will feature as a separate entity on the Inphase incident management system. Risks are reviewed annually by the risk manager, and shared with the audit and risk committee, and the Trust board of directors. • To date, there has been no materiality impact on the organisation.
Describe management's role in assessing and managing climate-related issues.
• The chief executive has assigned net zero leadership to the executive director of finance, estates and facilities with authority delegated to the director of estates, facilities and capital who has recruited an energy and sustainability manager to develop and implement the green plan and report against targets. • The deputy director of estates and facilities is responsible for mitigations across scope 1 and 2 emissions in their work programmes, including our Trust's plans for developing heat decarbonisation strategies.

- The sustainability group meets quarterly and provides a forum for directorate and corporate team leads to report on progress against the trust green plan and share learning on the key areas including systems leadership and workforce, sustainable models of care, digital transformation, travel and transport, waste reduction, estates and facilities, medicines, supply chain and procurement, food and nutrition and adaptation.
- The impact of climate-related issues is covered in team business continuity plans, and the incident response plan, which is in development and will include modules on extreme weather events.
- The executive management group reviews the bi-annual sustainability report and recommendations contained within and submits an update to our Trust board of directors.

Processes by which the relevant management structures are informed about climate related issues and how those structures monitor climate-related issues.

- Data around climate-related issues can be collated from various sources, such as the Inphase incident reporting system, which should capture events related to extreme weather. This will require additional risk classifications and staff training to embed the process.
- Operational matters are directed to estates and facilities leads and, if necessary, escalated to senior management and directors via regular directorate management team meetings.
- Climate-related issues identified would be reported in the quarterly sustainability group and included in the six-monthly reports on green plan progress. Metrics and targets are to be developed.
- Going forward, the number of heat and flood events will be reported via the estates return information collection (ERIC) Return.

Risk management

Describe the organisation's processes for identifying and assessing climate-related risks.

- Our Trust has developed a generic risk within the Board Assurance Framework for failure to deliver the green plan which includes failure to comply with environmental legislation, adverse impacts of the changing climate, and failure to meet carbon reduction targets.
- Risks related to extreme weather will be incorporated within our emergency planning risk register, however we recognise that a key future step is to complete a climate change risk assessment (CCRA).
- A CCRA would assess climate risks and impacts using a series of national and local tools, including the national adaptation programme (NAP) and LCAT tool.
- It is anticipated that climate risks are shared across Integrated Care Boards and should be monitored via the assurance committee and Integrated Care Board (ICB). These are monitored by our Trust's EPRR and ICS sustainability

programme as well as by the ICB director of estates meeting and sub-groups. Our Trust EPRR lead attends monthly ICB EPRR meeting.
Describe the organisation's processes for managing climate-related risks.
• There has been no recorded material risk to the Trust to date. • Processes for recording climate events on Inphase will be embedded and included in the six-monthly update reports.
Describe how processes for identifying, assessing and managing climate-related risks are integrated into the organisation's overall risk management approach.
• Extreme weather risks are managed by services through EPRR and business continuity plans, owned by services. Business continuity plans currently include modules on hot weather, cold weather, storm, and flood. Weather alerts are issued by EPRR / health and safety on global emails for operational preparedness.

Metrics and targets
Disclose the metrics used by the organisation to assess climate-related risks and opportunities in line withs its strategy and risk management process.
• Our Trust applies metrics and measurements as guided by NHS England, following the creation of its board-approved green plan 2022 – 2025 and reports its performance against targets through the bi-annual green plan and sustainability report, and in the annual report yearly. • Metrics and measurements are reported annually within the estates return information collection (ERIC) with kWh/m2 for energy, m2 / m3 for water, kg / m2 for waste, % of LED coverage and number of heat or flood events that triggered a risk assessment. • Green plan key performance indicators include % of reduction against our 2019/20 baseline carbon footprint.
Describe the targets used by the organisation to manage climate-related risks and opportunities and performance against targets.
• We have pledged to meet the NHS net zero target by 2040 for direct emissions (NHS carbon footprint) and 2045 for the wider NHS carbon footprint plus, in compliance with NHS requirements and the Health and Care Act 2022. We report our performance against targets and green plan action plan through the bi-annual sustainability report, and in the annual report.

Health inequalities

Providers of NHS services have a statutory duty to tackle health inequalities. This includes considering health inequalities in the exercise of their functions and working with communities to improve health outcomes for all.

The communities we serve are diverse. As well as wonderful community assets and environments, the area covered by our Trust contains some of the most deprived

neighbourhoods in England. This contributes to some of the country's poorest social, physical, and mental health outcomes. Deprivation creates additional stress and exacerbates any health condition (mental and physical), and our services therefore need to meet increased and more complex demand.

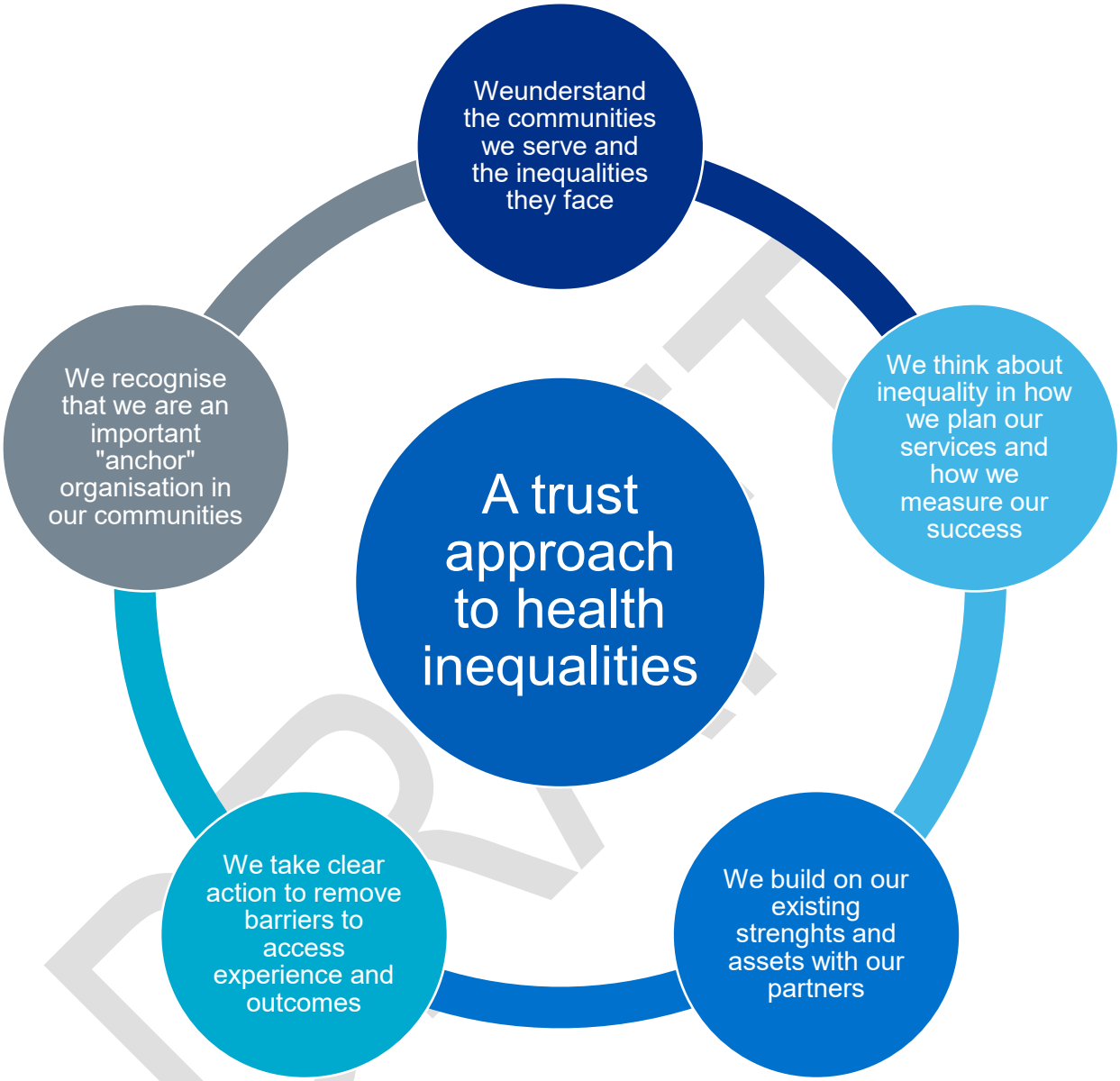
The things that drive inequality and poor health outcomes in our patient population are complex and overlapping. People often face multiple challenges at one time across mental health, learning disability, neurodiversity, physical health, and social and economic circumstances. Three of the major drivers of inequality and health harms in our patient population include:

- Physical ill health
- Poverty and financial exclusion
- Drug and alcohol related harm

Rurality and isolation also contribute significantly for some of our communities.

In 2023/24 we developed and adopted a co-created approach to tackling health inequalities within our Trust based around the following commitments (see illustration below). Lived experience engagement was central to the development and initial implementation of this approach and forms a core part of ongoing delivery.

Our approach to health inequalities



Co-creating a justice-based approach to care and support

Areas of progress in meeting these commitments in 2024/25 includes:

- A co-creation video on health inequalities has been completed and shared on our Trust YouTube channel (www.youtube.com/@TEWVNHSFT)
- A reflective session was held for staff who attended a patient safety summit on health inequalities in 2023/24 and a Trust-wide health inequalities “team challenge” which saw over 30 teams participate.

- A benchmarking exercise has been completed using The NHS Providers health inequalities self-assessment tool and reducing inequalities: a guide for trust board members

- Our Trust co-authored the development of a national toolkit in partnership with the Public Mental Health Implementation Centre and Royal Collage of Psychiatrists to outline the practical action clinicians can take to address inequalities in everyday practice.

- A new webpage and resource bank on the T drive are now in place for our staff to access including easy links to local joint strategic needs assessments.

- Our updated equality impact assessment policy now includes requirement to consider health inequalities/inclusion health.

- Trust wide governance arrangements for physical health have been refreshed and the development of a Trust-wide physical health plan underpinned by clinical advisory groups in key areas of practice including public health.

- MECC training has been promoted through online training and preceptorship and international nurses training events.

- A bowel screening pathway is now in place for all eligible inpatients with stays of over six months and will be rolled out across other national screening pathways. A flu campaign was delivered throughout the autumn/winter period.

- Secure inpatient services dietetic team have led obesogenic environments project. Between March 2024 and March 2025, the service has seen overweight and obesity levels reduce from 93% to 84% of patients.

- A specialist diabetes nurse in partnership with our acute partners in CDDFT was recruited for six months in 2025/26 and resulted in a range of improvements, project outputs will be used to build a business case for implementing this model of practice.

- The learning from a programme of poverty proofing undertaken in partnership with Children North East within our children and adolescent mental health service (CAMHS) in South Tees continues to be rolled out through clinical networks. Our CAMHS team has developed a video resource to share their approach to working with families experiencing socioeconomic challenge and the changes we can make as a service.

- The did not attend/was not brought (DNA/WNB) policy has been updated and reflects the impact of economic and wider inequality on engagement with services.

- A strategic approach to dual diagnosis began development in 2024/25. This focusses on workforce skills and competency and policy and pathway adherence including routine screening and partnership working.

- A new model of specialist substance use inpatient in-reach is now in place in Durham and Darlington.
- Specialist nurse roles across Teesside continue to provide enhanced support and facilitate partnership working.
- Recovery connections provide in-reach to Roseberry Park and the services are exploring expansion of this to include wider specialist substance use service in-reach.
- A social determinants key worker funded by a local public health partnership is attached to the crisis suite at Roseberry Park to support those experiencing multiple disadvantage including substance use.
- A pilot of community team naloxone carrying pilot has been completed and evaluated and a model of practice adopted by both care groups.
- The North Yorkshire, York and Selby dual diagnosis partnership continues to thrive, dedicated clinical leadership is in place to drive clinical practice in partnership and the North Yorkshire "Drink and Drug Hub" is being explored as a model to support workforce competency and development across our Trust.
- Data has been collected and reported at executive level to support implementation of the patient and carer race equality framework.
- Our Trust employs a community link worker who has shared community insights to support action in response including the importance of community engagement.
- Our early intervention in psychosis team has undertaken dedicated work to better understand why people from ethnically minoritised backgrounds are more likely to come into services through crisis or wards.
- One of our Trust equality objectives focuses on supporting access to service for our Gypsy, Roma and Traveller communities. In 2024/25 this included a range of activity including research, training, and practice guidance.
- A partnership with public health South Tees and Teesside University has been formed with our Trust to address under diagnosis of dementia in South Asian communities in South Tees.
- We continue work to make our clinical environments more accessible to autistic people including initial environmental audits in adult mental health wards and are rolling out mandatory autism training and online Oliver McGowan training.
- We continue work towards our transformation programmes with health inequalities, understanding of and connection to our communities at the heart.

In response to NHS England (NHSE) statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) a full health inequality report has been published and can be viewed at LINK TO REPORT TO FOLLOW

Engaging with our communities 2024-25

We continue to improve how we listen to our service users, carers, and partners. We have established groups and roles dedicated to amplifying lived experience voices. We now have services user and carer groups embedded across each of our specialties. These specialty groups work very closely with services in shaping business as usual policies, as well as redesigning services where necessary. In this manner, we have continued to amplify lived experience voices over the last year, to underpin how we deliver care.

This year we launched our co-creation framework, which has been co-developed over several years with the aim of giving clear definitions, co-creation values and types of co-creation that we can use across our Trust and with our partners. This has been promoted throughout our Trust and now forms the foundation of all co-creation work that we do across the organisation. Through this work, we have updated our co-creation strategy to reflect the needs expressed by staff, service users and carers on their own individual co-creation journey and to break down barriers to involvement for all.

Our co-creation boards are now established in both care groups having been launched in 2023. As the co-creation boards continue to develop and mature, we are seeing our service users and carer members develop their lived experience leadership. This includes having service users and carers join our Durham Tees Valley and forensic care board. This offers unique input and reflection for the care board on how they conduct meetings and think about working in partnership with service users and carers across the geography.

Our patients, carers, and lived experience community partners have played a significant role in shaping and developing our major transformation work across the Trust. This includes our urgent care programme, driving the trust's approach towards personalised care plans, and the way we implement the use of Oxevision.

Our services continue to ensure lived experience underpins safety plans, and there is work underway to embed patient safety partner roles within our wards.

We also produce and publish an annual quality account to NHS England. For the first time, this year our quality account was co-created with service users and carers. They defined the three main priority areas which the organisation will focus on for improvements.

We worked with service users and carers to refresh our strategy, Our Journey to Change, over the last year with several workshops held.

We have completed the review of our complaints process, co-created from start to finish with people with lived experience of our services and organisation.

We have completed the review of our patient experience service and are co-creating together with our service users and carers our new patient and carer experience surveys. This will improve how we listen, capture, and learn from our service users' experiences of our services.

We continued to focus on some key areas as part of our co-creation journey including:

- Expanding and developing lived experience roles and leadership, including peer support workers. Partnership working and system leadership continues through co-delivery of systemwide training with Teesside University. We now have established peer networks across Teesside, Durham, and York alongside voluntary, community and social enterprise organisations.
- The development of involvement community days, which have been co-developed by involvement members. Held quarterly, they bringing together involvement community together from across our geographical footprint to connect, celebrate success and work through opportunities to involve together.
- We have launched our co-creation community of practice, which gives opportunities for staff across the trust to become dedicated co-creation champions within their service. Train-the-trainer training has been co-codeveloped and has been rolled out to champions throughout the year, who have taken this back into their teams to work through barriers to co-creation as a service and to empower staff to work with co-creation methodology.
- In December we celebrated the 10-year anniversary of Arch Recovery College in Durham and launched a new website for Recovery College Online. Both services co-develop and co-deliver courses for service users and carers from a lived and professional perspective and continue to grow, including a new partnership with Help for Heroes.
- A number of key trust wide transformation projects and policy creation now has dedicated lived experience input them. Including our Oxehealth policy and procedure which was co-produced with people with lived experience, our positive and safe strategy, and our personalised care planning policy.

Embed and grow co-creation across the organisation - continued progress has been made on this priority:

- 465 people remain on the involvement register. Recruitment of young people and adult learning disability (ALD) and service users with autism and carers is ongoing, including their involvement on co-creation boards.
- The involvement and engagement team continues to explore opportunities to reach more diverse communities and have developed key relationships with a range of voluntary and community sector colleagues over the period.

- 207 new involvement opportunities were sent out during this reporting period, covering a range of co-creation activities including interviews, quality improvement projects and training.

Bribery

Our commitment and approach to preventing bribery is set out in our “anti-fraud and corruption policy”. No instances of bribery were discovered during the financial year.

Human rights issues

The Trust has put in place control measures to ensure that all of our obligations under equality, diversity and human rights legislation are complied with. Human rights issues are reported to the equality, diversity and human rights steering group. We review human rights as part of our equality impact assessment on all policies, procedures and projects. We are also working with the British Institute of Human Rights to provide training to colleagues on human rights issues.

Equality objectives 2023 – 2027

A revised set of equality objectives was approved by the Trust board of directors in January 2023 in order to more fully realise the vision, mission and strategic goals of the Trust. As part of the development of this strategy a consultation was held with service users, carers and staff during 2022. Clear themes emerged from this consultation and these themes helped shaped the objectives.

Objectives 1 and 3 relate to service delivery and supports our Trust’s ambition to co-create a great experience for our patients, carers, and families.

- **Objective 1 transgender and non-binary - To monitor the experiences of staff and service users who identify as trans or non – binary and to identify actions to improve their experiences.**
    - Additional information and guidance were included in the privacy and dignity policy for staff supporting trans and non-binary patients.
    - A trans awareness intranet page was developed to include information and resources for staff supporting trans patients.
    - A campaign was launched to promote the importance of pronouns on staff ID badges, pronoun pins where appropriate, email signatures and on MS Teams, to help ensure LGBTQ+ patients feel welcomed in our services.
    - Developed a trans reference group to support staff making complex decisions about the admission of trans service users.

- **Objective 3 Working in partnership with other stakeholders to explore how to improve access to mental health, learning disability and autism services for the Gypsy, Roma, Traveller (GRT) community.**
    - Training continues to be delivered for our Trust staff by the specialist GRT nurse and GRT wellbeing practitioner in Durham, over 400 staff have attended this training since 2023. This training helps staff to understand the cultural differences within the GRT communities and how staff can make services more accessible to people from these communities.
    - Working in partnership with our Trust, York University undertook an engagement piece of work exploring mental health and the barriers to services in the GRT communities. A report has been written and shared across our Trust which include best practice. A further project has been commissioned.

The publication of patient information

Our Trust publishes annual information that demonstrates how we comply with the three aims of the public sector equality duty. The information helps us to understand whether and why particular groups in the community are under or overrepresented in its patient population and to act as appropriate. It identifies any differences in experience between protected groups and the patient population in general to ensure high quality care is delivered for all.

This information includes access to services, patient experiences and clinical outcomes.

The full report can be found at: https://www.tewv.nhs.uk/about/equality-and-diversity/approach/

Equality delivery system (EDS) 2022

We completed the EDS 2022 and published the report in March 2025. One of the aims of the EDS is to help our Trust to improve the services we provide for the local communities, improving patient access, health outcomes and experience.

The full report and action plans can be found at:

https://www.tewv.nhs.uk/about/equality-and-diversity/approach/

Important events since end of financial year

Brent Kilmurray left our Trust in April 2025 to **become** the Chief Executive of Mid-Yorkshire NHS Trust.

Patrick Scott was appointed as Interim Chief Executive with Beverley Murphy was also appointed as Interim Deputy Chief Executive; a role held in conjunction with her responsibilities as the Chief Nurse.

Kathryn Ellis joined our Trust board of directors as the Interim Executive Director of Transformation and Strategy which encompassed the remainder of Patrick's former responsibilities including leadership of the directorate.

David Jennings left the Trust in May 2025 for personal reasons. The Council of Governors appointed Bev Reilly as the Interim Chair for up to a period of six months pending the appointment of a new substantive.

The accountability report

In the accountability report we provide information on our governance arrangements, staffing and the remuneration of directors and senior managers in order to demonstrate how we comply with best practice and key rules and requirements.

Beverley Murphy
Acting Interim Chief Executive

25 June 2025

The directors' report

Group Board members as at 31 March 2025

David Jennings
Chair of the Trust and chair of the nomination and remuneration committee
David is a qualified accountant and auditor with 36 years' experience in local government and the NHS. He has worked for a number of years as a senior finance professional with Redcar and Cleveland County Council covering finance, IT, assets and the strategic capital programme. Before that he had 27 years working for the Audit Commission, as a district auditor and later as a senior inspector. He has previously been a Non-Executive Director with TEWV.

Qualifications: Chartered Institute of Public Finance and Accountancy. Hons Degree

Principal skills and experience: Senior NHS non-executive leadership experience. A professional career in governance, performance improvement, strategic and cultural change, and the delivery of outcomes, including user experience. Specific professional expertise in finance.

Term of office: 1 September 2022 to 31 August 2025 (first term)

Date of Initial appointment: 1 September 2022

Non-Executive Directors

Roberta Barker
Non-executive director, chair of the people culture and diversity committee, interim chair of the mental health legislation committee and wellbeing guardian
Roberta is the European Director of People for Teva Pharmaceuticals, a global $17bn business, where she has led on people strategy, transformation programmes and culture change. She has also established shared services and centres of excellence led by technology alongside a learning management system across a global footprint.

Roberta began her career in finance and general management moving to the HRD position with sporting retailing giant Nike. From there, she moved on to Daichii Sankyo EMEA as Director of People and Performance before taking on responsibility for the Director of People and OD role for the Business Services Authority, covering multiple divisions of services for the NHS.

Roberta has held various permanent and interim leadership positions within the Health Service including Trust Director of Workforce People and OD at Medway NHS Foundation, Director of Workforce & OD at Yorkshire Ambulance Trust, Director of People and OD at NHS Digital and Director of HR and OD at Royal Surrey County Hospital.

Qualifications: Master of Business Administration, Durham University, Common Purpose, Sunderland University

Principal skills and expertise: HR and OD strategy, change management, strategic planning, operational implementation, communications and employee engagement, stakeholder management

Term of office: 1 September 2022 to 31 August 2025 (first term)

Date of Initial appointment: 1 September 2022 - prior to her appointment, Roberta served as an associate non-executive director (non-voting)

Dr Charlotte Carpenter
Non-executive director and chair of resources and planning committee
Charlotte is Director of Skills, Inclusion and Public Service Reform at the North East Combined Authority, prior to which she held several senior roles within housing associations.

Charlotte is an alumnus of Cambridge and York universities and holds a PhD in medieval history.

She is a former member of the CBI North East Council, the CBI's National Infrastructure Board, and the Chartered Institute of Housing's Policy Advisory Committee.

Qualifications: PhD, MA (Cantab), MA (York).

Principal skills and expertise: Strategy and strategic planning, public policy, communications, marketing and public affairs, organisational transformation, research and insight, programme and project management.

Term of office: 1 September 2024 to 31 August 2027 (second term)

Date of initial appointment: 1 September 2021

John Maddison
Non-executive director and chair of the audit and risk committee and NED lead for digital/cyber
John joined our Trust as an associate non-executive director on 1 January 2020 as part of our Trust's succession planning arrangements. He retired in June 2019 after working in the NHS for 37 years. He studied economics and accountancy at Loughborough University and joined the NHS as a graduate trainee accountant in Yorkshire. The majority of John's career was based in the North East working in finance, primarily in the acute sector and senior positions at the strategic tier including NHS England. He was Director of Finance and Informatics at an acute FT in the North East and a large teaching hospital in the North Midlands prior to joining Gateshead Health FT in 2014 as Group Director of Finance and Informatics and

latterly as Deputy Chief Executive and Acting Chief Executive for the final year prior to retirement.

Qualifications: BSc Econ/Acc. Chartered Institute of Public Finance and Accountancy.

Principal skills and expertise: Operational and strategic finance and planning, governance and risk management, performance management.

Term of office: 1 July 2023 to 30 June 2026 (second term)

Date of initial appointment: 1 July 2020 - prior to his appointment John served as an associate non-executive director (non-voting)

Jules Preston
Non-executive director, senior independent director, chair of the charitable funds committee and NED lead for freedom to speak up and safe working
Jules has extensive experience in the NHS, having served as the inaugural Chairman of the Northumberland, Tyne & Wear NHS Foundation Trust, one of the largest mental health and learning disability Trusts in the country. During his period of chairmanship, the trust successfully came together having been three separate organisations and it achieved Foundation Trust status in 2009/10. In 2012 Jules began a new Chairman's post at Mid Yorkshire Hospitals NHS Trust.

Jules had previously been a non-executive director of other NHS organisations, including the former Sunderland Health Authority (1996-2000) and the then Northumberland, Tyne and Wear Strategic Health Authority (2000-2006).
Jules has also held senior positions with the Manpower Services Commission (Department of Employment) and was Chief Executive of Sunderland City Training and Enterprise Council & Business Link. Following that he was, for more than two years, part-time Chief Executive of the National Glass Centre in Sunderland.

He was until 2012 an assessor, both in the UK and internationally, of organisations that were working to achieve 'Investor in People' status and received an MBE in 1999 for services to training, particularly for those with special needs.

Qualifications: Left school at 16 and trained as articled clerk in chartered accountancy for 2½ years focussing on audit work before joining the Civil Service as a clerical officer. Principal grade within 20 years, focusing on adult and youth training, small business development and Investors in People. Training and education through personal development, on the job.

Principal Skills and Experience: People skills, leadership, change management, understanding of finance, 25 years involved as a non-executive within the NHS.

Term of Office: 1 September 2022 to 30 August 2025 (first term)

Date of initial appointment: 1 September 2022 - prior to his appointment Jules served as an associate non-executive director (non-voting)

Bev Reilly
Non-executive director, deputy chair, chair of the quality assurance committee, NED lead for learning from deaths and doctors' disciplinary independent person
Bev has been a Nurse for 38 years. Bev was the Director of Nursing and Quality for NHS England covering Cumbria and the North East up until 2019. Her long career has spanned a number of organisations across acute, primary and community care settings at a local, regional and national level. She is experienced in quality assurance and regulatory requirements having led on this as part of her role within NHS England and close working with NHS Improvement and the Care Quality Commission.

Qualifications: RGN, BA (Hons)

Principal skills and expertise: Nursing leadership, quality assurance, patient safety, patient and staff experience, risk management, strategic planning, partnership working. Bev also has personal and carer lived experience.

Term of office: 1 September 2022 to 31 August 2025 (second term)

Date of initial appointment: 1 September 2019

Jane Robinson
Non-executive director
Jane is a qualified occupational therapist who has worked across the North East for over 30 years in a range of health, social care and commissioning roles. Jane has a passion for person-centred, high quality care, delivered in an integrated way.

Jane holds an Executive MBA from Newcastle University and completed the Strategic System Leadership Programme at Yale University in 2019.

Jane has recently retired from her role as corporate director for adults and health services at Durham County Council where she was responsible for adult social care, commissioning and public health. She also held the role of chair of the North East Association of Directors of adult social services.

Additionally Jane is chair of Willow Burn Hospice.

Qualifications: Diploma in Occupational Therapy (Exeter), Executive MBA (Newcastle

Principal skills and expertise: Senior NHS and Local Government leadership experience with expertise in adult social care, public health and commissioning, governance and risk management, integrated working and relationship management, performance improvement and service quality based on user experience and involvement, creating a positive culture based on promoting well-being.

Term of office: 1 December 2024 to 30 November 2027 (first term)
Date of initial appointment: 1 December 2024

Catherine Wood
Non-executive director
Catherine has over 30 years of experience working in the health and social care sector supporting people with learning disabilities and autistic people. She has worked for local authorities, the NHS and third sector organisations across the North East and Yorkshire moving from direct support roles though a range of management and business development roles. Prior to joining TEWV Catherine was Chief Executive at a third sector provider of support to adults with learning disabilities in West Yorkshire.

Catherine also has extensive lived experience as a carer for people with complex needs. This combination of professional and personal experience is the driver for her continued passion for developing support to be the best it can be for everyone who needs it.

Catherine has a special interest in end of life and palliative care for people with learning disabilities and led a national award-winning project. She sits on the steering group of the British Institute of Learning Disabilities (BILD) Growing Older with Learning Disabilities (GOLD) group and is also a member of the special advisory group for the Palliative Care Network for People with Learning Disabilities (PCPLD)

Qualifications: BSc Social Sciences (Newcastle), Registered Managers Award plus multiple work-related qualifications.

Principal skills and expertise: Working co-creatively, lived experience, people and coaching skills, leadership, change management, partnership working, working with diverse communities, project leadership and experience of working with CQC.

Term of office: 1 December 2024 to 30 November 2027 (first term)

Date of initial appointment: 1 December 2024

Executive directors

Brent Kilmurray
Chief executive
Brent has been a NHS executive director since 2005, working in senior roles across a range of acute, community health and mental health NHS organisations. He joined us after two years as Chief Executive of Bradford District Care NHS Foundation Trust, a combined community and mental health trust providing services in Bradford and the Yorkshire Dales, as well as children’s services in Wakefield.

His board level experience includes executive and divisional roles at City Hospitals Sunderland NHS FT, joint Managing Director at NHS South of Tyne and Wear Community Health Services, Executive Director of Business Strategy and Performance for South Tyneside Foundation Trust, and Chief Operating Officer and Deputy Chief Executive for Tees, Esk and Wear Valleys NHS Foundation Trust.

Alongside his Trust role, Brent also sits on the NHS Providers Board of Trustees, which is a national membership body for all NHS organisations where he represents provider views in discussions alongside other Trust Chief Executives and Chairs from across the country.

Qualifications: MA European Studies and BA (Hons) Government and Politics

Principal skills and expertise: Quality improvement and innovation, leadership development, partnership and system working, operational service management, performance management, tendering and business development, contract management, commercial matters.

Appointed: June 2020

Ann Bridges
Executive director of corporate affairs and involvement (non-voting)
Ann joined our Trust in September 2021 bringing extensive skills, knowledge and expertise in strategic communications and engagement, having worked in local government and across the public sector at senior level for over 20 years.

Originally from Edinburgh, Ann moved to the North East in 1999 leaving behind a career with Scottish Enterprise in regeneration and economic development marketing roles, having delivered the first and now renowned Edinburgh Christmas Market. Ann cut her teeth in local government having joined Newcastle City Council in 2000, working her way through the organisation as well as with central Government, and was laterally head of communications at Northumberland County Council before joining our Trust.

The corporate affairs and involvement department brings together our primary customer service teams including our patient and carer experience and complaints functions, our team leading the charge on embedding and facilitating co-creation in the Trust, plus the communications, stakeholder engagement and corporate affairs teams. We also work closely with our people and culture colleagues on staff experience and engagement and provide support, training and engagement for Governors.

Ann is also a member of the CIPR North East, former member of the CIPR Local Public Services Committee, CIPR Health Committee.

Qualifications: Professional Diploma from the Chartered Institute of Marketing (CIM), Chartered Institute of Public Relations (CIPR) Accredited Practitioner

Principal skills and expertise: strategic communications and engagement

Appointed: September 2021

Prof Hannah Crawford
Executive director of therapies (non-voting)

Prof Hannah Crawford qualified as a speech and language therapist in 1995, and has worked for Tees, Esk and Wear Valleys NHS Foundation Trust (or its predecessor organisations) all her working life. She mainly specialised clinically in working with adults with a learning disability. Between 2017 and 2019 Hannah worked one day per week for NHS Improvement as the national patient safety expert adviser for adults with learning disabilities. She left this position at the end of 2019 to take up the role of Professional Head of Speech and Language Therapy within TEWV. Hannah achieved the role of Executive Director of Therapies in April 2022.

She currently holds a range of honorary positions including being a professional advisor for the Royal College of Speech and Language Therapists, a Visiting Professor at Teesside University and a Visiting Research Fellow at the University of York. Hannah has a PhD from the University of Edinburgh, which investigated the lived experience of family carers of adults with profound and multiple disabilities and dysphagia.

Hannah has extensive experience in clinical leadership having spent 15 years as a consultant clinician. She then moved into broader very senior NHS leadership roles as Professional Head of Speech & Language Therapy, Acting Lead for Allied Health professionals and most recently Executive Director of Therapies.

Qualifications: BA (Hons), Post Grad Diploma, MSc, PhD.

Principal skills and expertise: Clinical speech and language therapy (dysphagia), ethics, patient and carer experience, leadership, coaching, research, teaching.

Appointed: April 2022

Zoe Campbell
Managing director for North Yorkshire and York care group
Zoe has extensive experience in the health and social care sector built up across local authority, the private sector and local and national charities. She has held several leadership positions including leading improvement and efficiency programmes across health and regional government, business development within a national provider of domiciliary and home-based health care; and as Director of Operations at a dementia charity covering England, Northern Ireland and Wales.

Her previous roles have encompassed commissioning, service and continuous improvement, business development, strategy development and she has successfully delivered several large-scale transformational change and improvement programmes at local, regional and national levels.

Alongside this, she has understanding and experience gained as a volunteer at the Citizen' Advice Bureaux, as a Governor in a social, emotional and mental health school, a mentor for young people; and a Trustee at a mental health and learning disability charity.

Qualifications: BA(Hons) Social Policy., Post Grad Diploma Coaching for Strategic Leadership, Lean Six Sigma Green Belt.

Principal skills and expertise: Leadership, continuous improvement, programme and project management, commissioning and contracting, co-production.

Appointed: June 2022

Dr Sarah Dexter-Smith
Joint executive director for people and culture (non voting)
Sarah is a fellow of the Chartered Institute of Personnel and Development and a consultant clinical psychologist who has worked in the NHS for over 25 years alongside roles in social care and education. She was appointed in February 2021 and was previously Director of Therapies. She brings a broad range of applied psychology and research experience having worked on regional and national bodies. She has a particular interest in culture and leadership that combines strong governance with positive impact for teams and communities.

Qualifications: Fellow CIPD, Doctorate Clinical Psychology, PhD Psychology, ILM5, PGDips Supervision/ Neuropsychology

Principal skills and expertise: Leadership, coaching/ mentoring, applied psychology, research, training/ development.

Appointed: February 2021

Kate North
Joint executive director for people and culture
Prior to joining our Trust as Deputy Director of People and Culture in 2021, Kate has spent her career working across a number of health and care organisations in the North of England including local authority, acute, community and mental health services. Kate has held a wide range of people related roles including head of human resources for adult social care, system talent lead for the North East and North Cumbria Integrated Care System and leadership of both workforce planning and equality diversity and inclusion across two NHS Trusts.

Kate is committed to promoting inclusive cultures, equity and fairness across our Trust through effective engagement, development and support of our staff and volunteers working into our communities.

Qualifications: Fellow of the Chartered Institute of Personnel and Development (FCIPD), Post Graduate Diploma in Human Resource Management, Post Graduate Certificate in Strategic Workforce Planning for Health and Care

Principal skills and expertise: Equality, Diversity and Inclusion, Human Resources/Employee Relations, Organisational Development, Strategic Workforce Planning

Appointed: September 2024 *as Job Share arrangement with Sarah Dexter-Smith*

Dr Kedar Kale
Executive medical director

Kedar is a Consultant in general adult psychiatry and has nearly 30 years' experience in the field.

He trained in Mumbai, India and worked there as a Consultant Psychiatrist before moving to England. He retrained in Norwich and later Cambridge (where he also obtained his MPhil), before moving to the North East working within Cumbria Northumberland Tyne and Wear NHS Foundation Trust (CNTW) for nearly 15 years as a Consultant Psychiatrist. He has held various leadership roles before taking up his current role.

His clinical practice is with early intervention in psychosis team currently. Previously he has worked with service users having long term conditions, providing holistic care and focusing on recovery.

He is passionate about continuous service improvement, coproduced with our service users and carers. He has led several improvement programmes over the years which brought significant change in practice and benefitted service users and staff.

He has enthusiastically trained postgraduate doctors for several years and is keen to ensure our Trust provides them a high quality training experience, and welcomes them as a place to work.

Qualifications: MBBS, DPM, MD, FRCPsych, MPhil

Principal skills and expertise: leadership, mentoring, teaching.

Appointed: June 2022

Naomi Lonergan
Interim managing director of Durham, Tees Valley and forensics care group
Naomi qualified as a social worker in 1996 and worked in health and social care throughout her career, moving to Tees, Esk and Wear Valleys NHS Foundation Trust in 2005. Naomi specialised in substance misuse services and has worked across specialities in adult mental health and mental health services for older people. Most recently she has been a director of operations for North Yorkshire and York, moving to secure inpatient services in Durham, Tees Valley and Forensic in 2022. Naomi has held several leadership positions in her career with the Trust and is passionate about improving services for the people in our communities.

Alongside her role in the Trust, Naomi works as a volunteer in the charitable sector and as a Trustee at a learning disability charity.

Qualifications BA (Hons) Diploma in social work, leadership in management, quality improvement certified lead
Principle skills and expertise: leadership coaching and mentoring, and quality improvement.

Appointed: September 2024 as interim managing director

Beverley Murphy
Chief nurse
Beverley has worked as a chief operating officer, chief nurse and deputy chief executive in a number of mental health organisations and is delighted to be back 'home' where she first trained as a nurse in 1985. Having worked as a mental health nurse for 40 years, Beverley has a held a range of clinical leadership roles including in nurse led eating disorder care, in acute inpatient care and in forensic mental health. Beverley has actively sought roles in mental health Trusts where improvement was required by regulators.

Beverley is committed to delivering consistently high-quality care to every person, every day and to do so supports the development of nursing practice and nurse leadership. Beverley is a council member of the national Forum for Mental Health and Learning Disability Nursing Directors and in 2024 co-authored practice principles to guide enhanced care. Beverley is an active coach and mentor and is currently undertaking formal executive coach training at Tavistock Consulting.

Qualifications: RMN, MA

Principle skills and expertise: leadership, quality governance, quality improvement, professional development, and executive coaching.
Appointed: May 2023

Liz Romaniak
Executive director of finance, estates and facilities
Liz joined the NHS over 34 years ago and has extensive associate/deputy director and executive board-level experience from roles within commissioning and community and mental health provider organisations. Liz's previous role was as director of finance, contracting and estates at Bradford District Care NHS Foundation Trust, where she led work in 2014 to 2015 to develop the organisation's long term financial plan and successfully navigate all financial aspects of the trust's Monitor FT application and due diligence processes. Liz also had responsibility for planning and performance and between 2017-2021, was deputy chief executive, both roles affording opportunities to develop greater operational and clinical perspectives. Liz has lobbied, including via NHS representative bodies, for parity of esteem (and resources) for mental health, including relating to capital developments. Liz is also a board member of the AuditOne NHS Audit consortium.

Since joining the Trust she led work to successfully navigate and settle a significant legal case between 2020 and 2024, and is an active member of two national finance Committees of the HFMA.

Qualifications: qualified accountant, ACMA
Principal skills and expertise: NHS finances (strategy, costing, financial accounting and management, commissioner and provider), financial strategy, planning and performance management.

Appointed: October 2020

Patrick Scott
Deputy chief executive
Having started out as a health care assistant over 30 years ago, Patrick has extensive senior level NHS experience across both hospital and community services both as senior clinician and operational leader and is passionate about value driven care and the concept of co-creation. Prior to his current role, he was the chief operating officer at Bradford District Care NHS Foundation Trust and was previously the director of operations at TEWV before joining Bradford. He returned to the Trust in April 2022 as managing director of Durham, Tees Valley, and Forensics care group, and is currently the full time Deputy Chief Executive of the Trust.

Patrick has a strong track record of working with clinicians, service users and commissioners across health and social care to drive service transformation, continuous quality improvement, service developments and growth. He has also played a leading role in integrated care partnerships across the north east, working collaboratively with partners to jointly develop and deliver new services.

Qualifications: RMN; MSC in Evidence Based Practice; Post Grad certification in Strategy, Policy and Leadership; Diploma in the Care and Management of Individuals Displaying Suicidal and Parasuicidal Behaviour.

Principal skills and expertise: Operational delivery; performance management; strategic planning and system working; quality improvement; governance.

Appointed: April 2022

Statement on the Independence of each non-executive director

The Trust confirms that each non-executive director is considered independent taking into account the criteria set out in the Code of Governance.

Changes to the group board of directors during 2024/25

Jill Murray, non-executive director retired from the Board, at the end of her term of office in August 2024, following her appointment as the chief executive of the homeless veterans' charity, Launchpad.

Mike Brierley, assistant chief executive, retired from the Board in August 2024.

Jane Robinson and Catherine Wood joined the Board as non-executive directors in December 2024,

The following interim arrangements were introduced during the year:

- Patrick Scott's role as the deputy chief executive was expanded to fulltime to take on the majority of the portfolio of the assistant chief executive.

- Naomi Lonergan became the managing director of the Durham Tees Valley and Forensics Care Group
- Kate North was appointed as the joint executive director of people and culture with Sarah Dexter-Smith

Registers of Interests

Details of company directorships or other material interests in companies held by directors which might conflict with their responsibilities are included in the "Registers of Interests". This document is available for inspection on our website www.tewv.nhs.uk.

Accounting policies

The Trust prepared the financial statements in accordance with the NHS Group Accounting Manual (GAM) for 2024-25 as directed by NHS England, and fully complies with accounting requirements as set out in International Financial Reporting Standards (IFRS).

The Trust's accounting policies are set out in the Annual Accounts and have been consistently applied over the comparator period. The Trust reported Group accounts for the first time, consolidating its subsidiary company Positive Individual Proactive Support Ltd. Prior year comparators in financial statements and notes have been restated to reflect Group totals.

Accounting information

The accounts are independently audited by Forvis Mazars LLP as external auditors in accordance with the Health and Care Act 2022 and the National Audit Office Code of Audit Practice. As far as the directors are aware, all relevant audit information has been fully disclosed to the auditor and no relevant audit information has been withheld or made unavailable. Nor have any undisclosed post balance sheet events occurred.

No political or charitable donations were made by the Group during 2024-25.

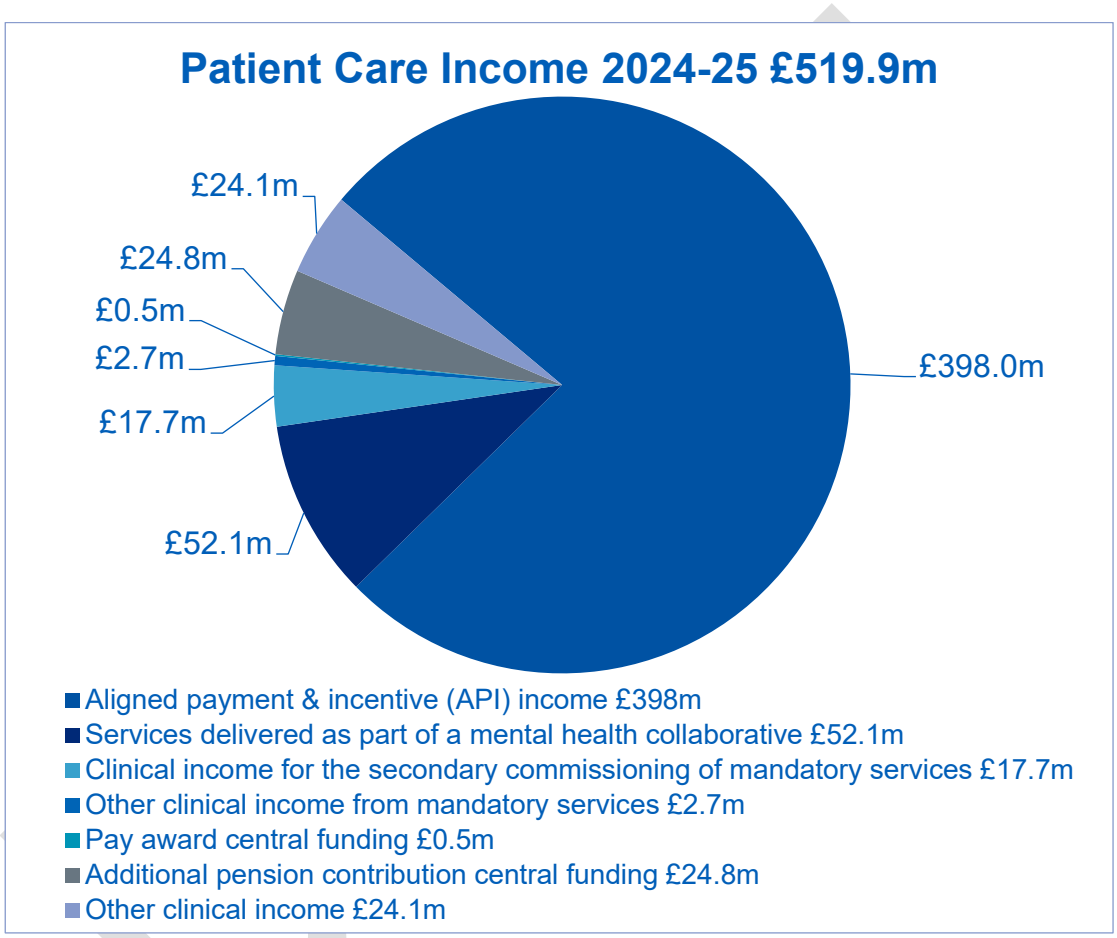
Accounting policies for pensions and other retirement benefits are set out in the accounts, and details of senior managers remuneration can be found in the remuneration report.

The Group has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Income generation

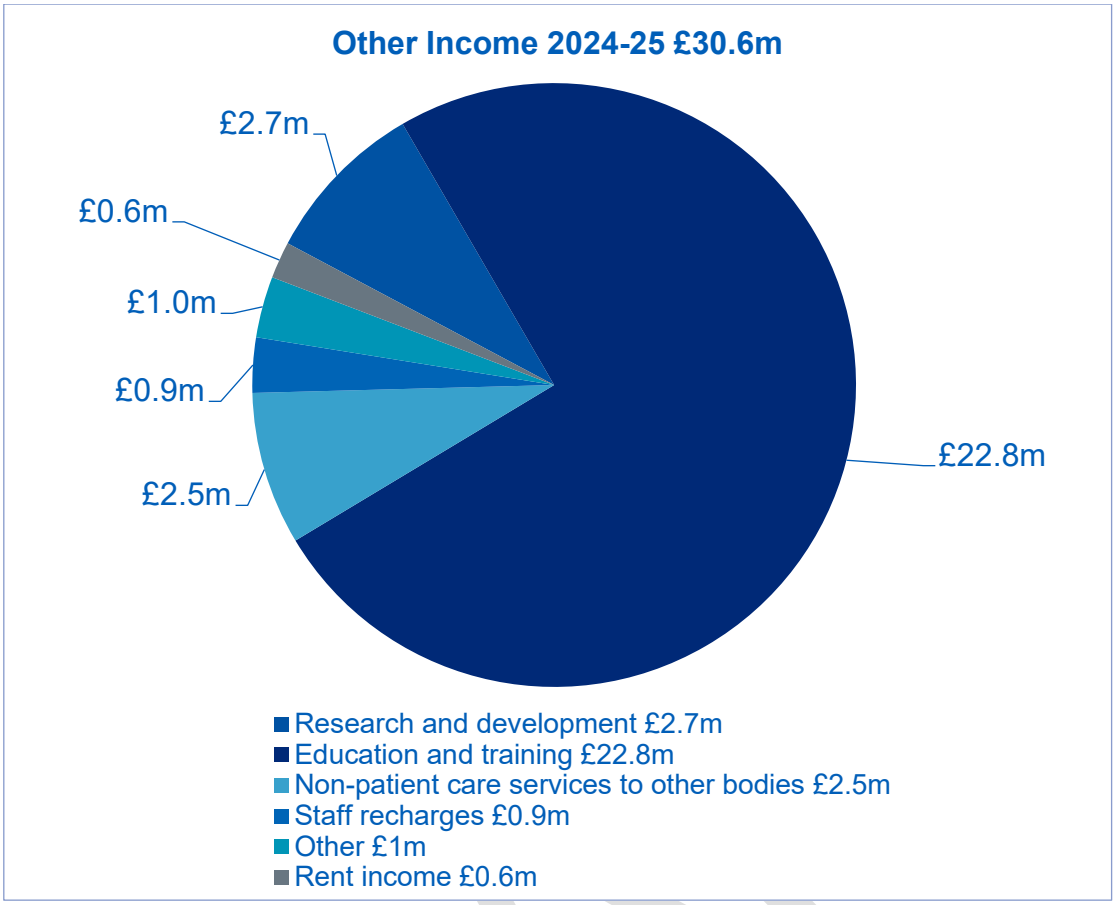
During 2024-25, income generated was £550.46m from a range of activities; 94.4% being from direct patient care.

This included patient care income totalling £519.90m which came from the following areas:



API income is received mainly from North East and North Cumbria ICB, Humber and North Yorkshire ICB, and NHS England. The additional pension contributions were received from NHS England. Other clinical income is from Offender Health services, Local Authorities and Primary Care Networks.

A further £30.59m was received in respect of education and training, research and development and other non-patient care services.



As shown above, the Trust's income from the provision of goods and services for the purposes of health services in the UK was greater than its income from the provision of goods and services for any other purposes. The provision of goods and services for any other purposes had no negative impact on the provision of health services.

Better Payment Practice Code

The Better Payment Practice Code, which monitors the prompt payment of suppliers by the Public Sector, requires that the Group aims to pay all undisputed invoices by the due date, or within 30 days of receipt of goods or a valid invoice, whichever is later.

It is Group policy to pay all creditors as they fall due, unless extenuating circumstances are apparent, e.g. a dispute in the amount being charged, or the services or goods provided. Improving performance for Non-NHS suppliers remains a key priority, including through the use of No Purchase Order No Payment procedures ('No PO, no Pay') within the Trust.

Performance for the financial year 2024-25 showed an improvement compared to prior year and was as follows:

	2024-25	
	Number of Invoices	**Value of invoices £000s**
NHS Creditors		
Total bills paid	2,069	22,431
Total bills paid within target	2,012	21,439
Percentage of bills paid within target	**97.25%**	**95.58%**
Non-NHS Creditors		
Total bills paid	72,660	114,904
Total bills paid within target	69,195	111,103
Percentage of bills paid within target	**95.23%**	**96.69%**
Total Creditors		
Total bills paid	74,729	137,335
Total bills paid within target	71,207	132,542
Percentage of bills paid within target	**95.29%**	**96.51%**

The total potential liability to pay interest on invoices paid after their due date during 2024-25 would be £2,279,006, a decrease on the estimated potential prior year liability (2023-24: £3,435,402). There have been minimal claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

NHS England's 'well-led' Framework

In this section of the Annual Report we provide an overview of how the Trust has had regard to NHS Improvement's well-led framework in arriving at our overall conclusions about the position of the organisation.

The eight domains of the well-led framework are as follows:

- Clarity of vision and a credible strategy
- Leadership capacity and capability
- Clarity of roles and systems of accountability
- The appropriateness and accuracy of information
- Engagement with service users and carers, the public, staff and external stakeholders
- Learning, continuous improvement and innovation
- Processes for managing risks, issues and performance
- Culture

A key focus for the year has been the refresh of our strategy which was approved by the Board in April 2025. Information on the development of Our Journey to Change – The Next Chapter is provided in the Accountability Report.

In previous annual reports we have highlighted the improvements we have made in response to the best practice described in a range of governance reviews; provided by NHSE's intensive support team; and following inspections and investigations undertaken by the Care Quality Commission (CQC) and Niche

During 2024/25 we have made significant progress across the domains of the well-led framework. Key areas include:

- The completion of the CQC implementation plan (developed in response to the Trustwide inspection in 2023)
- Assurance from Niche on changes in both practice and governance which have been delivered within relevant services since the events which led to the firm's patient safety reports (commissioned by NHS England) published in 2022/23
- The signing off of the action plan developed in response to the governance review undertaken by Deloitte LLP in 2023/24 which covered the following three broad themes:
    - Strategy
    - Governance arrangements
    - Supporting governance arrangements

Overall, we consider that, taking into account the well-led domains, we continue to make significant progress in strengthening our leadership, governance, risk and internal control arrangements,

Further information on our governance framework and internal control arrangements is provided in the Annual Governance Statement.

The NHSI Well-led Framework is available at: www.england.nhs.uk/well-led-framework/

(Note: Deloitte LLP has no other connection with the Trust or individual directors).

CQC inspection report

The most recent Care Quality Commission (CQC) trust-wide inspection was published in October 2023. At that time our overall rating stayed at requires improvement and the CQC recognised that we're making progress. Seven out of 11 of our services were rated 'good' and four areas were rated as 'requires improvement'. Overall, the service line ratings were an improvement since our last inspection in 2021. All services were rated 'good' for caring, and nine out of 11 services were rated 'good' or 'outstanding' for effective. An improvement plan was developed following the inspection which has now concluded, an independent internal audit has offered substantial assurance that actions have been delivered in line with internal reports to the Trust board of directors.

The most recent inspection was of mental health crisis services and health-based places of safety Trustwide. The report was published in February 2025 and the speciality rated as 'good' overall with rating of good for safe, effective, caring, and responsive and, 'requires improvement' for well-led.

We are continuing to focus on Our Journey to Change to set the direction, we know there's more to do and we're committed to continuous improvement across all services.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Requires Improvement →← Oct 2023	Requires Improvement →← Oct 2023
Community-based mental health services of adults of working age	Requires Improvement ↓ Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Requires Improvement →← Oct 2023	Good ↑ Oct 2023	Requires Improvement →← Oct 2023
Wards for older people with mental health problems	Requires Improvement →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Community mental health services for people with a learning disability or autism	Requires Improvement ↓ Oct 2023	Good ↑ Oct 2023	Good ↓ Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023
Forensic inpatient or secure wards	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Specialist community mental health services for children and young people	Requires Improvement Sept 2022	Good Dec 2021	Good Dec 2021	Requires Improvement Dec 2021	Requires Improvement Dec 2021	Requires Improvement Dec 2021
Community-based mental health	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020

services for older people						
Wards for people with a learning disability or autism	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Requires Improvement →← Oct 2023	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023
Specialist eating disorder service	Requires Improvement Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Mental health crisis services and health-based places of safety	Requires Improvement ↓ June 24	Good →← June 2024	Good →← June 2024	Good →← June 2024	Good →← June 2024	Good →← June 2024

The report on the CQC's last inspection of PIPs was published in May 2023 with the company rated as follows:

	Safe	Effective	Caring	Responsive	Well-led	Overall
PIPs	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

The remuneration report

Introduction

In the remuneration report we disclose information on those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Group. This means those who influence the decisions of the Group as a whole rather than the decisions of individual directorates or sections within the NHS foundation trust.

The terms and conditions of service of the Group's executive directors and senior managers are overseen by the Nomination and Remuneration Committees.

Annual Statement on remuneration

In accordance with the NHS Code of Governance, levels of remuneration should be sufficient to attract, retain and motivate directors of quality, with the skills and experience required to lead the trust successfully, and collaborate effectively with system partners.

In 2023/24, the Nomination and Remuneration Committee of the Board of Directors concluded a review of pay for very senior managers based on national and regional comparator benchmarking information.

In 2024/25, the Committee approved:

- A 5% cost of living uplift to all staff on very senior manager contracts (which includes all executive directors) as recommended by the Senior Salaries Review Body and accepted by the Secretary of State for Health and Social Care.
- Reviewed the remuneration of a number of posts linked to interim structure changes.

Bev Reilly

Chair of the Board's nomination and remuneration committee

(NOTE: The remuneration of Directors of PIPS is determined by its Board of Directors)

Policy disclosures

Basic pay	The VSM Pay Framework is based on the national benchmarking for comparable providers and comparable roles. We have reviewed these when new appointments were made in line with the national benchmarks. The same committee reviews the objectives and appraisals of the executive directors to ensure: • Through these arrangements the Trust has satisfied itself that senior managers' remuneration is reasonable. • The basic pay arrangements support the short and long-term strategic objectives of the Trust by enabling the Trust to recruit and retain talented individuals who undertake key leadership roles using levels of remuneration that represent value for money and which are comparable to or lower than those of other similar organisations.
Performance related Components	There are no performance-related components

Recruitment and Retention Premia (RRP)	The Nomination and Remuneration Committee has the option of paying Recruitment and Retention Premia (RRP) but these should only be paid where there is clear evidence that the payments can be justified. No VSM staff were paid this during 2023/24.
Allowances	Car and on call allowances are included within basic pay.
Provisions for the recovery of sums paid to directors or for withholding payments of sums to senior managers	There is contractual provision for making appropriate deductions from notice period payments. Entitlement to pay progression, where applicable, is subject to confirmation from the individual's line manager that their performance over the preceding 12 months period has been rated as being good. The Nomination and Remuneration Committee of the Board of Directors agreed to the incorporation of an 'earn back' clause whereby up to 10% of salary is put at risk pending an annual review of performance against objectives set. This has not been applied to any VSM staff this year.
Remuneration above £150,000	A comparison is undertaken with the national benchmarking. All the VSM salaries are reported nationally through the national survey.
Arrangements specific to individual senior managers	Not applicable

- Service contracts obligations: none identified.
- Policy on payment for loss of office: a contractual entitlement to three months' notice, other than in the case of summary dismissal. Where eligible an entitlement to a redundancy payment in accordance with Section 16 of the National Terms and Conditions of Service.
- Diversity and inclusion: The Nomination and Remuneration Committee's approach to diversity and inclusion is based on the Trust's Human Rights, Equality and Diversity Policy. This policy, which is available on the Trust's website, lays down expected standards in relation to equality, diversity and human rights in employment and service delivery. This was actively considered in relation to the gender pay gap and the varying salaries amongst VSM colleagues. The standards in the policy are that we:
    - Respect and protect the human rights of all patients, colleagues and anyone else who has a relationship to the Trust.
    - Take breaches of policy very seriously, particularly those that when breached have a harmful effect on other people. Victimisation, harassment, discrimination (or an attempt to do so) and bullying will not be tolerated and will, where substantiated, lead to disciplinary action.
    - Colleagues who identify with protected groups have the right to be treated fairly and with dignity and respect and without the fear of unlawful discrimination, harassment, victimisation or bullying.

- Commit to the ongoing development of staff awareness and knowledge of equality, diversity and human rights. Staff development begins on employment and continues throughout an individual's career until they leave the Trust.
- Commit to monitoring, evaluating and reporting on issues of equality, diversity and human rights in employment and service provision.
- Work towards best practice standards of equality, diversity and human rights and not merely comply with legislation.
- Promote equality, foster good relations and take an anti-discriminatory approach in all areas of employment and service delivery.
- Ensure barriers to accessing services and employment are identified and removed so that no person is treated less favourably because they identify with a protected group/s.
- Recognise the importance of this policy in the employment relationship it has with its staff and in provision of services for patients, and will reflect this commitment in all Trust policies, procedures and practices.

The policy extends outside the workplace and Trust staff should be aware that workplace behaviour includes time when they are not physically at work but are participating in activities where work is a factor, for example, team nights out, shopping trips with colleagues etc.

This is because abusive, discriminatory and/or unethical behaviour outside of work could still affect the relationship between the Trust and its employees, particularly if it is deemed to be so serious that it would warrant disciplinary action or allegations of gross misconduct, as would be the case if the individual or group concerned were at work.

The policy supports the delivery of the Trust's Equality Strategy. Progress on the delivery of the equality objectives, included in the strategy, is monitored by the Equality, Diversity and Human Rights Steering Group.

Further information on equality and diversity is provided in the Accountability Report, while demographic information on the Trust's senior managers is provided in the Staff Report.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

A combination of an independent job evaluation scheme, to establish respective job weights, and independently gathered and reported information about Very Senior Manager (VSM) remuneration levels in comparable Trusts were used to establish the original VSM Pay Framework.

Capita undertook the job evaluation exercise and provided information about remuneration levels of equivalent posts within comparable organisations. This information has been used by the Nomination and Remuneration Committee to establish and operate the VSM Pay Framework since 2014. This includes

consideration of updated independent remuneration reports. Since then, the national benchmarking process, which we also contribute to, has been the foundation on which we have reviewed our own scales

Trust non-executive director remuneration

Basic Remuneration	The basic fees payable to the Chair and Non-Executive Directors have been set by the Council of Governors taking into account information provided by Capita on fees payable by other Foundation Trusts. Associate Non-Executive Directors receive the same level of remuneration as the Non-Executive Directors. The Non-Executive Directors have not received an increase in their remuneration since 2013/14. In 2024/25 the Council of Governors agreed to reinstate annual reviews of remuneration in 2025/26.
Additional fees paid for other duties	Additional fees are payable to the Deputy Chair, the Chair of the Audit and Risk Committee and the Senior Independent Director.
Allowances	The Chairman and Non-Executive Directors are able to claim reimbursement of expenses (for example travel) in line with Trust policy.

Beverley Murphy
Acting Interim Chief Executive

25 June 2025

Senior managers' remuneration (subject to audit)

Name and Title	2023-24						2022-23					
	Salary ****	Other Remuneration **	Benefits in Kind *	Pension related benefits *****	Total Remuneration	Expenses Paid	Salary	Other Remuneration ***	Benefits in Kind *	Pension related benefits	Total Remuneration	Expenses Paid
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £2500) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £2500) £000	(bands of £5000) £000	Rounded to the nearest £100
Mr Brent Kilmurray, Chief Executive***	215 - 220	-	1,700	87.5 - 90.0	305 - 310	2,000	195 - 200	0 - 5	4,400	12.5 - 15.0	215 - 220	1,500
Mrs Zoe Campbell, Managing Director North Yorkshire York and Selby	140 - 145	-	0	32.5 - 35.0	175 - 180	400	130 - 135	0 - 5	0	30.0 - 32.5	170 - 175	700
Mr Patrick Scott, Deputy Chief Executive & Managing Director Durham Tees Valley and Forensic Services ***	135 - 140	-	8,700	-	145 - 150	0	135 - 140	0 - 5	3,800	-	145 - 150	0
Mrs Naomi Lonergan, Managing Director Durham Tees Valley and Forensic Services (Started	75 - 80	-	8,900	-	85 - 90	0	-	-	-	-	-	-

01 September 2024)***												
Mrs Liz Romaniak, Director of Finance, Estates and Capital	155 - 160	-	0	15.0 - 17.5	170 - 175	0	145 - 150	0 - 5	0	-	150 - 155	300
Mrs Beverley Murphy, Chief Nurse (started 01 May 2023)***	140 - 145	-	1,100	-	140 - 145	4,100	120 - 125	0 - 5	800	-	125 - 130	0
Dr Kedar Kale, Medical Director ***	165 - 170	-	20,400	-	185 - 190	1,300	170 - 175	5 - 10	1,900	567.5 - 570.0	750 - 755	1,600
Dr Sarah Dexter-Smith, Joint Director of People and Culture	120 - 125	-	0	17.5 - 20.0	140 - 145	2,200	130 - 135	0 - 5	0	-	135 - 140	1,600
Mrs Kate North, Joint Director of People and Culture (Started 01 September 2024)	60 - 65	-	0	77.5 - 80.0	140 - 145	300	-	-	-	-	-	-
Mr Mike Brierley, Assistant Chief Executive (left 31 August 2024)***	60 - 65	-	200	-	60 - 65	700	120 - 125	0 - 5	1,300	-	125 - 130	400
Mrs Ann Bridges, Director of	115 - 120	-	4,400	27.5 - 30.0	150 - 155	1,000	115 - 120	0 - 5	1,900	27.5 - 30.0	145 - 150	800

Corporate Affairs and Involvement***												
Dr Hannah Crawford, Director of Therapies***	125 - 130	-	900	7.5 - 10.0	135 - 140	1,000	120 - 125	0 - 5	800	127.5 - 130.0	250 - 255	0
Mr David Jennings, Chair	50 - 55	-	0	-	50 - 55	2,600	50 - 55	-	0	-	50 - 55	3,400
Prof. Pali Hungin, Non-Executive Director (left 28 February 2024)	-	-	-	-	-	-	10 - 15	-	0	-	10 - 15	400
Mrs Beverley Reilly, Deputy Chair	20 - 25	-	0	-	20 - 25	1,000	20 - 25	-	0	-	20 - 25	900
Mr John Maddison, Non-Executive Director & Chairman of the Audit and Risk Committee	15 - 20	-	0	-	15 - 20	0	15 - 20	-	0	-	15 - 20	0
Dr Charlotte Carpenter, Non-Executive Director and Chair of the Resources and Planning Committee	10 - 15	-	0	-	10 - 15	0	10 - 15	-	0	-	10 - 15	0

Mrs Jillian Murray, Non-Executive Director (left 31 August 2024)	5 - 10	-	0	-	5 - 10	100	10 - 15	-	0	-	10 - 15	1,100
Mr Jules Preston, Non-Executive Director, Senior Independent Director and Chair of the Charitable Funds Committee	15 - 20	-	0	-	15 - 20	2,400	15 - 20	-	0	-	15 - 20	1,100
Mrs Roberta Barker, Non-Executive Director and Chair of the People, Culture and Diversity Committee and Interim Chair of the Mental Health Legislation Committee	10 - 15	-	0	-	10 - 15	0	10 - 15	-	0	-	10 - 15	0
Mrs Jane Robinson, Non-Executive Director (started 01 December 2024)	0 - 5	-	0	-	0 - 5	100	-	-	-	-	-	-
Ms Catherine Wood, Non-Executive	0 - 5	-	0	-	0 - 5	400	-	-	-	-	-	-

Director (started 01 December 2024)												

Fair pay disclosures relating to the Foundation Trust (subject to audit)

Remuneration ranged from		0 - 5
Remuneration ranged to		305 - 310
Band of highest paid directors total remuneration (£000)		215 - 220
Percentage increase from prior year of highest paid director salary		10.1%
Percentage increase from prior year of median salary		5.5%

Remuneration ranged from	10 - 15
Remuneration ranged to	750 - 755
Band of highest paid directors total remuneration (£000) #	195 - 200
Percentage increase from prior year of highest paid director salary #	11.3%
Percentage increase from prior year of median salary #	5.0%

The above table shows the remuneration for time worked as a senior manager only. Where this was for part year (dates shown in table) the table reflects this.

* Benefits in kind are the provision of lease cars.

** Other remuneration includes a non-consolidated pay award made during the reported period, and a clinical excellence award for the medical director.

*** These directors have salary sacrifice schemes which can result in increases and decreases in pension related benefits as schemes are entered into and withdrawn from.

In 2024-25, 23 (2023-24, 29) employees received remuneration in excess of the highest-paid director / member.

Pension related benefits

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. Decreases in pension are shown as zero.

The pension benefit table provides further information on the pension benefits accruing to the individual.

2024-25	25th percentile	Median	75th percentile
Salary component of pay	25,674	36,483	46,148
Total pay and benefits excluding pension benefits	29,114	38,844	48,526
Pay and benefits excluding pension: pay ratio for highest paid director	7.5:1	5.6:1	4.5:1

2023-24	25th Percentile	Median	75th percentile
Salary component of pay	24,336	34,581	42,618
Total pay and benefits excluding pension benefits	27,151	35,675	46,091
Pay and benefits excluding pension: pay ratio for highest paid director	7.3:1	5.5:1	4.3:1

Beverley Murphy
Acting Interim Chief Executive

25 June 2025

Senior managers' pension benefits (subject to audit)

Name and title	Real increase in pension at retirement age for time in post	Real increase in pension lump sum at retirement age for time in post	Total accrued pension at retirement age at 31 March 2025	Lump sum at retirement age related to accrued pension at 31 March 2025	Cash Equivalent Transfer Value at 31 March 2025	Cash Equivalent Transfer Value at 31 March 2024	Real Increase in Cash Equivalent Transfer Value for time in post less employee pension contributions
	(bands of £2500) £000	**(bands of £2500) £000**	**(bands of £5000) £000**	**(bands of £5000) £000**	**£000**	**£000**	**£000**
Mr Brent Kilmurray, Chief Executive	5.0 - 7.5	2.5 - 5.0	75 - 80	200 - 205	1,786	1,557	96
Mrs Liz Romaniak, Director of Finance, Information and Estates	0.0 - 2.5	-	65 - 70	175 - 180	1,523	1,384	25
Dr Kedar Kale, Medical Director	-	-	65 - 70	165 - 170	1,471	1,606	0
Dr Sarah Dexter-Smith, Joint Director of People and Culture	0.0 - 2.5	-	40 - 45	110 - 115	962	866	19

Mrs Kate North, Joint Director of People and Culture (Started 01 September 2024)	5.0 - 7.5	-	50 - 55	-	866		119
Mrs Zoe Campbell, Managing Director North Yorkshire York and Selby	2.5 - 5.0	-	5 - 10	-	122	73	25
Mr Patrick Scott, Deputy Chief Executive & Managing Director Durham Tees Valley and Forensic Services	-	-	75 - 80	210 - 215	1,792	1,778	0
Dr Hannah Crawford, Director of Therapies	0.0 - 2.5	-	45 - 50	110 - 115	1,011	920	12

Mrs Ann Bridges, Director of Corporate Affairs and Involvement	0.0 - 2.5	-	5 - 10	-	126	84	21

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

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

Benefits and related CETVs do not include values for a future adjustment for eligible employees arising from the McCloud judgment.

Decreases in pension values are shown as zero.

Beverley Murphy
Acting Interim Chief Executive

25 June 2025

Expenses of Governors

At 31 March 2025 the Trust had 30 Governors (31 March 2024, 34), with 6 receiving reimbursement of expenses (2023-24, 17). The total amount reimbursed as expenses was £1,592, (£820 in 2023-24).

Pay terms and conditions

With the exception of directors, non-executives and medical staffing the workforce are covered by Agenda for Change. All inflationary uplifts for staff employed under national terms and conditions have been in accordance with nationally determined pay arrangements. All executive directors are on a permanent contract and have a notice period of 3 months.

The nomination and remuneration committee is responsible for executive directors pay.

Beverley Murphy
Acting Interim Chief Executive

25 June 2025

The staff report
Staff costs - Group (subject to audit)

	Permanent	Other	2024/25 Total	2023/24 Total
	£000	£000	£000	£000
Salaries and wages	317,425	28,611	**346,036**	314,296
Social security costs	30,132	2,638	**32,770**	31,830
Apprenticeship levy	1,477	134	**1,611**	1,563
Employer's contributions to NHS pension scheme	57,630	5,208	**62,838**	50,623
Pension cost - other	363	7	**370**	324
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	11,555	**11,555**	18,701
NHS charitable funds staff	-	-	**-**	-
Total gross staff costs	**407,027**	**48,153**	**455,180**	**417,337**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**407,027**	**48,153**	**455,180**	**417,337**
Of which				
Costs capitalised as part of assets	1,045	245	**1,290**	2,720

Average number of employees (WTE basis)

	Permanent	Other	2024/25 Total	2023/24 Total
	Number	Number	Number	Number
Medical and dental	314	145	**459**	439
Ambulance staff	-	-	**-**	-
Administration and estates	1,661	85	**1,747**	1,734
Healthcare assistants and other support staff	2,085	-	**2,085**	2,151
Nursing, midwifery and health visiting staff	2,301	488	**2,789**	2,833
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	587	248	**834**	873
Healthcare science staff	-	-	**-**	-
Social care staff	138	-	**138**	86
Other	12	-	**12**	16
Total average numbers	**7,098**	**967**	**8,064**	**8,131**
Of which:				
Number of employees (WTE) engaged on capital projects	22	0	**22**	39

Demographic information - Trust

The table below shows the minimal change in proportions of male and female staff over this financial year and the slight growth in overall workforce numbers. For senior staff there has been an increase in the proportion of executive directors who are female and a consistent picture for non -executive directors.

	March 2024		March 2025	
Female Staff	6509	79.5%	6593	78.99%
Male Staff	1675	20.5%	1754	21.01%
	8184		**8347**	

	March 2024			March 2025		
	Female	Male	Total	Female	Male	Total
Executive Directors	6	4	10	8	2	10
Non-Executive Directors	5	2	7	4	2	6
Other Very Senior Managers	2	5	7	2	5	7
			24			**23**

Sickness and absence data

Information on sickness absence up to and including December 2024 for the Trust is available via:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Occupational health

Our Trust's occupational health service contract with People Asset Management (PAM) came to an end on 31 March 2025 and after an appropriate procurement process, a new provider, Optima Health now provides these services from 1 April 2025.

Provision includes a range of services including pre-employment screening, vaccination and immunisation, needlestick support and specialist occupational health employment advice. We continue to work collaboratively to maintain and improve staff health and wellbeing.

Employee assistance/counselling services are provided via VIVUP who also provide a range of staff benefits. These services are in addition to our comprehensive in-house staff wellbeing support such as the employee support service, employee psychology service, mindfulness and many more.

Staff policies and actions applied/taken during the year

The Trust has a range of policies and procedures which support our commitment to being a good employer and providing equal opportunities to present and potential employees.

Our recruitment and selection procedure is followed for each recruitment episode.

The procedure has been equality impact assessed, ensuring application of the procedure does not impact negatively on people with disabilities.

We are signed up to the disability confident scheme and guarantee an interview to all applicants with a disability who meet the minimum essential criteria for a job vacancy. We make reasonable adjustments to support candidates through the recruitment process if this is required. We advise recruiting managers to check whether their new starter requires any reasonable adjustments to be put in place due to a disability/long-term health condition and encourage them to contact Access to Work at their earliest opportunity and direct them to our Reasonable Adjustments Team for support.

Specific advice can be gained from occupational health as to recommendations to support a staff member whilst at work. Reasonable adjustments will be made for staff with disabilities. We have a dedicated reasonable adjustment team which supports this process along with our workplace adjustments procedure. If a staff member can no longer work in the role they are employed, we will explore redeployment into another suitable alternative role.

We are fully committed to ensuring all colleagues with disabilities and long-term health conditions have a positive experience and equitable access to training, career development and promotion. To facilitate this, our reasonable adjustment team and reasonable adjustments procedure provides for individual workplace adjustment plans detailing the adjustments that staff would need to undertake their job role, access training and career development and achieve promotion.

We provide a number of health and wellbeing support mechanisms to help staff throughout their employment. Our Staff Led Health & Wellbeing Council has awarded £74,758 in charitable funds in the past 12 months to various teams within the Trust for projects which support the health and wellbeing of staff. We have a

thriving network of more than 350 Health & Wellbeing champions who help to embed, improve and share the health and wellbeing offers available to staff.

We regularly share information with colleagues on matters of concern to them, as employees, through our weekly staff briefing and on our staff intranet.

The CEO regularly hosts webinars for all staff, co-hosted with other directors or other staff members depending on the focus.

We hold regular “working together in our trust” coffee break type sessions for staff to talk with the Joint Directors for People and Culture and other leads about anything relating to employment in the Trust. The Director for Corporate Affairs and Involvement also regularly attends these. This also allows an opportunity for people and culture colleagues to share progress on workforce delivery plans, updates on our people journey and other developments which impact our workforce.

The Joint Directors for People and Culture continue to meet with the chairs of the staff networks on a bi-monthly basis and each staff network is sponsored by an executive director ensuring that their concerns are heard and acted on.

Local consultative committees (LCC) take place regularly within each care group and corporate services. A joint consultative committee (JCC) also takes place bi-monthly. Items affecting the workforce are discussed at both LCC and JCC, at which staff side representation are in attendance. A pay and workforce group was fully embedded in 2023 and reports to JCC. This group negotiates on workforce related local agreements in a timely way submitting proposals to JCC for consideration. Staffside sit on all workforce groups in the Trust

For any formal changes affecting the workforce we follow the organisational change procedure. Consultation consists of group meetings and one to one meetings with staff (along with staff side representation). Staff have an opportunity to provide comments in relation to proposals prior to implementation.

Countering fraud and corruption

Our Trust has an established anti-fraud and corruption policy which aims to minimise the risk of fraud, bribery or corruption by detailing the key roles and responsibilities of employees and related parties as well as promoting an anti-fraud culture.

The policy and related materials are available on our Trust’s intranet, and counter-fraud information is prominently displayed both on the Trust's intranet and throughout our premises.

The Trust’s Local Counter Fraud Specialist (LCFS) reports to each audit and risk committee, and through an annual report, and agrees a programme of work designed to provide assurance to the committee and Trust Board about fraud and corruption.

The LCFS provides regular fraud awareness sessions to staff, investigates concerns reported by staff and liaises as necessary with the police. If any issues are substantiated, we take appropriate criminal, civil or disciplinary measures.

Staff turnover

Through 2024-25 the Trust addressed multiple factors and instigated an internal transfer scheme and an independent thinking about leaving process. Our leavers' rate has fallen month on month, and we are now one of the higher performing Trusts nationally in terms of leaver rates.

NHS Workforce Statistics - December 2023 (Including selected provisional statistics for January 2024) - NHS England Digital

Staff experience and engagement

The following principles describe how the Trust will achieve our ambitions set out in our people journey - more people, working differently, in a compassionate and inclusive culture, and how we will work together:

- Co-creation
    - Ensuring everyone who works at our Trust has a voice – meaning that they are heard when they raise concerns or ideas, and they know that this has been listened to by colleagues and change is possible.
    - Working with service users and carers to understand how we can support our colleagues to provide a great experience of care.
    - Working with our partners, collaborating on regional priorities, working with education and training providers, social care and the voluntary sector so that our workforce is skilled, innovative and emotionally astute.
    - Working with our communities to build attractive and supportive routes into employment across the wide range of current and future roles that we embody.

- Value-based
    - Underpinned by our values of respect, compassion, and responsibility in the way we work, the way we behave, and the way the organisation is run.

- Centred around our clinical journey
    - Our future work will be prioritised and planned to support the ambitions of our clinical journey, to help to ensure patients and families have great experience of care.

NHS staff survey

The NHS staff survey is conducted annually. From 2021/22, the survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in 2020/21 and earlier years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2024/25 survey among Trust staff was 44% (2022/23: 48 %).

Scores for each indicator together with that of the survey benchmarking group are presented below.

Indicators ('People Promise' elements and themes)	**2024/25**		**2023/24**	
People Promise:	**Trust Score**	**Benchmarking Group**	**Trust Score**	**Benchmarking Group**
We are compassionate and inclusive	7.46	7.90	7.49	7.93
We are recognised and rewarded	6.32	6.83	6.37	6.90
We each have a voice that counts	6.81	7.31	6.92	7.35
We are safe and healthy	6.34	6.72	6.37	6.70
We are always learning	5.78	6.37	5.77	6.45
We work flexibly	6.57	7.34	6.58	7.25
We are a team	6.94	7.48	7.00	7.47
Staff engagement	6.86	7.49	6.94	7.46
Morale	6.06	6.66	6.07	6.61

	2024/25		2023/24	
	Trust score	**Benchmarking group score**	**Trust score**	**Benchmarking group score**
Equality, diversity	8.42	8.68	8.48	8.72
and inclusion	7.14	7.53	7.15	7.61
Health and wellbeing	59.35%	74.34%	59.93%	76.56%
Immediate manager works together with me to come to an understanding of problems	73.30%	81.29%	73.32%	81.04%
immediate manager is interested in listening to me when I describe challenges I face.	75.62%	83.59%	75.44%	82.84%
immediate manager cares about my concerns.	74.43%	81.78%	74.68%	82.09%
immediate manager takes effective action to help me with any problems I face.	71.23%	79.55%	70.75%	78.72%
Quality of appraisals	4.92	5.77	4.80	5.87
Quality of care	56.45%	79.18%	55.39%	80.42%
Safe environment – violence Patients/service users	16.70%	6.21%	14.31%	7.28%
Staff engagement	6.86	7.49	6.94	7.46

- We are ranked #12 against 21 mental health (MH) trusts for final response rate, who commission Picker for the survey. This is compared to #14 in 2023 (against 23 MH Trusts).
- We are ranked #9 in overall positive score change.
- All TEWV staff were invited to participate via email.
- The final response rate was 44% compared to 48% in 2023.
- 3521 participants in total – a decrease of 261 staff from 2023.

Future priorities and targets

Trust-wide priorities for 2024/25:

- Continued focus on quality of appraisals with the new appraisal system – TEWVision.
- Continue to focus on scope for growth career conversations. This will be to develop all managers to have these all-important conversations, which will support with Our Journey to Change and the strategic goals.
- There is a large piece of work underway to ensure all our systems are aligned so that future staff surveys accurately represent the directorates in the new structure (for information comms currently also reflects planning and performance, Trust board reflects a series of Trust-wide roles)
- Workforce planning across our Trust based on the NHS Long Term Workforce Plan which was released in June 2023.
- We have launched the first TEWV Leadership and Management Academy, where there will be a focus on developing our current and future leaders and managers.

Recording of Trade Union facility time (1st April 2024 – 31st March 2025) - Trust

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
37	8,063.55 FTE (calculated as per Regulations)

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	29
1 – 50%	5
51-99%	0
100%	3

Percentage of pay bill spent on facility time

First Column	Figures
Provide the total cost of facility time	£114,892 (calculated as per Regulations)
Provide the total pay bill	£ 442,836,000 (calculated as per Regulations)
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.28.%

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	**16% (calculated as per Regulations)**

during the relevant period ÷ total paid facility time hours) x 100	

Off payroll arrangements - Trust

Highly-paid off-payroll worker engagements as at 31 March 2025 earning £245 per day or greater:	Number
Number of existing engagements as of 31 March 2023	49
Of which:	
The number that have existed for less than 1 year at the time of reporting	11
The number that have existed for between 1 and 2 years at the time of reporting	24
The number that have existed for between 2 and 3 years at the time of reporting	7
The number that have existed for between 3 and 4 years at the time of reporting	4
The number that have existed for 4 or more years at the time of reporting	3

All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater	Number
Number of off-payroll workers engaged during the year ended 31 March 2023	96
Of which:	
Number not subject to off-payroll legislation	0
Subject to off-payroll legislation and determined as in-scope of IR35	96
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

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024	Number
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.	12

Consultancy Costs

Expenditure on consultancy costs was £74k during 2024-25. No arrangements for 2024-25 required access to national NHSE approvals for management consultancy work of £50k or above.

Ill health retirements **(Trust)**

During 2024-25 8 Trust employees retired early on the grounds of ill health; the value of these early retirements (from NHS Pensions) was £0.7m.

Exit packages (subject to audit) **(Group)**

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	-
£10,000 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-

£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**-**	**-**
Total cost (£)	£0	£0	**£0**

Reporting of compensation schemes - exit packages 2023/24

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	**Number**	**Number**
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	1	**1**
Total number of exit packages by type	**1**	**1**	**2**
Total resource cost (£)	£98,000	£241,000	**£339,000**

Exit packages: other (non-compulsory) departure payments

	2024/25		2023/24	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	**£000**	**Number**	**£000**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	1	241
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**-**	**-**	**1**	**241**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Gender pay gap

The Trust's latest gender pay gap report can be accessed via the Cabinet Office using the following link: https://gender-pay-gap.service.gov.uk/.

A copy of the report and previous reports are available on our Trust website which can be accessed via the following link:

https://www.tewv.nhs.uk/about/publications/gender-pay-gap-report-2024/

In addition pay gap reports in regard to other protected characteristics are available at:

Disability Pay Gap Report 2024:

https://www.tewv.nhs.uk/about/publications/disability-pay-gap-report-2024/

Equality Pay Gap Report 2024:

https://www.tewv.nhs.uk/about/publications/ethnicity-pay-gap-report-2024/

All the reports are also linked from the 'Why Choose TEWV' page

https://www.tewv.nhs.uk/careers/about/

Governance including the Foundation Trust Code of Governance Disclosures

In this section we provide information on the Trust's corporate governance arrangements. We explain who sits on the Board of Directors, its committees, and Council of Governors and how they operate.

How the Trust is governed

As a public benefit corporation, the Trust is required to have the following governance arrangements:

- A legally binding constitution
- A Non-Executive Chair
- A Board of Directors comprising Non-Executive and Executive Directors
- A Council of Governors comprising elected public and staff Governors and Governors appointed by key stakeholder organisations
- A public and staff membership

The Trust's Constitution requires both the Board and the Council of Governors to

- Observe the Nolan principles of Public Life of selflessness, integrity, objectivity, accountability, openness, honesty and leadership
- Seek to comply, at all times, with the Code of Governance

Statement on the Application of the Code of Governance

The code of governance, published by NHS England, provides an overarching framework for corporate governance and complements the statutory and regulatory obligations placed on NHS providers.

Tees, Esk and Wear Valleys NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis.

During 2024/25 the Trust complied with all the principles of the Code.

Under the Code of Governance the Trust is required to disclose the following information:

Code ref:	*Summary of Disclosure Requirement*	*Page(s)*
A 2.1	*The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to*	136 - 156

	tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	
Disclose A 2.3	*The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.*	12
A 2.8	*The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.*	*5 - 10*
B 2.6	*The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: has been an employee of the Trust within the last two years has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust has received or receives remuneration from the Trust apart from a director's fee, participates in the Trust's performance-related pay scheme or is a member of the Trust's pension scheme has close family ties with any of the Trust's advisers, directors or senior employees holds cross-directorships or has significant links with other directors through involvement with other companies or bodies has served on the Trust board for*	50

	more than six years from the date of their first appointment • is an appointed representative of the Trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	
B 2.13	*The annual report should give the number of times the board and its committees met, and individual director attendance.*	94 – 96 99 - 119
B 2.17	*For foundation Trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.*	120 98 93
C 2.5	*If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.*	*107 & 126*
C 2.8	*The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.*	*127*
C 4.2	*The board of directors should include in the annual report a description of each director's skills, expertise and experience.*	*40 - 50*
C 4.7	*All Trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the Trust or individual directors.*	*55 - 56*

C 4.13	*The annual report should describe the work of the nominations committee(s), including: the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.*	*98-99*
C 5.15	*Foundation Trust governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.*	*127 - 128*
D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	94
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	136 - 156
D 2.8	The board of directors should monitor the Trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	136 - 156

D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	10 - 11
E 2.3	Where a Trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings	Not applicable
Appendix B, para 2.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	121 125
Appendix B, para 2.14	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation Trust's website and in the annual report.	129 - 130
Appendix B, para 2.15	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation Trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	96 - 97
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one	Not applicable

	or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	

The Board of Directors

Our Board of Directors provides overall leadership and vision to the Trust and is ultimately and collectively responsible for all aspects of performance, including clinical and service quality, financial performance and governance.

The general statutory duty of our Board and each director, individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

Our Board of Directors:

- Has retained certain decisions to itself as set out in the reservation of powers and scheme of delegation (available on our website).
- Exercises certain functions in conjunction with our Council of Governors.

Any powers which the Board has not reserved to itself or delegated to a committee are exercised on its behalf by our Chief Executive.

Information on the Board Members as at 31st March 2025, including details of their qualifications, skills and expertise, is provided in the Accountability Report.

The Board considers that, as at 31st March 2025:

- Its composition meets the requirements of the National Health Service Act 2006 and the Constitution
- All its members are "fit and proper" persons to be Directors of the Trust in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- There is an appropriate balance and breadth of skills, knowledge and experience amongst the Non-Executive Directors
- All the Non-Executive Directors meet the independence criteria set out in the Foundation Trust Code of Governance

Statement on the Directors' responsibility for preparing the Annual Report and Accounts

The Directors are required under the National Health Service Act 2006, and as directed by NHS Improvement, to prepare accounts for each financial year.

NHS England, with the approval of HM Treasury, directs that these accounts shall show, and give a true and fair view of the NHS foundation trust's gains and losses, cash flow and financial state at the end of the financial year. NHS England further directs that the accounts shall meet the accounting requirements of the Department of Health Group Accounting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury.

In preparing these accounts, the Directors are required to apply on a consistent basis for all items considered material in relation to the accounts, accounting policies contained in the Department of Health Group Accounting Manual; make judgements and estimates which are reasonable and prudent; and ensure the application of all relevant accounting standards and adherence to UK generally accepted accounting practice for companies, to the extent that they are meaningful and appropriate to the NHS, subject to any material departures being disclosed and explained in the accounts.

The Directors are responsible for keeping proper accounting records which disclose, with reasonable accuracy, at any time the financial position of the Trust. This is to ensure proper financial procedures are followed, and that accounting records are maintained in a form suited to the requirements of effective management, as well as in the form prescribed for the published accounts.

The Directors are also responsible for safeguarding all the assets of the Trust, including taking reasonable steps for the prevention and detection of fraud and other irregularities.

Each of the Directors, holding office on 31st March 2025, confirms that the annual report and accounts, taken as a whole, are fair, balanced and reasonable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.

Attendance at Board meetings

The following table provides details of the attendance at the 8 meetings of the Board of Directors held during 2024/25:

Board Member	Position	No. of board meetings attended
David Jennings	Chair of the Trust	8

	Chair of Board of Directors Nomination & Remuneration Committee	
Brent Kilmurray	Chief Executive and Accounting Officer	8
Roberta Barker	Non-Executive Director Chair of Mental Health Legislation Committee (from May 2024) Chair of People, Culture and Diversity Committee (from September 2024)	5
Charlotte Carpenter	Non-Executive Director Chair of Strategy & Resources Committee/ Resources & Planning Committee	5
John Maddison	Non-Executive Director Chair of Audit & Risk Committee	7
Jill Murray	Non-Executive Director (to August 2024) Chair of People, Culture and Diversity	3 (4)
Jules Preston	Non-Executive Director Senior Independent Director Chair of Charitable Funds Committee	8
Bev Reilly	Non-Executive Director Deputy Chair Learning from Deaths Lead Chair of Quality Assurance Committee	8
Jane Robinson	Non-Executive Director (from December 2025)	1 (2)
Catherine Wood	Non-Executive Director (from December 2025)	2 (2)
Ann Bridges	Executive Director for Corporate Affairs and Involvement	6
Mike Brierley	Assistant Chief Executive (to August 2024)	4 (4)
Zoe Campbell	Managing Director, North Yorkshire, York and Selby Care Group	6
Hannah Crawford	Executive Director of Therapies	8
Sarah Dexter-Smith	Joint Executive Director for People and Culture	7
Kedar Kale	Executive Medical Director	6

Naomi Lonergan	Interim Managing Director, Durham, Tees Valley and Forensic Care Group (from October 2024)	4 (4)
Beverley Murphy	Chief Nurse	6
Kate North	Joint Executive Director for People and Culture (from July 2024)	3 (5)
Liz Romaniak	Executive Director for Finance, Estates and Facilities	8
Patrick Scott	Managing Director for Durham, Tees Valley & Forensic (to October 2024) Deputy Chief Executive (from October 2024)	8

Note: *The maximum number of meetings to be attended by those board members who held office during part of the year is shown in brackets*

The following arrangements were maintained during the year to ensure the Board was kept informed of the views of Governors and members:

- Regular meetings between the involving the Chair, the Managing Directors and the Director of Corporate Affairs and involvement and Governors in their Care Group areas.
- Attendance by Board Members at meetings of the Council of Governors.
- The provision of reports on the outcome of consultations with Governors, for example on the Our Journey To Change Delivery Plan.
- Governors encouraged to observe public Board meetings.
- Regular liaison between the Chair and the Lead Governor.
- Feedback from Governors on briefings circulated to them.

Jules Preston, as the Senior Independent Director, was also available to Governors if they had concerns regarding any issues which had not been addressed by the Chair, Chief Executive or other usual business arrangements.

In general, with regard to attendance at meetings of the Council of Governors:

- The Chair, as the chair of the Council, attends all meetings.
- There is a standing invitation for the Non-Executive Directors to attend meetings.
- Executive Directors attend meetings, if required, for example to deliver reports, or as observers.

The Council of Governors has powers to require attendance of a director at any of its meetings, under paragraph 26 (2) (aa) of Schedule 7 of the National Health Service

Act 2006, for the purpose of obtaining information on the Foundation Trust's performance of its functions or the Directors' performance of their duties. The Council of Governors did not exercise these powers during 2022/23.

In total the Council of Governors held six formal meetings, including the Annual General Meeting (AGM), during 2024/25. Board Member attendance at these meetings was as follows:

Board member	No. of meetings attended (including AGM)
David Jennings	6
Brent Kilmurray	5
Roberta Barker	4
Charlotte Carpenter	4
John Maddison	4
Jill Murray	1 (2)
Jules Preston	6
Bev Reilly	6
Jane Robinson	2 (2)
Catherine Wood	2 (2)
Ann Bridges	5
Mike Brierley	2 (2)
Zoe Campbell	4
Hannah Crawford	5
Sarah Dexter-Smith	3
Kedar Kale	3
Naomi Lonergan	3 (4)
Beverley Murphy	1
Kate North	0 (5)
Liz Romaniak	3
Patrick Scott	3

(The maximum number of meetings to be attended by those Board Members who held office during part of the year is shown in brackets)

Resolution of disputes with the Council of Governors

A process has been established for the resolution of disputes between the Board and the Council of Governors.

Led by the Chairman or Deputy Chairman and supported by the Senior Independent Director, the process is based on discrete steps by which the matters in dispute are formally stated, considered and responded to.

If resolution cannot be achieved the view of the Board will prevail unless the issue falls within the Council of Governors' statutory powers.

Nothing within the process restricts the Council of Governors from informing NHS Improvement or the Care Quality Commission of relevant concerns.

The dispute resolution procedure was not invoked during the year.

Further details on the dispute resolution procedure are Provided in Annex 9 of our Constitution.

Evaluating Board performance

The performance of the Board, and its committees, is evaluated both by regular independent reviews and through the use of surveys of Board members.

Appointments to the Board and how they can be terminated

Appointments to the Board of Directors are made through open competition. They are overseen by the Nomination and Remuneration Committees of the Board and Council of Governors.

Formal, rigorous and transparent procedures are in place to ensure that all appointments:

- Are made solely in the public interest, with decisions based on integrity, merit, openness and fairness.
- Comply with CQC standards, NHS Employer standards, statutory requirements and the Code of Governance.
- Are made against objective criteria and, within this context, promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths.
- Promote co-creation and service user and carer involvement and reflect our values and those of the broader NHS.

The terms of office of the Chair and Non-Executive Directors are usually for three years. They will be appointed for a further term, without the need for external competition so long as:

- They continue to perform satisfactorily in their role
- The continue to meet the independence criteria set out in the Code of Governance
- They remain a fit and proper person to be a director of the foundation trust
- The skills and experience required on the Board have not changed since their initial appointment

They may also be appointed to serve a further third term (three, three-year terms in total); so long as they continue to meet the above criteria and the appointment is subject to rigorous review by the Council of Governors.

In exceptional circumstances a further extension may be approved by the Council of Governors if it is the best interests of the Trust.

The terms of office of Executive directors are not time limited.

During 2024/25 the Trust established a leadership academy to aid succession planning for both executive and non-executive directors.

The composition of the Board has been evaluated by external assessors as part of governance reviews conducted under NHSE's well-led framwork.

Appointments can be terminated for the following reasons:

- By resignation
- By ceasing to be a public member of the Trust
- Upon becoming a Governor of the Trust
- Upon being disqualified by the Independent Regulator
- Upon being disqualified from holding the position of a director of a company
- Upon being adjudged bankrupt
- Upon making a composition or arrangement with, or granting a Trust deed for, his/her creditors
- Upon being convicted of any offence and a sentence of imprisonment being imposed (whether suspended or not) for a period of not less than three months (without the option of a fine)
- Upon removal by the Council of Governors at a general meeting
- If they cease to be a fit and proper person to be a director of the Trust in accordance with the Licence, the Constitution or the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Board's committees

As of 31 March 2025 there were seven standing committees of the Board: the Audit and Risk Committee; the Charitable Funds Committee; the Mental Health Legislation Committee; the Nomination and Remuneration Committee; the People, Culture and Diversity Committee; the Quality Assurance Committee; and the Resources and Planning Committee.

The importance of the Board's committees in the delivery of our risk and control framework is described in the Annual Governance Statement.

The roles, functions and membership of the Committee are set out in their reports together with relevant disclosure required by the Code of Governance.

Following every meeting the Chair of the Committee reports to the next meeting of the Board of Directors:

- To advise of the business transacted.
- To escalate any material matters of concern or risks, which may require a response from the Board, or which might impact on the functions of another Board Committee.
- To provide a report on the assurances it has received, drawing the Board's attention to any positive assurances and gaps in assurance (including actions being taken to address them).
- To provide assurance on the management of strategic and operational risks which relate to its purpose and functions and to advise the Board of any new risks identified and actions being taken to address them.
- To seek the Board's approval of any recommendations made by the Committee.
- To inform the Board of any other matters that the Committee considers important to bring to its attention.
- To inform the Board of any 'cross cutting' matters or themes that may be considered in another Committee reporting to the Board.

The terms of reference for each of the committees, which were reviewed during 2024/25, can be found at our website (www.tewv.nhs.uk).

The Audit and Risk Committee

The Committee remains responsible for providing the Board with advice and recommendations on matters which include:

- the effectiveness of the framework of controls in the Trust.
- the adequacy of the arrangements for managing risk and how they are implemented and embedded.

- the adequacy of the plans of our auditors and how they perform against them.
- the impact of changes in accounting policy and the Committee's review of the Annual Accounts.

The membership of the Audit & Risk Committee consists of not less than three independent Non-Executive Directors.

The Board should satisfy itself that the membership of the committee has sufficient skills to discharge its responsibilities effectively and ensure that at least one member of the committee has recent and relevant financial experience. The committee is chaired by Mr John Maddison who has been performing this role since 1st September 2020 and is a former Executive Director of Finance with significant NHS experience.

There were six formal meetings during 2024/25.

An additional developmental meeting was held on 9th December 2024 for Committee members to review the governance of the meetings, including the anonymised feedback from a survey of members and the Executive lead, and consider any areas for improvement. Meetings were held virtually.

	No. of meetings attended
John Maddison (Chair)	6
Charlotte Carpenter	3
Jules Preston	4
Bev Reilly	5
Liz Romaniak (Executive Lead)	6

The Committee met its responsibilities during 2024/25 by:

- Reviewing the effectiveness of processes through which strategic risks are monitored and managed using the Board Assurance Framework, including its timely review and the effectiveness of controls as overseen through respective Board Committees.
- Providing assurance to the Board on the effectiveness and robustness of the Trust's broader risk management arrangements and controls environment, including through electronic risk registers and escalation to the Corporate Risk Register.
- Monitoring progress with the embeddedness of the risk management framework.
- Approving the Risk Management Strategy and Policy.
- Reviewing risk and internal control-related disclosures, such as the Annual Governance Statement (for the 2023/24 annual accounts).
- Receiving the Local Counter Fraud Annual Report for 2023/24.
- Reviewing the work and findings of the Local Counter Fraud Specialist for 2024/25 and progress to deliver their agreed annual plan for proactive and reactive work.

  The Committee ensured focus was given on the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these met the NHS Counter Fraud Authority's requirements as reported through an annual self-assessment against their standards.

- Receiving the Head of Internal Audit Opinion for 2023/24 and considering learning from related planning arrangements to agree improvements for 2024/25.
- Reviewing the work and findings of Internal Audit, including consideration and approval of the 2024/25 and 2025/26 Internal Audit annual plans, consideration of the outcome of Internal Audit reports and implications for the operation and effectiveness of sound control systems. This included seeking additional reporting for limited assurance reports, and noting positive progress to implement agreed Internal Audit recommendations responsively. The Committee

monitored progress to deliver the 2024/25 Internal Audit plan to service a timely and well-informed Head of Internal Audit Opinion.

- Reviewing the work and findings of External Audit, Mazars LLP for the 2023/24 annual accounts audit and their plan for the 2024/25 annual accounts audit.
- Reviewing the process by which clinical audit is undertaken, which is also reported into the Quality Assurance Committee.
- Receiving assurance that the organisation is compliant with the NHS England, Emergency Preparedness Resilience and Response (EPRR) core standards and has effective business continuity arrangements.
- Receiving assurance from presentation of detailed planning processes for production of the Annual Accounts and Annual Report, that robust arrangements are in place to ensure timely and accurate content that meets regulatory and other requirements.
- Reviewing the 2023/24 Financial Statements and Annual Report and supporting analysis on key movements and issues of note, prior to their recommendation for approval by the Board and submission to NHS England.
- Seeking assurance from the Executives that the financial statements have been appropriately compiled on a going concern basis and making such a recommendation to the Board.
- Reviewing and approving the Trust's Standing Financial Instructions and Scheme of Delegation.
- Approving the Register of Interests for the Trust Board of Directors.
- Seeking assurance in relation to Trust arrangements to ensure compliance with regulatory requirements, including progress (overseen through the Quality Assurance Committee) to implement and embed improvements in response to recommendations made by the Care Quality Commission.
- Reviewing the schedule of losses and compensations and considering reporting on salary overpayments and the effectiveness of management actions to prevent and/or recover these.

- Receiving analysis from the Legal department on claims relating to the Clinical Negligence Scheme for Trusts (CNST) to identify any themes, hot spots and plans to reduce incidents leading to claims and providing assurance on the operation of good systems of control.
- Providing alerts, assurance and escalations to the Board following each of its meetings.

The External Auditors

Mazars LLP have been the Trust's external auditors since 2013.

Following a competitive tendering process exercise in 2022/23, overseen by members of the Committee and Governors, the Council of Governors reappointed the firm for an initial period of three years (from 1 April 2023) with the option to extend for a further two years (in one-year increments).

The cost of providing external audit services during 2024/25 was £98k excluding VAT. This includes the cost of the statutory audit, the independent review of the accounts of the charitable funds and the whole Government accounting return.

The Internal Auditors

Internal audit services are provided by AuditOne; a not-for-profit provider of internal audit, technology risk assurance and courter fraud services to the public sector in the North of England.

Preetha Kumar, Associate Director of Internal Audit (Digital), at AuditOne, is the Trust's Head of Internal Audit.

Each year the Audit and Risk Committee agrees an internal audit plan which sets out the reviews to be undertaken during the year which is aligned to the principal strategic risks identified by the Trust.

Progress reports are provided by the internal auditors to each meeting of the committee and contribute to the Head of Internal Audit's annual opinion on the Trust's system of internal control, which is used to inform the Annual Governance Statement.

Safeguarding auditor independence

The Audit and Risk Committee has agreed a policy to ensure that auditor objectivity and independence is safeguarded if the firm providing external audit services is commissioned to provide services outside of the external auditor's responsibilities. This policy stipulates that only the Chief Executive, Finance Director and Trust Secretary may commission the external audit firm for non-audit services and the appointment must be approved by the Chair of the Audit and Risk Committee.

Safeguards are required that:

- External audit does not audit its own firm's work.
- External audit does not make management decisions for the Trust.
- No joint interest between the Trust and external audit is created.
- The external auditor is not put in the role of advocate for the Trust.
- The external audit firm does not undertake certain functions including: preparation of accounting records and financial statements, advising on the selection, implementation or running of IS/IT systems, staff secondments, employee remuneration or selection and recruitment and finance or transaction services work within the Trust.
- The external auditor must ensure that the provision of non-audit services meets its own ethical standards and internal operational policies. - JB

The Charitable Funds Committee

As the Corporate Trustee, in June 2024, the Board of Directors agreed to establish a Charitable Funds Committee as a forum for more detailed consideration of charitable matters and to provide assurance to the board that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales.

The new committee will also support new objectives in relation to fundraising and will ensure the independence of the committee, both from decision related to costs charged to funds which are overseen by Strategy and Resources Committee and different membership from the governance arrangements at Audit and Risk Committee.

The Committee first met on 3 March 2025 and agreed the appointment of a member of staff to promote the charity, internally and externally, to develop a fund raising strategy and to liaise with colleagues in the region to tackle health inequalities. The committee agreed to meet at least three times per year.

The Nomination and Remuneration Committee of the Board

The Nomination and Remuneration Committee is responsible for overseeing the appointment of executive directors and directors who report directly to the Chief Executive, including succession planning, and is responsible for deciding their terms and conditions of service (where they are not determined nationally).

The Committee is also responsible for:

- Authorising applications to NHS Improvement and HM Treasury for permission to make special severance payments to an employee or former employee.
- The agreement of locally determined terms and conditions of service for all TEWV staff employed on national medical terms and conditions and all staff paid at, or above, Agenda for Change Band 8.

The membership of the Committee comprises the Chair of the Trust and all the Non-Executive Directors. The Chief Executive is an ex-officio member of the Committee in relation to all matters pertaining to the appointment to those director positions (excluding the role of the Chief Executive) which fall within its remit.

The committee held five formal meetings during the year. Attendance at which was as follows:

Committee Member	No. of meetings attended
David Jennings (Chair)	5
Roberta Barker	4
Charlotte Carpenter	3
John Maddison	5
Jill Murray	1 (1)
Jules Preston	5
Bev Reilly	2
Jane Robinson	2 (3)
Catherine Wood	3 (3)

Note: *The maximum number of meetings to be attended by those committee members who held office during part of the year is shown in brackets*

During 2024/25 the Committee:

- Oversaw the recruitment of a new chief executive
- Reviewed and agreed proposals for interim changes to executive portfolios and the Directors of Operations & Transformation within Durham, Tees Valley & Forensic (DTVF) Care Group

- Received assurance on the performance of executive directors from their annual appraisals
- Approved an annual uplift in the remuneration of very senior managers in line with the recommendations of the national senior salaries review body
- Approved an amendment to the job description of the Managing Director for the North Yorkshire York and Selby Care Group to recognise their role as the Accountable Officer for Emergency Preparedness Resilience and Response (EPRR)

Advice and/or services were provided to the Committee by:

- Brent Kilmurray, Chief Executive
- Sarah Dexter-Smith and Kate North, Joint Director of People and Culture
- Phil Bellas, Company Secretary
- Robin Staveley, Gatenby Sanderson

(Note: Gatenby Sanderson has no other connection with the Trust or individual directors).

The Mental Health Legislation Committee (MHLC)

The Mental Health Legislation Committee contributes to the delivery of our Strategic Goal Strategic Goal 'To co-create a great experience for our patients, carers and families' by providing oversight and assurance to the Board of Directors on the Trust's compliance with the Mental Health Act 1983 (as amended); the Mental Capacity Act 2005, the Deprivation of Liberty Safeguards and any statutory Codes of Practice.

Its functions include:

- Gaining assurance that mental health legislation is applied to each individual patient and that practice is compliant with statutory and regulatory requirements.
- Identifying themes arising from the findings of the Care Quality Commission following visits to Trust services and to gain assurance that appropriate learning and action is being undertaken in relation to them.
  (Note: monitoring the delivery of actions arising from CQC visits will be undertaken by the Quality Assurance Committee).
- Gaining assurance that the Trust actively listens to, and learns from the experiences of service users, families and carers in the application of mental health legislation.
- Gaining assurance that the Trust meets its reporting obligations to the Care Quality Commission in relation to deaths of detained patients and instances of absence without leave.
- Gaining assurance that the Trust is acting in accordance with the Mental Health Act Scheme of Delegation.

- Reviewing the Scheme of Delegation, prepared in accordance with the Mental Health Act Code of Practice, and making recommendations relating to its confirmation to the Board of Directors.
- Provision of oversight and assurance to the Board on the Trust's compliance with the Mental Health Act 1983 (as amended); the Mental Capacity Act 2005, the Deprivation of Liberty Safeguards (DoLS) and any statutory Codes of Practice (hereinafter referred to as "mental health legislation").
- Considering the implications of any changes to statute, including statutory Codes of Practice, or case law relating to the Trust's responsibilities as a provider of mental health services and to advising the Board accordingly.
- Reviewing national reports on mental health legislation.
- Commenting on relevant policies and procedures.
- Ensuring appropriate arrangements are in place for the appointment and appraisal of associate managers and to oversee managers' hearings.

Membership of the committee during 2024/25 comprised:

- Roberta Barker, Non-Executive Director (Chair of the Committee) (from May 2024)
- Catherine Wood, Non-Executive Director (joined in January 2025)
- Jules Preston, Non-Executive Director/Senior Independent Director (SID)
- Kadar Kale, Executive Medical Director
- Beverley Murphy, Executive Chief Nurse
- Zoe Campbell, Managing Director of North Yorkshire & York Care Group
- Patrick Scott, Managing Director of Durham, Tees Valley & Forensics Care Group (up until January 2025)
- Naomi Lonergan, Interim Managing Director of Durham, Tees Valley and Forensics (from January 2025)

All other Board Members are invited to attend and participate in meetings of the Committee (but not to vote).

Officers of the Trust are invited to attend meetings of the Committee to deliver reports and to support the Committee's discussions on them. The Lived Experience Directors are invited to the meetings to facilitate patient/service user and carer input to the matters discussed.

The committee held three formal meetings during the year. Attendance at which was as follows:

Committee Member	No. of meetings attended

Roberta Barker (Chair)	3
Zoe Campbell	0
Kedar Kale	3
Naomi Lonergan	1 (1)
Beverley Murphy	0
Jules Preston	3
Patrick Scott	0 (2)
Catherine Wood	1 (1)

Note: *The maximum number of meetings to be attended by those committee members who held office during part of the year is shown in brackets*

The Committee also held a developmental meeting (part I) on 14 March 2025. This was to consider and approve some performance measures to be included in a dashboard for the Committee to receive information. The dashboard will support the monitoring of progress on those areas which relate to Our Journey to Change and the strategic risks of the trust.

During 2024/25 the Committee:

- Received good assurance that the legislative requirements for patients held in the Trust on section 136 are being met. Reports were prepared by the care groups (DTVF and NYYS) to demonstrate the use of 136 suites and Health Based Places of Safety, which provided good assurance that patients were well cared for and looked after if they were waiting for an inpatient bed.

- Received substantial assurance that for Discharges from Detention, the number of times detained patients are discharged by the Tribunal or Hospital Managers is very low and within normal range.

- Received good assurance for Section 132b – the numbers are relatively low throughout the year for those patients who were discharged without being given their rights. Modern Matrons oversee the escalation process for any that are missed.

- Received good assurance on the use of holding powers (when a doctor for 72 hours and a nurse for 6 hours may prevent a patient from leaving hospital if they consider it is necessary for their health or safety for a period of up to 72 hours). The Internal Mental Health Operational Groups have been looking at variation across services as there is a much higher use of Section 5 with female patients.

- The first meeting took place in May 2024 for the newly established interagency Mental Health Operational groups, led by the two care groups (Durham, Tees Valley and Forensics and North Yorkshire, York and Selby).

    - The purpose of the groups is to take a proactive role and actively engage with partners, including the two Integrated Care Boards (ICB's), police, ambulance service, various local authorities to help influence service transformation and improve the health of the communities we serve.

- Two new Internal Mental Health Legislation Operational Groups were established in July 2024, led by the Mental Health Legislation team. They include representation from clinical teams, including service development managers, practice development practitioners, modern matrons and clinical leads. These two groups, one for each of the care groups, started to look at areas of focus, one of which included the multiple uses of Section 5.

    - The purpose of the groups is to provide assurance to the Mental Health Legislation Committee on operational matters linked to legislation.
- Received good assurance on the Scrutiny of MHA documentation (annual report) that the administrative and medical scrutiny processes take place.

- Received substantial assurance that the CQC have been notified of every instance of absence without leave (AWOL), that the trust is required to notify them of.

- Received reasonable assurance that the Trust is meeting its requirements under the Mental Capacity Act/Deprivation of Liberty Standards and that the use and reporting of DoLS is being carried out as required.

- Requested progress reports from the care groups on compliance with section 17 leave and time away from the ward. A suite of improvement actions were implemented in January 2024 with evidence of some progress by the end of March 2024.

- Considered the progress on the implementation of the Trust wide Positive and Safe Strategy, including the changes the organisation must make to comply with the Mental Health Units use of Force Act.

- Received substantial assurance that the statutory duty to inform the CQC of every instance of absence without leave was met.

The committee undertakes a review of its performance every year. The results of the performance evaluation for 2023/24 were mostly positive. The Committee is striving to ensure it holds to account rather than wading into operational details.

The People Culture and Diversity Committee

On behalf of the Board of Directors, the Committee is the lead provider of oversight and assurance on the delivery of the Trust's Strategic Goal: "To co-create a great experience for our colleagues" as delivered through our 'People Journey' which is aligned to the national strategic plans. It gains assurance that the Trust understands its strategic workforce needs (including wellbeing, culture, recruitment, retention, development of people, and organisational capacity) and oversees the development and monitoring of plans to progress delivery. The Terms of Reference were reviewed and refreshed in May 2024.

To inform its work the Committee invites colleague stories at the start of each meeting.

Apart from the regular reviews of PCD risks within the Corporate Risk Register, in May 2024, the Committee also undertook a 'deep dive' into four risks which demonstrated good assurance on the decision making relating to the changes in risk scores and mitigating actions being taken. In addition, there was good assurance throughout the year that the strategic risk "safe staffing" was being managed effectively in the Board Assurance Framework.

Throughout the year there was good assurance of a robust process being followed for running the staff networks (Long Term Health Conditions, Neurodivergent, BAME, Rainbow and Armed Forces Networks, plus Menopause Cafe and Working Carers group) and that the right actions were being taken to maintain the Trust's Apprenticeship workforce. Foundation Apprenticeships, supported by the introduction of the new 'Under 18's' procedure, have been available from 2025 to enable apprenticeships to be provided to 16 and 17-year-olds and above.

The Committee had good assurance that a robust process had been followed to measure both successes and challenges against the 11 Equality Delivery System (EDS) outcomes for the protected characteristic and vulnerable community groups across the following 3 domains: Commissioned or provided services; Workforce health and well-being; and Inclusive leadership.

The Committee had good assurance that the Trust followed a robust process in recruiting, training, and inducting the volunteers who support the Trust's 'Journey to Change' through improving patient experience and staff wellbeing.

The Committee had good assurance that the Trust was following a robust process in analysing its staff data by protected group and that in doing so it was meeting its NHS Standard Contract requirements and Equality Act duties.

The Committee welcomed the development of significant anti-racism work during the year including: Show Racism the Red Card training sessions with Unison and the BAME Staff Network. Support was provided to staff including international recruits during the period of community unrest in conjunction with the BAME Network.

Progress continued with strategic workforce planning alongside the emerging clinical network models and the TEWV Leadership and Management Academy was launched in May 2024.

The number of cases for the Freedom to Speak Up (FTSU) Guardian stabilised through the year. There were changes during the year with the FTSU Non-Executive Director role transferring from Roberta Barker to Jules Preston once Roberta Barker assumed the role of Committee Chair. A productive link was established with Professional Nurse Advocates (PNAs) in December 2024, with 40 PNAs being trained in December 2024 as Speak Up Ambassadors, 5 of whom volunteered as FTSU Champions. In addition, the People and Culture directorate has been planning for the forthcoming award of the contract for FTSU services.

- The Committee noted that a staff experience survey (in addition to the national annual Staff Survey) had informed the identification of the following themes for the activities of the monthly Violence Prevention and Reduction Steering Group:
- Continuing Domestic Abuse and Sexual Violence work (in line with the National Charter);
- Aligning clinical and health and safety processes;
- Ensuring feedback to teams about learning and proactive support; and
- Working more effectively with local police forces.

The Committee noted that the Equality Act 2010 introduced a statutory requirement to produce information outlining details of any gender pay differences within an organisation. The Trust currently reports information on pay gaps in relation to gender, ethnicity and disability. By 2026, the Trust will be required to complete seven pay gap reports for all protected characteristics.

As the year drew to a close the committee was engaged in a review of the BAF and the People Journey in light of the refreshed strategy.

As at 31 March 2025, the membership of the Committee comprised:

- Roberta Barker, Non-Executive Director (Chair of the Committee)
- Sarah Dexter-Smith, Joint Executive Director for People and Culture
- Kate North, Joint Executive Director for People and Culture
- Ann Bridges, Executive Director of Corporate Affairs and Involvement
- Patrick Scott, Managing Director for Durham, Tees Valley Care Group/Deputy Chief Executive
- Zoe Campbell, Managing Director for North Yorkshire and York Care Group.

The committee held four formal meetings during the year. Attendance at which was as follows:

Committee Member	No. of meetings attended
Jill Murray (Chair)	1 (1)
Roberta Barker (Chair)	4
Ann Bridges	2

Zoe Campbell	1
Hannah Crawford	3 (3)
Sarah Dexter-Smith	2
Naomi Lonergan	2 (3)
Kate North	3 (3)
Jules Preston	1 (1)
Jane Robinson	1 (1)
Patrick Scott	1 (1)

Note: *The maximum number of meetings to be attended by those committee members who held office during part of the year is shown in brackets*

The Quality Assurance Committee

The Board should be assured that the membership of the committee has sufficient knowledge and experience to discharge its responsibilities effectively and ensure that at least one member of the committee has clinical experience.

The Committee is responsible for providing assurance to the Board of Directors on the quality, safety and effectiveness of the Trust's clinical and operational services. It provides assurance to the Board that the Trust is discharging its duty of quality and safety in compliance with the Health and Social Care Act 2008 and ensures that standards of quality and safety as set out in the Fundamental Standards prescribed in the Health and Social Care Act (Regulated Activities) Regulations 2014 are being met. The committee, in gaining and providing assurance to the Board of Directors, monitors regulatory requirements and activities across each location, which enables the Trust to maintain registration with the Care Quality Commission.

The membership of the quality assurance committee consists of three independent Non-Executive Directors.

As at 1 April 2025 the membership of the Committee comprised:

- Bev Reilly, Chair of Committee, Interim Chair of Trust/Non-Executive Director
- Jules Preston, Non-Executive Director/Senior Independent Director
- John Maddison, Non-Executive Director (from February 2025)
- Catherine Wood, Non-Executive Director (joined the Trust in February 2024)
- Beverley Murphy, Executive Chief Nurse
- Kedar Kale, Executive Medical Director
- Hannah Crawford, Executive Director of Therapies
- Zoe Campbell, Managing Director, North Yorkshire, York and Selby Care Group
- Patrick Scott, Managing Director, Durham, Tees Valley & Forensics Care Group (up until January 2025)
- Naomi Lonergan, Interim Managing Director, Durham, Tees Valley & Forensics (from January 2025)

The committee is chaired by Mrs Bev Reilly, who has been performing this role since May 2021, the Chair is a Registered Nurse and has a deep understanding of quality governance. Executive members will have a nominated deputy to attend if they are not available.

There were ten meetings held during 2024/25. Meetings were held in person as is the standard with some colleagues attending virtually by arrangement. The Committee also held a developmental meeting in May 2024 to review the effectiveness of the committee, Deloitte were invited as independent contributors to the meeting to share areas for improvement following the review of Trust governance in 2023. All members of the committee had an opportunity to anonymously feedback their view of committee effectiveness.

Each meeting is reviewed at the end to ensure that the committee has met the responsibility to work within Trust values.

	No. of meetings attended (invited to)
Bev Reilly (Chair of Committee	10 (10)
Jules Preston	9 (10)
John Maddison	1 (2)
Catherine Wood	2 (2)
Beverley Murphy	8 (10)
Kedar Kale	4 (10)
Hannah Crawford	9 (10)
Zoe Campbell	8 (10)
Patrick Scott	2 (4)
Naomi Lonergan	4 (6)

The committee, in gaining and providing assurance to the Board of Directors, monitors regulatory requirements and activities across each location, which enables the Trust to maintain registration with the Care Quality Commission.

The committee has oversight and monitors statutory and regulatory requirements and national guidance relating to quality and safety of care delivery including but not limited to:

- Safe Staffing
- Infection Prevention and Control
- Safeguarding
- Medical Devices
- Medicines Management
- Mortality Reviews including Learning Disabilities Mortality Review (LeDeR)
- Health and Safety
- The Duty of Candour
- Complaints
- Serious Incidents

The Committee met its responsibilities during 2024/25 by considering reports which detail the standards of care being delivered and any associated risks to Quality. From this, the Committee alerts the Board of the

risks to quality as well as providing assurances about the quality of care.

The reports include:

- Board Assurance Framework.
- Corporate Risk Register.
- Executive Review of Quality Group summary reports.
- Trust quality and learning report.
- Integrated Performance Dashboard
- The quality dashboard.
- PALS/Complaints and Patient Carer Experience.
- Trust Quality Account.
- Medicines Management
- Progress with implementation of the recommendations following the CQC inspection in 2023 (Improvement Plan) and all matters related to CQC activity.
- Trust Organisational Learning Group.
- Infection, Prevention and Control.
- Safeguarding reports.
- Positive and safe, the reduction of restrictive interventions and Use of Force annual report.
- Compliance with Duty of Candour.
- Physical healthcare.
- Quality Assurance Programme.
- Sexual safety and receiving the Eradicating Mixed Sex Accommodation annual statement of compliance.

To provide assurance to the Board on those matters linked to the strategic risks of the Trust the following escalated quality risks were reported to committee:

Serious incident recovery plan, waiting times in community services, safety planning for section 17 leave, clinical outcomes, teams in recovery, use of restrictive interventions, potential impact of using temporary staffing, high bed occupancy, performance with making contact with people within 72 hours of discharge from inpatient care, mixed sex accommodation breaches, the prevalence of people using ligatures, accuracy of supervision recording, working effectively with local Police where there has been violence and aggression and the implementation of CiTO.

Note: *The maximum number of meetings to be attended by those committee members who held office during part of the year is shown in brackets*

The Resources and Planning Committee

The purpose of Planning and Resources Committee is to oversee the stewardship of the Trust's finances, investments, sustainability, reputation and physical and digital infrastructure on behalf of the Board of Directors.

It also provides assurance to the Board of Directors on processes to develop and track progress against the Trust's vision and strategy (as articulated in Our Journey

to Change) and provides oversight and assurance on delivery of the Trust's strategic goal "To be a great partner".

The committee's principal functions include:

- Leading the agreement of processes to develop and update the Trust strategy and business plan, including related financial planning activities.
- Identifying and, where necessary, escalating any significant risks relating to the committee's purpose to the board, including in relation to financial performance and sustainability.
- Providing assurance that the priorities identified in the business plan are triangulated from a financial, workforce and operational perspective, and will effectively deliver Our Journey to Change
- Gaining assurance that the non-staffing resources are appropriate and sufficient to deliver its Business Plan and are deployed effectively.
- Monitoring delivery of the delivery plan approved by the Board of Directors and assuring itself that any changes proposed by management will not impact materially on the delivery of Our Journey to Change.
- Gaining assurance that the priorities identified in the Business Plan are aligned to those of strategic partners.
- Reviewing the scope, impact and management of risks contained within the Board Assurance Framework and the Corporate Risk Register, as relevant to the Committee's purpose and functions, and gaining assurance on the delivery and effectiveness of mitigation plans.
- Receiving wider environmental, partner and system updates and considering their alignment to the Trust's strategy, and drawing any opportunities, implications or risks to the attention of the Board of Directors.
- Overseeing investments and business cases for strategic projects and any statutory consultations on major service changes.
- Maintaining oversight of, and gaining assurance on, processes for the robust management of clinical service sub-contracts.

These principal functions were updated during the year following the standing down of Commissioning Committee in 2023 and the establishment of a Charitable Funds Committee and following review of its terms of reference, specifically its role in supporting strategy development.

At1 April 2024 the membership of the committee comprised:

- Charlotte Carpenter, Non-Executive Director (Chair of the Committee)
- John Maddison, Non-Executive Director
- Roberta Barker, Non-Executive Director
- Liz Romaniak, Executive Director of Finance, Estates and Facilities
- Mike Brierley, Assistant Chief Executive (part year)
- Ann Bridges, Executive Director of Corporate Affairs and Involvement
- Patrick Scott, Deputy Chief Executive (part year)

The committee held six meetings during 2024/25, including one extraordinary meeting in March 2025 to consider the draft 2025/26 financial plan. The Chair of the

committee reported alerts, assurances, advisory and escalation issues to the Board of Directors. Attendance during the year was as follows:

	No. of meetings attended
Charlotte Carpenter (Chair)	5
Roberta Barker	1
Ann Bridges	3
John Maddison	6
Mike Brierley*	1 (2)
Patrick Scott*	2 (4)
Liz Romaniak	6

*Mike Brierley left during the year and was replaced by Patrick Scott

Note: *The maximum number of meetings to be attended by those board members who held office during part of the year is shown in brackets*

Committee considered on behalf of the board:

- Submission of the 2024/25 financial plan (ahead of its submission to NHS England on 2nd May 2024), having received delegated authority from the board to consider and approve the final plan.

Committee considered and recommended to the board:

- Submission of the 2025/26 first draft financial plan, noting concerns in relation to the uncertain impacts of nationally negotiated pay awards during 2025/26, unclear guidance on asset valuation, the auto enrolment of staff into NHS pensions and the proposals from HM Treasury to revise asset valuation policy. It also considered that there were additional requirements to submit a board plan assurance statement.
- Receipt, on behalf of Trust Board, of an assessment of potential opportunities arising from various benchmarking reports and processes and linked to NHSE 'productivity packs', with committee agreeing to review these in detail and to receive more regular related reporting in future.
- The creation of a Charitable Funds Committee and implications of this for the Committee's own Terms of Reference.
- Progress in relation to the Electronic Patient Record.
- The implications, and recommendation to Board, of Trust involvement in proposals to establish a North East and North Cumbria Perinatal Provider Collaborative and the implications of a similar Yorkshire and Humber Perinatal Provider Collaborative.
- A report on the Committee's self-assessment of delivery against its agreed terms of reference.

Committee alerted the board to:

- Progress during the year on the deliverability of the 2024/25 financial plan in the context of a challenging financial position, including risks to delivery of Trust priorities, the impact of nationally agreed pay awards during 2024/25, progress against achievement of efficiency savings and grip and control measures.

Committee received assurance on:

- Digital and data activity, including related risks, the outcome of a digital and data baseline assessment, progress in relation to the Electronic Patient Record, improvements to Wi-Fi and staff compliance with mandatory training.
- The performance of the charitable funds – that they were within agreed boundaries and there were robust processes in place to manage funding requests and transactions.
- The effective management of strategic risks aligned to the committee (BAF risk 5: Digital, supporting change, BAF Risk 6: Estate/physical infrastructure, BAF risk 7: Data security and protection, BAF risk 9: partnerships and system working, BAF risk 12: Financial Sustainability) and the development of revised risk profiles.
- Corporate risk management processes in place, including the consideration of audit reports specific to the committee's remit and the Trust's response to related internal audit recommendations, including those from a specific financial 'grip and control' audit which had been commissioned for all 12 NHS system partners in the North East and North Cumbria.
- Processes in place to complete and submit the national PLACE, PAM and ERIC submissions – mandatory annual benchmarking submissions that help NHS organisations to understand and improve their relative performance, standards, and efficiency – and oversee annual improvement plans.
- Delivery of the Green Plan and progress against business plan milestones, which were progressing well following the appointment of a specialist Energy and Sustainability Manager.
- Processes in place to ensure an accurate and compliant national cost collection submission, in line with expected national requirements and approved the submission for 2023/24.
- The Trust's engagement with regional partners in the North East and North Cumbria to develop a Medium Term Financial Plan informed by the Trust's underlying position and 'drivers of deficit'.
- Feedback from NHS England on the 'exemplar' quality of the North East and North Cumbria Infrastructure Strategy, which had been developed through provider and ICB collaboration and reflected key Trust estate and digital priorities for capital.

Committee considered

- Intelligence on national policies and updates on partnership work including emerging governance within Humber and North Yorkshire, and on the collaborative development of system-wide Infrastructure Strategies for North East and North Cumbria and Humber and North Yorkshire.
- Proposals for, and preparations to share information ahead of, a Board Financial Sustainability workshop in July 2024.
- The 2024/25 Delivery Plan and subsequent progress to deliver the agreed annual Our Journey to Change Delivery Plan priorities.

- The robustness of arrangements for developing the next iteration of Our Journey for Change and 2025/26 Delivery Plan priorities.
- Progress to implement the recommendations of the Deloitte governance review action plan.
- Proposals to establish a Transformation and Strategy Board, to oversee major change and transformation initiatives and to continue to review the effectiveness of these arrangements.
- Intelligence on national policies and from partners and received assurance on how that was disseminated for action within the Trust.

The Council of Governors

The statutory duties of our Council of Governors are:

- To hold the Non-Executive Directors individually and collectively to account for the performance of the Board
- To represent the interests of the members of the Trust as a whole and the interests of the public

It has specific responsibilities which it exercises by itself or in conjunction with the Board of Directors. These include:

- To develop our membership and represent their interests
- To assist with the development of the Trust's strategy
- To appoint or remove the Chairman and the Non-Executive Directors and to determine their remuneration and other terms and conditions of service
- To approve the appointment of the Chief Executive
- To receive the annual accounts and annual report
- To appoint or remove the Trust's external auditor
- To determine proposals to increase the proportion of the Trust's income earned from non-NHS sources by 5% or more in any financial year
- To determine (in conjunction with the Board of Directors) any proposed changes to the Trust's Constitution
- To determine (in conjunction with the Board of Directors) any questions on mergers, acquisitions or separation of the Trust or whether it should be dissolved
- To determine any significant transactions (as defined in the Constitution) proposed by the Board of Directors
- To consider any matters raised by the Care Quality Commission or NHS Improvement which might affect the Trust's compliance with the terms of its Licence or its registration of services

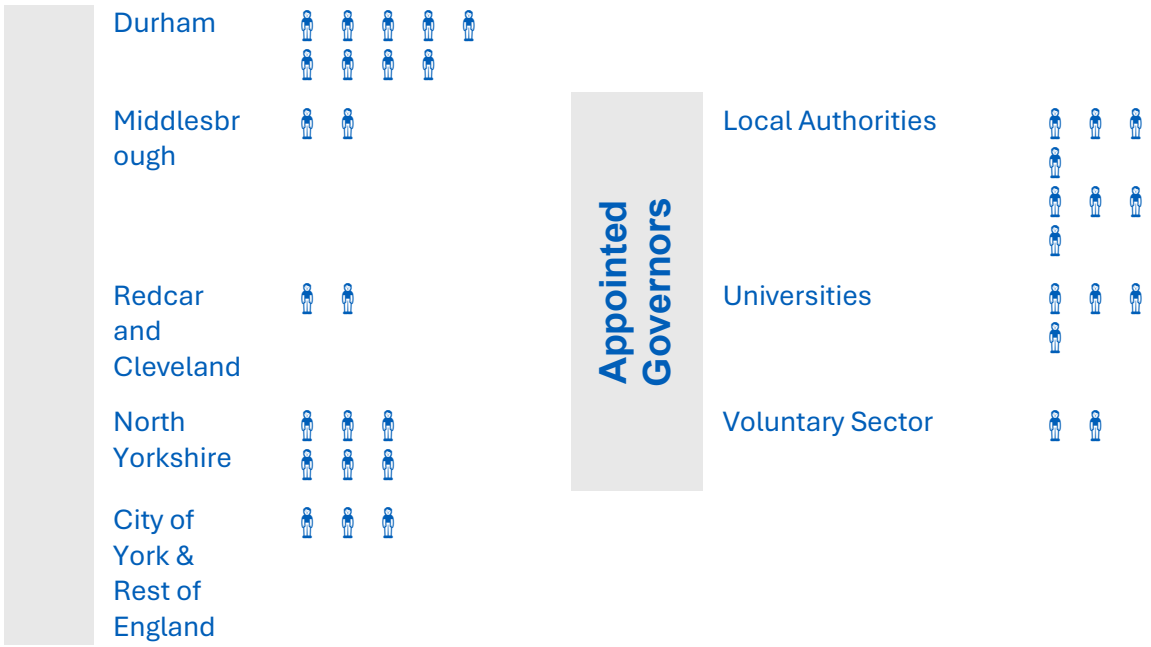
The Composition of the Council of Governors as at 31st March 2025

Public Governors

Stockton-on-Tees	3
Hartlepool	2
Darlington	2

Staff Governors

Corporate Directorates	1
Durham, Tees Valley & Forensics Care Group	3
North Yorkshire, York and Selby Care Group	1



(48 seats)

The Lead Governor

In accordance with the Code of Governance, the Lead governor has a role in facilitating direct communication between NHS England and the NHS foundation trust's Council of Governors (CoG). This is in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chair or the company secretary.

For 2024/25 the Lead Governor was Gary Emerson.

Membership of the Council of Governors during 2024/25

Information on the Governors who held office during 2024/25, including their attendance at the six meetings of the Council, is presented below.

Public Governors

Constituency / Class / Organisation	Name	Term of Office (From – To)	CoG meeting attendance incl. AGM (No. of eligible meetings)

Darlington	Joan Kirkbride	01/07/2023 - 30/06/2026	4 (6)
Middlesbrough	Mary Booth	01/07/2023 - 30/06/2026	6 (6)
Middlesbrough	Alicia Painter	01/07/2022 - 30/06/2025	6 (6)
North Yorkshire (Scarborough and Ryedale Constituency, prior to 01/07/24)	Judith Webster	01/07/2023 - 30/06/2026	4 (6)
North Yorkshire (Scarborough and Ryedale Constituency, prior to 01/07/24)	Lisa Holden	01/07/2022 – 31/07/24	0 (1)
North Yorkshire (Scarborough and Ryedale Constituency, prior to 01/07/24)	Gemma Birchwood	01/09/2023 - 30/06/2026	4 (6)
North Yorkshire (Scarborough and Ryedale Constituency, prior to 01/07/24)	Hazel Griffiths	01/07/2022 - 30/06/2025	6 (6)
North Yorkshire (Scarborough and Ryedale Constituency, prior to 01/07/24)	John Green	01/07/2022 - 30/06/2025	3 (6)
Stockton-on-Tees	Gillian Restall	01/07/2023 - 30/06/2026	5 (6)
Stockton-on-Tees	Dr Judy Hurst	01/07/2022 – 19/04/2024	0 (0)
Stockton-on-Tees	Gary Emerson	01/07/2023 - 30/06/2026	6 (6)
Durham	Jill Wardle	01/07/2023 - 30/06/2026	4 (6)
Durham	David Coombs	01/07/2024 – 30/06/2027	2 (5)

Durham	Pamela Coombs	01/07/2023 - 30/06/2025	2 (6)
Durham	Graham Robinson	01/07/2022 - 30/06/2025	4 (6)
Durham	Joan Aynsley	01/07/2023 - 30/06/2026	3 (6)
Durham	Jacci McNulty	01/07/2024 – 30/06/2027	4 (5)
Durham	Ross Guy	01/07/2024 – 19/12/2024	1 (3)
Hartlepool	Zoe Sherry	01/09/2023 - 30/06/2026	6 (6)
Hartlepool	Jean Rayment	01/07/2022 - 30/06/2025	2 (6)
Hambleton and Richmondshire	John Yorke	01/07/2023 – 08/04/2024	0 (0)
York	Christine Hodgson	01/07/2021 - 30/06/2024	0 (1)
York	Dr Martin Combs	01/07/2021 - 30/06/2024	0 (1)
York	Susan Croft	01/07/2022 - 30/06/2024	0 (1)

Staff Governors

Constituency / Class / Organisation	Name	Term of Office (From – To)	CoG meeting attendance incl. AGM (No. of eligible meetings)
Corporate Directorates	Cheryl Ing	01/07/2024 - 30/06/2027	4 (6)

Durham, Tees Valley and Forensics Care Group	Jane King	01/07/2021 - 30/06/2024	0 (1)
Durham, Tees Valley and Forensics Care Group	Clive Mackin	01/07/2023 – 30/06/2024	0 (1)
Durham, Tees Valley and Forensics Care Group	Heather Leeming	01/07/2024 - 30/06/2027	2 (6)
Durham, Tees Valley and Forensics Care Group	Karl Evenden-Prest	01/07/2024 – 30/06/2027	5 (5)
Durham, Tees Valley and Forensics Care Group	Ashley Douglass	01/07/2024 – 30/06/2027	0 (5)

Appointed Governors

Constituency / Class / Organisation	Name	Term of Office (From – To)	CoG meeting attendance incl. AGM (No. of eligible meetings)
University of Sunderland	Catherine Lee-Cowan	Appointed 27/10/2022	2 (6)
University of York	Rob Allison	Appointed 01/04/2022	2 (6)
Stockton-on-Tees Borough Council	Cllr Ann McCoy	Appointed 08/07/2014 – 04/04/2024	0 (0)
Stockton-on-Tees Borough Council	Cllr Pauline Beall	Appointed 04/04/2024	5 (6)
Hartlepool Borough Council	Cllr Moss Boddy	Appointed 07/11/2022	5 (6)
Darlington Borough Council	Kevin Kelly	Appointed 13/08/2015	0 (6)

Durham County Council	Lee Alexander	Appointed 03/01/2017	1 (6)
North Yorkshire County Council	Cllr Roberta Swiers	Appointed 20/03/2023	4 (6)
City of York Council	Cllr Claire Douglas	Appointed 04/08/2023	3 (6)
Redcar and Cleveland Borough Council	Cllr Lisa Robson	Appointed 02/08/2023	2 (6)

Note: The maximum number of meetings to be attended for those Governors who held office during part of the year is shown in brackets

Details of company directorships or other material interests in companies held by Governors where those companies or related parties are likely to do business, or are possibly seeking to do business with the Trust, are included in the "Register of Interests of the Council of Governors". This document is available for inspection on our website.

Elections held during 2024/25

Public Governors

Constituency Name	Date of Election	No of Seats	No. of candidates	No. of Votes cast	No. of eligible voters	Turnout (%)
City of York and Rest of England	01/07/2024	3	0	-	-	-
Darlington	01/07/2024	1	0	-	-	-
Durham	01/07/2024	5	3	-	-	-
Redcar and Cleveland	01/07/2024	2	0	-	-	-
North Yorkshire	01/07/2024	1	0	-	-	-

Staff Governors

Constituency Name	Date of Election	No of Seats	No. of candidates	No. of Votes cast	No. of eligible voters	Turnout (%)
Corporate Directorates	01/07/2024	1	1	-	-	-
Durham, Tees Valley and Forensics Care Group	01/07/2024	3	3	-	-	-
North Yorkshire. York and Selby Care Group	01/07/2024	1	0	-	-	-

All elections to the Council of Governors have been administered and overseen by Civica Election Services to ensure independence and compliance with the election rules contained within the Trust's Constitution.

Report of the Council of Governors' Nomination and Remuneration Committee

Chaired by the Chair of the Trust, the Nomination and Remuneration Committee supports the Council of Governors undertake its duties regarding the appointment and setting the remuneration and terms of service of the Chairman and Non-Executive Directors.

The Committee met five times during 2024/25. The business transacted by the Committee was as follows:

- To consider the outcome of the Chair's appraisal.
- To consider and gain assurance on the outcome of an investigation undertaken by the Senior Independent Director.
- To oversee the recruitment of two new non-executive directors.
- To consider the process for the re-appointment of the chair and non-executive directors following changes to the Code of Governance.
- To consider the approach to the remuneration of the chair and non-executive directors.

During the year the committee received advice and services from Hunter Healthcare *(Note: the firm has no other connection with the Trust or individual directors).*

The membership of the committee and their attendance at the four meetings held during 2024/25 was as follows:

	No of meetings attended
David Jennings (Chair of the Committee)	*3*

Mary Booth (Public Governor)	*4*
Gary Emerson (Public Governor)	*1(1)*
Graham Robinson (Public Governor)	*3*
Jill Wardle (Public Governor)	*4*
Jules Preston (Senior Independent Director)	*3 (3)*

Notes:

- *The maximum number of meetings to be attended by members of the committee is shown in brackets*
- *The Senior Independent Director is an ex officio member of the committee when matters relating to the appointment and appraisal of the Chair of the Trust are being considered)*

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

Training and development

Governor training and development is very important to our Trust, and our Governors continue to be involved in co-creating their training and development needs and requirements, as well as future priorities.

Governor participation in the development of the Operational and Business Plan

During 2024/25 our governors main input into the development of our future plans was around the development of our new Strategic Framework – *Our Journey to Change: The Next Chapter* which was approved by our Board of Directors on 10 April 2025.

At the Council of Governors meeting of 24 October 2024, governors were briefed on the key messages from the new Big Conversation and the assessment of the Board on progress / impact. Council of Governors agreed with the Board's view that:

- much of the 2021 Our Journey to Change strategic framework was still valid, but there were some elements that could be improved
- This improved version would be iteratively developed during the winter with a check and challenge engagement exercise taking place before the final version was produced

On 15 January 2025 a further update was provided for governors, including the Trust Board's proposals for the check and challenge engagement stage. Council of

Governors agreed with a relatively “tight” circulation in recognition of existing work to engage staff, service users and carers.

The Council of Governors then held a final discussion on a draft of the new strategic framework at their meeting on 26 March. They did not identify any changes that they wished to recommend to the Board of Directors.

Some governors who are also carers or service users were members of the Trust’s lived experience strategy and planning reference group which met monthly and influenced the changes that can be seen in the 2025 version from the 2021 original.

Governors also engaged with care group and corporate service directors at their meetings and briefings and influenced operational plans through this mechanism.

Membership report

The first way Membership is important in helping to make us more accountable to the people we serve, to raise awareness of mental health and learning disability issues and assists us to work in partnership with our local communities.

Public membership

Anyone (unless eligible to join the staff constituency) aged 14 or over who lives in the area covered by the public constituencies (as described in the constitution) may become a public member of the Trust.

Staff membership

All staff employed by the Trust (including those on a temporary or fixed term contract of 12 months or more) are eligible to become members of the staff constituency

Members of staff are “opted in” upon commencement of employment and given the choice to “opt out” of membership in writing

As at 31 March 2025 the Trust’s membership was as follows:

- Public members – 8,871
- Staff members – 9,060

The following table provides an analysis of our public membership compared to the population covered by the Trust:

Public constituency	Number of members	Eligible membership
Public constituency	Number of members	Eligible membership

Age (years):		
0-16	4	335,628
17-21	23	104,868
22+	8,270	1,424,887
Ethnicity:		
White	7,934	1,724,723
Mixed	61	20,806
Asian or Asian British	154	45,645
Black or Black British	81	11,762
Other	23	6,006
Socio-economic groupings*:		
AB	1,899	144,436
C1	2,400	232,476
C2	1,982	188,534
DE	2,386	242,146
Gender Analysis		
Male	2,875	914,571
Female	5,738	950,809

Notes:

The above analysis excludes:

- *411 public members did not provide a date of birth*
- *455 members did not state their ethnicity*
- *93 members with no gender*

Member Engagement

Membership is important in helping to make the Trust more accountable to the people it serves, to raise awareness of mental health, learning disability and autism issues and assist the organisation to work in partnership with the local community.

The focus of the Trust over this period was to grow a representative membership to enable accountability through engaging with its members.

Membership activities continued throughout 2024/25 including:

- A monthly membership newsletter providing updates from the Trust.
- Governor elections were held, and members encourage to engage and vote.
- Personal invitations were sent for the Annual General and Members' meeting.
- The Trust continued its use of social media to encourage attendance at meeting of the Board and Council of Governors.

- Members, who were also registered as involvement members, participated in a wide range of involvement and engagement activities.

In 2024/25 a membership task and finish group was also established by governors to explore how we can increase both recruitment and engagement of public members

Contacts

Members wishing to contact Governors and/or Directors of the Trust can do so via the Corporate Affairs and Involvement Directorate on 01325 552068, email tewv.ftmembership@nhs.net or via our website www.tewv.nhs.uk/get-involved/membership/

Applications for membership should be sent to the Company Secretary's Department at West Park Hospital or submitted using the online form on the Trust's website.

NHS system 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

Our Trust has been placed in segment 3.

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: https://www.england.nhs.uk/publication/nhs-systemoversight-framework-segmentation/

Modern Slavery Act statement

Human Rights, Equality Diversity and Inclusion Policy

As a major employer and provider of services, the Trust is committed to advancing equality of opportunity and providing fair access and treatment in employment and when delivering or procuring services or working in partnership. Our human rights, equality, diversity and inclusion policy makes clear the Trust's responsibilities under the Equality Act and Human Rights Act. We are committed to equality, diversity and inclusion and have a range of equality network groups, all of which are sponsored by an executive and therefore have a voice at Board.

Recruitment and selection procedure

We undertake our own recruitment activity through in-house functions. Robust processes are in place to ensure that the policy is adhered to and all staff with a responsibility for recruitment and selection must be aware of their legal obligations under existing employment legislation. Agency worker appointments are subject to the same rigour as staff appointed by the Trust, for example, Disclosure and Barring Service (DBS) checks (where applicable); proof of eligibility to work in the UK; any gaps in employment history. We work closely with our counter fraud team to ensure we act on any concern or advice they raise and have run a series of events for staff to raise awareness of fraudulent activity including at the recruitment stage.

Safeguarding

Our Safeguarding adult and safeguarding children policies support the Trust's commitment to preventing modern slavery and human trafficking and provide staff with clear routes to raising any concerns they may have about this issue. It is included in safeguarding training and advice about modern slavery and human trafficking is available to staff through the safeguarding team.

Procurement and our supply chain

The Trust understands the vital role procurement plays in preventing acts of modern slavery within both its business and supply chain. In line with this commitment, the Trust imposes those high standards on its suppliers.

The Trust uses the services of County Durham and Darlington Foundation Trust for its procurement processes. When undertaking procurement processes bidding suppliers are asked to confirm if they are a commercial organisation as defined in Section 54 ("Transparency in supply chains etc.") of the Modern Slavery Act 2015 ("the Act"). If they answer yes to this question they are asked if they are compliant with the annual reporting requirements contained within Section 54 of the Act. Such self-declarations are endorsed within the Public Contracts Regulations (PCR) 2015. Should there be any concerns with their self-declaration the responsible procurement

officer will investigate accordingly. In addition, the Procurement team works with suppliers to identify and minimise ethical issues in supply chains by investigating abnormally low bids in line with the PCR 2015 and challenging the status quo, including but not limited to; modern slavery, corruption, bribery, and human trafficking.

Through our procurement processes we seek assurance that our Agency worker supplier is complying with its duties under the Act. The Trust uses the National Framework for the Provision of Clinical and Healthcare staffing which contains clauses obliging suppliers to comply with the Modern Slavery Act and include clauses in their contracts with subcontractors anti- slavery and human trafficking.

Risk assessment and management

The Trust's risk management process is used to ensure risks are identified and mitigated with appropriate controls. Concerns raised through any route (e.g., incident report, Freedom to Speak Up/ Whistleblowing concerns, safeguarding concern or line manager) are investigated.

Accounting Officer statement

Statement of the chief executive's responsibilities as the accounting officer of Tees, Esk and Wear Valleys 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 Tees Esk and Wear Valleys 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 [name] NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS 66 foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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

Beverley Murphy
Acting Interim Chief Executive

Date: 25 June 2025

Annual Governance Statement 2024/25

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 group'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 Tees Esk and Wear Valleys NHS Foundation Trust Group, 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 the Tees Esk and Wear Valleys NHS Foundation Trust Group for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Group's governance arrangements, including its internal control and risk management processes, are designed to support, and provide continual assurance on, the delivery of Our Journey to Change.

The risk and control framework is overseen by the Board of Directors which has also retained responsibility for the approval of the risk management strategy and associated policies; setting the organisation's risk appetite and risk tolerances; and establishing the tone and culture for risk management in the Group.

Dynamic Board Assurance Framework and operational risk management arrangements are maintained through which the Board, and its committees, can monitor and gain assurance that a satisfactory level of internal control is being achieved.

The Audit and Risk Committee provides independent assurance to the Board on risk management and internal control. As set out in the Annual Report, membership of this Committee is limited to independent non-executive directors.

Other Board committees have responsibility for scrutinising and monitoring relevant risks aligned to our strategic goals and providing assurance to the Board that they are being managed and mitigated effectively.

Risk management groups are established and embedded at both the executive and care group levels of the organisation. These support the flow of assurance through the care group boards, the Executive Directors Group (EDG), the Board's committees to, ultimately, the Board ensuring that risks of all types are identified and, where practicable, controlled to an acceptable level.

As the Chief Executive I have responsibility and accountability for maintaining a sound system of internal control, assurance and risk management that supports the achievement of the organisation's objectives. I discharge these duties through the executive directors with the clear designation of accountability to individuals, in line with their portfolios, to support me in this role.

The arrangements are subject to ongoing development and refinement. Learning from good practice and assurance on the embeddedness of our arrangements has been provided, amongst other approaches, by:

- a range of governance reviews including those commissioned externally from the Good Governance Institute (2021) and Deloitte LLP (2024);
- guidance received from NHS England's Intensive Support Team (2023) particularly on quality governance;
- the findings of, and recommendations arising from, external inspections and investigations; and
- reviews of key controls undertaken by our internal auditors, AuditOne.

Capacity to handle risk is augmented by:

- The Company Secretary, the principal adviser to the Board on governance, regulation and law, whose responsibilities include the maintenance of the Board Assurance Framework and supporting the Board's ongoing review of risk appetite and tolerance;
- The Head of Risk Management who, together with a recently appointed dedicated and qualified Risk Manager, is responsible for supporting day-to-day management of the Trust's risk registers; the review, development and embedding of the Trust's Risk Management Strategy and Organisational Risk Management Policy; designing and implementing the provision of training on risk management across the organisation; and the overall design, development and management of the Trust's risk and quality management system;
- Risk management training, aligned to ISO 31000 guidelines, which continues to be delivered to agreed levels of staff across the organisation. One to one and team-based sessions are also undertaken to supplement and support the formal training. Support and information is also provided via the risk management intranet and written guides.
- Basic risk management awareness and training incorporated into the national patient safety training undertaken by all staff.

The ongoing development and embedding of the Trust's risk and quality management system, "InPhase", has improved risk management through increased visibility, triangulation and compliance, and enhanced our overall learning culture. For example, improvement in data categorisation and data quality relating to incidents is providing more meaningful insight into trends.

The risk and control framework

The key elements of the Trust's risk management arrangements, including how risks are identified, evaluated and controlled, are described in the Risk Management Strategy. The internal arrangements for implementing the Strategy are detailed within the Risk Management Policy.

Risk appetites, the amount and type of risk that an organisation is willing to accept in order to meet its objectives, have been defined using a matrix developed by the Good Governance Institute. These are reviewed annually by the Board based on an assessment of the Group's overall risk profile.

Risk tolerances, the maximum amount of risk the Group is willing to accept, have also been established for each type of risk.

Risks, or changes in risk, are identified from a number of sources, both internal and external to the organisation, for example:
Internal - though risk assessments; the development of the business plan; consultations with staff and patients; internal inspections and audits; and complaints, incidents and claims.
External – through assessments by regulators; environmental appraisals; intelligence from regional partnerships/developing system arrangements and information disseminated by national bodies; consultation with external stakeholders; and benchmarking.

A standardised approach to risk assessment, scoring and grading is used. This includes the assignment of initial, current and target scores. These scores are based on a 5 x 5 matrix for consequence and likelihood supported by descriptors of severity levels for each type of risk.

Controls in place to manage risk and related sources of assurance, positive assurance, gaps in control and assurance and mitigation plans are identified for each risk.

The response to the risk, how the risk will be addressed to achieve the target risk score, is based on the approach commonly known as the "4 T's": tolerate, treat; transfer and terminate. Which of these is considered appropriate will take into account the level of the risk in regard to its risk appetite; the ability to mitigate the risk in terms of costs and other constraints; the availability of third parties to share the risk; and the level of residual risk remaining or whether actions to address with risk will give rise to other significant risks.

As at 31st March 2025 the following strategic risks were included in the Board Assurance Framework:

Ref	Strategic Goals			Risk Name & Description	Present Risk Grade	Oversight Committee
	To co-create a great experience for our patients, carers and families	To co-create a great experience for our Colleagues	To be a great partner			
2	✓			**Demand** **There is a risk** that people will experience unacceptable waits to access services in the community and for an inpatient bed **caused by** increasing demand for services, commissioning issues and a lack of flow through services **resulting in** a poor experience and potential avoidable harm.	**High**	**Quality Assurance Committee**
3	✓	✓	✓	**Co-creation** **There is a risk** that if we do not fully embed co-creation **caused by** issues related to structure, time, approaches to co-creation and power **resulting in** fragmented approaches to involvement and a missed opportunity to fully achieve OJTC	**Moderate**	**Quality Assurance Committee**
4	✓	✓	✓	**Quality of Care** **There is a risk** that we will be unable to embed improvements in the quality of care consistently and at the pace required across all services to comply with the fundamental standards of care; **caused** by short staffing, the unrelenting demands on clinical teams and the lead in time for significant estates actions **resulting** in a variance in experience and a risk of harm to people in our care and a breach in the Health and Social Care Act.	**High**	**Quality Assurance Committee**
5	✓	✓	✓	**Digital – Supporting Change** There is a risk of failure to deliver OJTC goals, organisational and clinical safety improvements, caused by the inability to fully deploy, utilise, and adopt digital and data systems	**High**	**Resources & Planning Committee**

6	✓	✓	✓	**Estate / Physical Infrastructure** **There is a risk** of delayed or reduced essential investment **caused by** constrained capital resources **resulting in** an inability to adequately maintain, enhance or transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.	**Moderate**	**Resources & Planning Committee**
7	✓	✓	✓	**Data Security and Protection** There is a risk of data breach or loss of access to systems, caused by successful cyber-attack, inadequate data management, specialist resource gaps, and low levels of digital literacy resulting in compromised patient safety, impacts on business continuity, systems and information integrity, reputational damage and loss of confidence in the organisation.	**High**	**Resources & Planning Committee**
8	✓	✓	✓	**Quality Governance** **There is a risk** that our floor to Board quality governance does not provide thorough insights into quality risks **caused by** the need to further develop and embed our governance and reporting including triangulating a range of quality and performance information **resulting in** inconsistent understanding of key risks and mitigating actions, leading to variance in standards.	**Moderate**	**Quality Assurance Committee**
9			✓	**Partnerships and System Working** ***There is a risk that*** *failure to effectively align our strategic priorities to the priorities of the Integrated Care Boards, Provider Collaboratives and 'places' within which we operate* ***due to*** *our leadership capacity to the system governance arrangements* ***resulting in*** *our ability to influence service transformation and improve the health of the communities we serve being limited* (Draft revised – to be confirmed)	**Under review**	**Resources & Planning Committee**
10			✓	**Regulatory compliance** **There is a risk** that failure to comply with our regulatory duties and obligations, at all times,	**Moderate**	**Board**

				could **result** in enforcement action and financial penalties and damage our reputation		
11	✓	✓	✓	**Roseberry Park** **There is a risk that** the necessary Programme of rectification works at Roseberry Park and impacted by limited access to capital funding **could adversely affect** our service quality, safety, financial, and regulatory standing.	**High**	**Board**
12	✓	✓	✓	**Financial Sustainability** **There is a risk that** constraints in real terms funding growth **caused by** government budget constraints and underlying financial pressures **could adversely impact** on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing	**High**	**Resources & Planning Committee**
13	✓	✓	✓	**Public confidence** **There is a risk that** ongoing external scrutiny and adverse publicity **could lead to** low public and stakeholder perception and confidence in the services we provide	**High**	**Board**

Operational risks are managed, monitored and escalated within the Group's governance structure based on their current score. Two risk registers are in place for high risks (those with a score of 15+) differentiated by those risks having cross organisational significance (the Corporate Risk Register) and those impacting on discrete services.

Our broader governance structures and processes help to ensure that there are effective controls and escalation mechanisms in place to support decision-making and risk management.

All the Board's committees have responsibility for providing assurance to the Board on the management of risks; the effectiveness of controls; and for identifying and escalating new risks that could impact on the Group's ability to deliver Our Journey to Change.

The Audit and Risk Committee has specific responsibilities for:

- Providing assurance to the Board on the effectiveness and robustness of risk management arrangements and the controls environment.
- Reviewing the adequacy of all risk and control related statements (e.g. the Annual Governance Statement) prior to endorsement by the Board.
- Reviewing the Assurance Framework, prior to its presentation to the Board, to provide assurance on its coverage and comprehensiveness and the appropriateness and effectiveness of the mitigations for each principal risk.

The Committee utilises reports from management, including from the Executive Risk Group, and Internal Audit, in assessing the effectiveness of the BAF and risk management as components of the internal control framework.

A monitoring and assurance flow is in place through the care group boards, and their individual risk groups, through the Executive Risk Group to the Executive Directors Group.

The Quality Assurance Committee is responsible for oversight of quality governance arrangements within the Trust including overseeing the compliance with the CQC Quality Standards and Statements regarding quality and safety. It also considers statutory and regulatory compliance in regard to relevant matters including patient safety, safeguarding, medicines management, restrictive interventions, infection prevention and control and clinical effectiveness (including clinical audit).

During the year the Committee received assurance by way of:

- Reports from the Executive Review of Quality which highlighted the assurances taken about the quality of care and which provided advice to the committee on performance as well as identifying key risks to quality and safety. The work of the group is supported by flows of reporting from the care group clinical leaders and subject matter experts on a range of quality issues. (The core functions of this Group transferred to the remit of the Executive Directors Group in Quarter 4 2024/25.)
- The Integrated Performance Report to ensure triangulation of key quality and safety measures.
- Reports on the management of relevant risks including those presented within the Board Assurance Framework and the Corporate Risk Register.
- Regular reporting on the operation of key quality controls including infection prevention and control, clinical audit and research and development.
- Assurance reports on the delivery of quality improvements e.g the delivery of action plans in response to recommendations made by the Care Quality Commission, Independent Reviews and learning from patient safety incident investigations etc.
- Reports by exception where gaps in controls and assurance were identified.

It is of note that during 2024/25, internal audits have been undertaken with regard to the following areas which have provided assurance to the Quality Assurance Committee and Board:

- Compliance Audit: CQC Action Plan Embeddedness – Published March 2025, received substantial assurance
- Compliance Audit: Integrated Performance Approach (IPA)
- Compliance Audit: Complaints Processes

At an executive level, the Executive Directors Group gains assurance that organisational risks are being appropriately managed, assurance/mitigations are correctly identified and actioned through its Risk Group. This group has a crucial role supporting management by scrutinising, challenging and reviewing high level risks and holding care groups/corporate directorates to account for the timely and appropriate management of risk.

The care group boards are responsible for the management of risks within their services and the timely escalation of operational risks within the governance structure.

Underpinning the governance structure are key corporate processes which support the oversight of risk and internal control. These include:

- Summary reports on the BAF being provided to each Board and committee meeting which seek to focus discussions on the strategic risks and the operation of controls during discussions.
- The business cycles of the Board and its committees being aligned to providing assurance on the management of the risks, and the operation of related controls, included in the BAF.
- A standard reporting template focussing on the BAF risks. For assurance reports, the Lead Executive is expected to define the level of assurance they believe to be in place, providing relevant supporting evidence, so that it can be tested and additional information can be provided where there are considered to be further gaps.
- Reports from the Board's committees summarise those issues where they have gained assurance or wish to alert or advise the Board of significant issues. They also are used to draw the Board's attention to new material risks.
- The alignment of the key performance metrics in the integrated performance reports with the BAF risks.
- A range of performance improvement tools which, amongst other arrangements, provide mitigations for identified gaps in control and assurance.
- The alignment of Internal Audit and Counter Fraud Plans with the Trust's principal strategic risks.

In accordance with the provider licence, the Trust must apply those principles, systems and standards of good corporate governance as appropriate for a provider of health care services to the NHS.

As stated earlier in the annual report, the Board has demonstrated due regard to well-led principles and the well-led framework throughout the year.

Potential control weaknesses and opportunities for improvement are identified from a range of sources such as through feedback provided by Governors and external partners; the findings of key assurance processes (e.g. the integrated performance assurance approach, internal audit, counter fraud, clinical audit and quality governance processes); and other key areas of learning e.g the national staff and patient surveys.

In addition to these, during 2024/25, the Board has given specific consideration to internal control issues highlighted in:

- The findings of a developmental review of governance arrangements at the Trust undertaken by Deloitte LLP (report received March 2024)
- Potential controls weaknesses identified by the Board's Committees:
    - The ability to consistently manage Section 17 leave and time 'away from the ward' arrangements for inpatients
    - The historical management of medical device assets

    - Record keeping (following receipt of an Internal Audit Report in Quarter 4, 2023/24)
    - Compliance for ILS training
    - Neurodevelopmental assessments (CYP and adults)
    - The impact on the quality of care and support whilst people are waiting to access care
    - Rates of supervision and recording on TEWVision
    - The overall quality of care and patient experience provided by perinatal services in North Yorkshire York and Selby
    - The delivery of CiTo related actions due a change freeze
- Key performance metrics which have been identified as consistently having limited performance assurance and negative controls assurance during the year:
    - Unique Caseload
    - Agency price cap compliance
    - CRES Performance - Recurrent
- Variation from plan in the delivery of major projects e.g. the implementation of CiTO.

Improvement plans are agreed to address any internal control issues identified which are monitored, on behalf of the Board, by relevant committees based on assurances provided by the executive directors. Indeed, based on assurances received from management, the Board closed the action plan developed in response to the recommendations of Deloitte LLP, at its meeting held in April 2025 with the few remaining outstanding actions being transferred to “business as usual” arrangements.

Risk is embedded in the activities of the organisation in the following ways:

- Quality impact assessments (QIA), requiring consideration by the Medical Director and Chief Nurse, for all Cash Releasing Efficiency Savings (CRES) schemes to assess the impact they will have on clinical performance, and ultimately, the quality of patient care.
- An open reporting culture which encourages staff to report all incidents through its internal reporting system. The embedding of the new Risk Management and Quality System, which incorporates incidents recording and management, has enabled:
    - the identification of areas for improvement to support increased learning and strengthened local response and management of incidents; and
    - improved notification, viability and reporting of areas/ types of incidents and full live reporting.
- The arrangements, as set out in the Trust’s Incident Policy CORP 0043, by which all incidents are reported within the Trust, with all Patient Safety Incidents directly flowing into the national Learning From Patient Safety Incidents (LFPSE) system,and are systematically reviewed and analysed to prevent/minimise their repetition. These include the involvement of patients and families from the beginning of the incident where appropriate.
- The Trust implemented the Patient Safety Incident Response framework (PSIRF) on 29 January 2024. During the year the learning from all serious incidents has been reviewed to ensure that the themes of learning are understood and acted upon on

across all services. This makes it easier to reduce the burden of bureaucracy and focus energy on improvements in practice.

- Incident notifications go to teams and specialists enabling full visibility and awareness and a rounded approach to response. The equality and diversity team, for example, is notified of any incidents involving equality and diversity, the team have full visibility of the incident record, contact staff involved to ensure they are safe and well and identify if support is needed, recording on the incident record.
- Reports with data, graphs and incident listings, providing intelligence at Trust, care group or team level, have been developed, and will continue to be developed for all areas needed. For example a report dashboard for equality and diversity related incidents provides the Equality, Diversity and Human Rights Steering Group with the intelligence needed to identify trends and areas of concern, while also enabling teams to analyse local incidents and patient and staff involvement.
- Equality impact assessments (EIAs) are carried out on all policies and procedures and a dedicated team review all EIAs to ensure a consistent process. In addition, staff are trained in how to complete an EIA.
- Incidents marked as racist etc on the incident reporting system are sent to the Equality, Diversity and Inclusion (EDI)) team and are reported to the Equality, Diversity and Human Rights (EDHR) steering group. The patient safety and CQC teams also send any EDI related incidents to the EDHR steering group.
- Members of the Equality, Diversity and Inclusion (EDI) team also sit on preliminary employee relations panels where there are indications that the concern may be related to a protected characteristic.
- Business case approval processes through which investment requirements are articulated, risk assessed, costed and refined to ensure value for money.

The Trust involves public stakeholders in identifying and managing risks to its strategic objectives in a number of ways. These include:

- Feedback from Governors on concerns raised by their Members.
- Patient satisfaction surveys including the “Friends and Family Test”.
- Feedback from the Trust’s complaints process to inform actionable learning.
- The involvement of patients and the public in the development and evaluation of services.
- Feedback received from patients, staff and the public through CQC enquiries and Mental Health Act complaints.
- Our commitment to co-creation involving multiple stakeholders

Close links with Local Authorities, the Integrated Care Boards, voluntary sector partners and others to ensure the delivery of integrated care and treatment.

The Group continues to progress well in line with the strategic goal of being a great employer.

Consistently achieving safe staffing across all services is recognised as a significant risk and this is reflected in the BAF and related risk score. Systems and processes have been put in place to deliver assurance to the Board that our workforce is able to

provide safe, high quality, compassionate care which is financially sustainable. This has improved in this 12 month period; however, the risk is dynamic and requires consistent attention.

The People Journey, which reflects the Developing Workforce Safeguards published in 2018, provides the strategic framework for advancing a safe, sustainable and effective workforce.

A range of processes are in place to deliver assurance on the delivery of the People Journey and the operation of workforce controls through the Board's committees to the Board:

- The new combined monthly Executive Directors Group (EDG) meeting focused on people and resources ensures greater alignment of these core corporate functions; enabling financial and workforce mitigations to maintain the workforce elements of safe care as well as employee experience and outcomes.

  Standard reporting for these meetings is supplemented by rotating quarterly deep dives into key controls which are aligned to the BAF and risk appetite and the financial position as well as to the regional and national strategic direction for all staff groups.

  Reporting to the EDG is supported by sub-groups, including the Safer Staffing Group and the Temporary Staffing and Overtime Group which provide oversight of key data e.g. effective roster use, agency and overtime reduction, training compliance and supervision levels.
- Through 2024/25 the first of the Board's committee level dashboards was developed in the Integrated Information Centre enabling greater oversight and assurance by the People, Culture and Diversity Committee. This shared data set can be tracked for statistical change at different levels and sections of the organisation and to support targeted action.
- The Trust's workforce planner has been building capability and capacity through delivery of a development programme for managers and those interested in workforce planning, which has included a successful 'Future of Workforce' event. Working together the various professional reference groups', communities of practice and Care Groups' work has begun to develop clinical workforce models which will enable short, medium and longer term resource planning.
- Daily operational processes ensure that staff are deployed who are suitably qualified, competent and skilled. Safe Care is the mechanism to assess and record the clinical dependency and the staffing available to meet this need.
- A monthly safer staffing meeting is chaired by the Chief Nurse which considers performance against the key performance indicators for all inpatient wards. Strong partnership working between nursing and operational leaders has greatly improved our oversight of the risks to quality where achieving safe staffing is a challenge. The meeting is consistent with the National Quality

Boards (NQB) guidance, and reports into the Executive Directors Group and also the Quality Assurance Committee.

- Annual establishment reviews take place in line with NQB requirements including a report to the Board of director. Mid year reports are made to the Quality Assurance Committee.
- The Trust has been assessed by NHSE to ensure that we have met the National Quality Board guidance on the governance of safe staffing which includes meeting the requirement for a staffing review that is conducted in line with the evidence base, includes professional judgement and outcomes.

During 2024/25 progress has been made on the themes of our People Journey, aligned to key controls in the BAF, as follows:

- Strategic Theme – More Staff
  - The Future Talent Team have been promoting health and care careers within schools and colleges. 16 and 17 year olds are now employed into key roles within the organisation.
  - The maximum use of the apprenticeship levy has continued to further support our 'grow our own' approach to succession planning.
  - A range of developmental frameworks, enabling applicants to move from one band to another, continue to support staff development and retention.
  - The Internal Transfer Scheme has proved highly successful in enabling staff members to move to other teams and services at the same banding, aiding retention.
  - An independent process for staff who are leaving, or thinking about leaving, has helped identify areas of concern more quickly and in some cases actively supported the person to find ways of staying.
  - Processes have been improved and strengthened which have resulted in the time taken for recruitment having been reduced by 20 days for internal candidates and 30 days for external candidates. The changes have also brought our work on recruitment with the NHS Business Services Authority to an end.
  - International recruitment has continued for both medical and nursing staff throughout the year with dedicated support provided to help settle colleagues into their new roles.
  - Support from our volunteers, who provide a valuable impact on patient care experience, has continued to grow in numbers and reach, both in the range of roles and entry to employment opportunities. A Veterans' Volunteer to Career programme has been established as well as the Steps to Employment workshops. One of our volunteers won the BBC Radio Tees Award.

- Strategic Theme – Working Differently
  - All staff were supported by a professional reference group reporting to an executive director and, thereby providing representation on the

Board. These groups provide opportunities for relevant staff to be directly involved in the consideration of issues about workforce planning, standards and development.

- The Leadership and Management Academy (LaMA) Board, launched in 2024/25, oversees executive development, leadership programmes, management training programmes and talent management. Dedicated programmes are being developed to help remove barriers to career progression for under-represented groups aligned to our staff networks.
- A new system has been implemented for recording appraisals and supervision (management and clinical) for all staff. The policy and the system have been amended leading to a steady increase in recorded appraisal rates and compliance being achieved.
- The Trust is a signatory to, and compliant with, the national Memorandum of Understanding on mandatory and statutory (M&S) training. Aligned to this, work has been undertaken which has reduced the training load on staff as well as improving access to, and recording of, training. Compliance has continued to improve for all courses and "did not attend" rates are reducing.
- The Managing Concerns of Potential Conduct Policy has also been reviewed with staffside to ensure learning from the previous changes is continually built upon. The time taken to complete investigations has reduced from 150 to 47 days.
- We have significantly improved digital quality in the electronic staff record system (ESR) to 87% and increased process automation.

- Strategic Theme – A compassionate and inclusive culture
  - The Trust has achieved gold status in the Better Health at Work accreditation process.
  - Joint work and data sharing has led to new work on violence and aggression, including increased alignment of the After Action Review and Health and Safety review following an incident.
  - Insights from a survey of over 500 staff will enable gaps in the staff experience after an incident to be addressed.
  - Joint work with local police forces has ensured clarity on roles and responsibilities; aligning with work on reducing restrictive practice interventions.
  - Processes involving alleged incidents of sexual harassment are subject to oversight from the Deputy Director of People and Culture, with contact by the health and wellbeing team, following the signing of the Domestic Abuse and Sexual Violence Charter.
  - The HR team has changed its approach to patterns of behaviour in an investigation following work undertaken on stalking with the Alice Ruggles Trust.
  - Tendering for a new occupational health provider has completed successfully and the service will commence in 2025/26.
  - More effective and efficient triangulation of information, increased knowledge and early escalation of issues have positively impacted upon

outcomes on Speaking Up. Improved processes are enabling more effective and timely support and intervention.

- EDI compliance reporting continues to show strong assurance, and proactive work with different staff groups and communities has increased. The Trust signed the Anti-Racism Charter with Unison and introduced workshops from Show Racism the Red Card for all senior staff. The staff networks continue to grow in membership and influence and a new Trans steering group was set up and supported by externally run workshops. Upstander training was made available to all staff and a cultural engagement programme of events was undertaken throughout the year. Despite this, staff reporting experience of discrimination at work increased and the support, formal process and training on offer, particularly through work with Show Racism the Red Card, continues to be reviewed.
- By March 2025 the Reasonable Adjustments Team had worked with over 550 colleagues, reclaimed £65k related costs from Access to Work and achieved colleague ratings of over 4.5/5 from staff, managers, and internal partners for responsiveness and usefulness. This was also reflected in an increase of 3% to 77% in September 2024 in response to the staff survey question 'my organisation made reasonable adjustments to enable me to carry out my work'.

Key workforce metrics shown in the IPR show a continuing improving position:

- Our leaver rate has remained at reduced levels following a peak in June 2022.
- Agency utilisation has dropped significantly both for WTE deployed and expenditure incurred
- Bank fill rate has increased
- Compliance with local induction has improved
- Appraisal rates have increased

Testing of people controls by the Internal Auditors has provided the following assurances:

- Local Induction: Nurses and HCAs (2023/24 audit) - reasonable
- Data Quality – KPI of Percentage of Staff in Post with a Current Appraisal – substantial
- KPI – Staff Leaver Rate (2023/24 audit) – good

Outcomes from the following Internal Audits are awaited:

- Appraisal and supervision
- Recruitment

To mitigate the risk to data security, the Trust issues monthly cyber security eLearning to all staff. All new staff complete mandatory Data Security and Protection Training, and we perform phishing simulations with the findings and learning that are shared Trust-wide.

Cyber is one of the risks on the Board Assurance Framework (BAF) and is regularly reviewed through the Strategy and Resource Group and Committee.

The Trust employs cyber defences within its estate and is about to embark on the delivery of a comprehensive Cyber strategy from 2023-2025 in line with the National Cyber strategy to further strengthen its cyber position and to keep pace with emerging threats. Cyber security assurance is considered good within the Trust, and reflected in several audits, that have been consistently carried out year on year.

The Trust performs supplier assurance in line with the NHS Digital Technology Assessment Criteria (DTAC) process when new software, systems and suppliers are being considered for use within TEWV. This constitutes verifying privacy statements, certification and cyber approach with prospective suppliers in addition to data protection and technology best practice areas.

These checks include verifying any security certifications they may have (ISO 27001, CE, CE+, SOC2). We check privacy statements and look at where the information is held, how it is stored and what security applied to safeguard it.

This allows us to assure ourselves that the supplier is aware of and compliant with GDPR/DPA 2018. Data and cyber security are a core and essential part of maintaining quality patient care within TEWV and our efforts reflect this.

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

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*' 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.

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

The Trust has agreed processes to ensure that resources are used economically, efficiently and effectively that involve:

- Agreeing an annual financial plan aligning operational, workforce and financial requirements, with triangulation of those elements via and NHSE plan tool.
- A rigorous process to set annual financial plans and to develop cash releasing efficiency savings (CRES) programme.
- Periodic review of Standing Financial Instructions and Scheme of Delegation.
- Robust financial performance management arrangements, including monthly re-forecasting and consideration of necessary recovery actions.
- Support to care groups and directorates to better understand and manage their respective income and expenditure, including the agreement of forecasts to allow monitoring against internal 'control totals' to plan and oversee the mitigation of in-year pressures and support delivery of the agreed financial plan.
- Breaking down the Trust's overall national cost collection indicator to support benchmarking of costs and using comparison of unit costs by providers to understand the Trust's relative cost efficiency.
- Leveraging efficiencies through internal and collaborative procurement initiatives.
- Using service benchmarking and nationally published performance and productivity metrics to inform plans for improved inpatient and community service efficiency.
- Developing workstreams to progress the Estates Master Plan and aim to rationalise and / or better utilising the estate footprint and make progress on sustainability targets.
- Improving workforce productivity, including through innovation, technology and hybrid working.
- Benchmarking costs of corporate functions, including reference to national tools including Model System.
- Utilising annualised business planning and care group and corporate engagement to generate ideas for cost reductions and share good practice (workshops in September 2023 for 2024/25 and in October 2024 and January 2025 for 2025/26).
- Deploying Quality Improvement (QI) methodology to review how the Trust operates, maximising efficiency and minimising waste.
- Working with partners to improve the overall local health economy in terms of quality and efficiency, including developing non-Trust pathways and assuming commissioning functions to improve cost effectiveness and outcomes. The Trust has strategic partnerships with ICBs in both North East and North Cumbria, and Humber and North Yorkshire; works collaboratively with NHS England and with CNTW and others in Provider Collaboratives for specialist services and develops new services for people with Learning Disability using PIPS.
- Robust capital planning functions locally adopting the NHS England business case approvals process guidance, using agreed prioritisation processes to ensure transparent agreement of relative priorities and impact assessments where resource constraints limit Trust ambitions.

The Board plays an active role by:

- Determining the level of financial performance it deems appropriate, including understanding consequent implications for quality, and with reference to the wider operational, performance and financial context.
- Reviewing in detail at each meeting the Trust's year to date and forecast financial performance, financial risk and mitigations and delivery against planned CRES, supplemented by more detailed discussion at Resources and Planning Committee.
- Allocating oversight for key relevant strategic risks to the Trust's Resources and Planning Committee.
- Agreeing the integrated Annual financial, operating and workforce plans submitted to NENC ICB and to NHS England.
- Considering plans for all major revenue and capital investment (and disinvestment).
- For plans in 2025/26 the Board has completed assurance statements, fulfilling national plan submission requirements to consider the broader range of productivity and benchmarking information.
- Annually considering a recommendation (and the rationale for) from the Audit and Risk Committee as to the appropriateness of the Trust producing annual accounting statements on a Going Concern basis.

The Group's Audit and Risk Committee has a key role on behalf of the Board in reviewing assurance. It approves a risk-based annual Internal Audit programme after considering key controls and required assurances relating to strategic risks noted in the Board

Assurance Framework and following individual discussions with Executive Directors and Committee Chairs. The Audit and Risk Committee have received:

- Substantial assurance on key financial and payroll systems through this process.
- The findings of an additional Internal Audit into financial 'grip and control' linked to a wider NENC-wide assurance processes, and through which processes were RAG rated as 'green' overall
- All Internal audit reports findings including weaknesses in key systems of control and the action taken by Management to implement related (high, medium, or low priority) recommendations.
- Local Counter Fraud Specialist findings in relation to fraud.
- External audit reports on specific areas of interest.

The Trust also gains assurance from The Care Quality Commission reports.

Information governance

There were 12 incidents reported in the Data Security and Protection Toolkit by the Trust during the period 1 April 2024 to 31March 2025:

- 4 incidents were privacy breaches affecting 4 persons – inappropriate staff access to local or national patient information systems.
- 4 incidents were confidentiality breaches with a variety of causes.
- 2 incidents were relating to a failure to rectify records in a timely manner.
- 1 incident was a failure to use BCC affecting c. 200 people.
- 1 incident was a duplicate report of an incident already reported.

- All incidents were investigated by the appropriate Trust team.

No cases resulted in regulatory action by the Information Commissioners Office.

Data quality and governance

The following steps have been put in place to ensure that appropriate controls are in place to ensure the accuracy of data:

Who	What	When	Why
Digital Performance and Assurance Group	To monitor and oversee the data quality within the organisation, which covers all information systems managed by Digital and Data Services	Monthly	Provide strategic leadership, direction, and oversight
Data Quality Working Group (DQWG)	To monitor Trust-wide data quality issues and develop action plans to take remedial action. The group will also take a proactive role in ensuring that existing systems are used to record information in line with agreed trust and National standards and use systems to proactively view, monitor and improve data quality on an ongoing basis.	Monthly	Develop action plans to improve the data quality of the organisation. Monitor improvements and report progress, escalating any areas of concern. Monitor nationally available data quality metrics. Raise any business/clinical processes that are leading to poor data quality.
NHS England	Assesses the completeness of data to make assessments for specific outcomes (i.e., employment) using MHSDS	Monthly	For monitoring compliance by NHS FTs with their terms of Authorisation

The Trust has been subject to several audits in which data quality has been measured and targets established to improve the quality of the data captured on information systems.

The Data Quality Assessment Tool (DQAT) is a fundamental part of our “assurance” to the Board, providing confidence that:

- There are clearly defined measures/key performance indicators which are robust and fit for purpose
- Testing processes ensure that the measures remain accurate and up to date.

The tool provides assurance on the quality of data being reported as part of our Integrated Performance Dashboard, focussing on our quality and confidence in:

- the source of the data
- the accuracy and consistency of the data
- the measure construction
- the assurance/audit testing undertaken

The results (scores) from the data quality assessment are reported to Trust Board within our Integrated Performance Report and are overseen by the DQWG to ensure that all improvement actions identified as part of the assessment are completed. Strategic improvements in the monitoring and oversight of Data Quality are described and implemented within the Digital and Data Journey for Change.

In the most recent NHS Digital published results (November 2024) TEWV gained a score of 94% for the Data Quality Maturity Index which is a measurement of data quality in the NHS.

The Trust has the following policies linked to data quality:

- IT-0030 Data Management Policy
- CORP-0026: Records Management Policy
- CORP-0026-007: Records Management and Safe Haven procedure
- CORP-0026-005-v2: Moving records and other sensitive information
- CORP-0026-002-v1.1 Minimum standards for clinical record keeping
- CORP-0006: Information Governance Policy
- IT-0011: Registration Authority Policy
- IT-004: Network User Access Procedure
- IT-0031: Access to Information Systems Policy
- IT-0010: Information Security and Risk Policy
- IT-0014: NHS Number Procedure
- CLIN-0066: Clinical Coding Procedure
- [Multiple]: System Specific Policies of those trust systems containing patient information

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 Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have

been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and the Quality Assurance Committee and other Board committees. and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review has specifically taken into account:

- The assurances provided by NICHE (independent consultants commissioned by NHS England) on the changes in both practice and governance which have been delivered within relevant services since the events which led to the firm's patient safety reports published in 2022/23.
- The delivery of recommendations arising from the Deloitte LLP governance review undertaken in 2024 with the improvement plan signed off by the Board in April 2025 and the remaining outstanding action being taken forward as business as usual.
- The delivery of the improvement plan following the CQC's trustwide inspection of the Trust in 2023/24 with remaining residual actions be managed alongside the Crisis/ HBPOS and Liaison Plan.
- The delivery of a financial surplus and CRES outturn both of which were marginally better than planned.
- The conclusions of the Board, based on assurances provided by the Audit and Risk Committee, that the Trust remains a going concern.
- The Trust's position against NHS England's Oversight Framework (segment 3) and the feedback received from the region on continuing progress.
- The action taken to address the internal control issues identified with the implementation of CiTO.
- The overall conclusions of the annual opinion of the Head of Internal Audit for 2024/25 that:
  "From my review of your systems of internal control, I am providing good assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives. Controls are generally being applied consistently."
- The findings of individual internal audit assignments on key controls and the assurances provided to the Audit and Risk Committee on strengthening controls, during the year, through the delivery of agreed audit recommendations.

  Of particular note has been the substantial assurances provided on:
  - The BAF and risk management
  - Key Controls Relating to Key Financial and Payroll Systems
  - Data Quality – KPI Percentage of Adults and Older Persons Showing Measurable Improvement Following Treatment
  - Data Quality – KPI of Percentage of Staff in Post with a Current Appraisal
  - CQC Action Plan Embeddedness

  Two assignments received limited assurance, immutable backups and transfer of care transmissions; neither of which highlighted any significant control weaknesses.

- The assurances provided to the External Auditors by the Audit and Risk Committee on the controls in place to manage fraud and the application of laws and regulations.

Conclusion

In conclusion, the Group has continued to strengthen its governance, risk management and internal controls arrangements to support the delivery of Our Journey to Change. This is evident from feedback from NICHE, partners and regulators and the progress made in the delivery of improvement plans.

Whilst some control issues were identified during the year, none of them are considered to be significant and timely action has been taken to address them.

Beverley Murphy
Acting Interim Chief Executive

25 June 2025

Independent auditor's report to the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust Group

To be inserted

The accounts 2024/25

The accounts, for the year ended 31 March 2025, have been prepared by Tees, Esk and Wear Valleys NHS Foundation Trust Group in accordance with paragraphs 24 & 25 of Schedule 7 to the NHS Act 2006.

Beverley Murphy
Acting Interim Chief Executive 25 June 2025

Consolidated Statement of Comprehensive Income

		Group		Trust	
		2024/25	2023/24	2024/25	2023/24
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	519,903	484,698	506,578	472,534
Other operating income	4	30,592	29,032	30,592	29,032
Operating expenses	7,9	(569,142)	(522,382)	(556,054)	(510,800)
Operating deficit from continuing operations		**(18,647)**	**(8,652)**	**(18,884)**	**(9,234)**
Finance income	11	3,242	3,787	3,242	3,787
Finance expenses	12	(2,032)	(3,573)	(2,032)	(3,573)
PDC dividends payable		(2,246)	(2,588)	(2,246)	(2,588)
Net finance costs		**(1,036)**	**(2,374)**	**(1,036)**	**(2,374)**
Corporation tax expense		(59)	(138)	-	-
Deficit for the year from continuing operations		**(19,742)**	**(11,164)**	**(19,920)**	**(11,608)**
Deficit for the year		**(19,742)**	**(11,164)**	**(19,920)**	**(11,608)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	8	(720)	(1,851)	(720)	(1,851)
Revaluations	14.1	343	166	343	166
Total comprehensive expense for the period		**(20,119)**	**(12,849)**	**(20,297)**	**(13,293)**

The trust has consolidated one of its subsidiary organisations into its accounts (Group headings) as its income and expenditure levels are now considered material. Prior year financial statements and notes have been presented to include Group comparatives.

Statements of Financial Position

		Group		Trust	
		31 March 2025	31 March 2024	31 March 2025	31 March 2024
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	13	2,753	2,531	2,753	2,531
Property, plant and equipment	14	130,856	144,082	130,856	144,082
Right of use assets	15	7,000	6,085	7,000	6,085
Receivables	17	403	406	403	406
Total non-current assets		**141,012**	**153,104**	**141,012**	**153,104**
Current assets					
Inventories	16	1,223	1,286	1,223	1,286
Receivables	17	20,288	17,612	19,562	16,505
Cash and cash equivalents	18	51,368	60,606	50,458	60,198
Total current assets		**72,879**	**79,504**	**71,243**	**77,989**
Current liabilities					
Trade and other payables	19	(51,091)	(51,319)	(50,170)	(50,342)
Borrowings	21	(3,179)	(3,471)	(3,179)	(3,471)
Provisions	22	(311)	(3,173)	(311)	(3,173)
Other liabilities	20	(759)	(655)	(624)	(519)
Total current liabilities		**(55,340)**	**(58,618)**	**(54,284)**	**(57,505)**
Total assets less current liabilities		**158,551**	**173,990**	**157,971**	**173,588**
Non-current liabilities					
Borrowings	21	(33,960)	(32,497)	(33,960)	(32,497)
Provisions	22	(3,233)	(2,974)	(3,233)	(2,974)
Total non-current liabilities		**(37,193)**	**(35,471)**	**(37,193)**	**(35,471)**
Total assets employed		**121,358**	**138,519**	**120,778**	**138,117**
Financed by					
Public dividend capital		165,922	162,964	165,922	162,964
Revaluation reserve		5,628	6,005	5,628	6,005
Income and expenditure reserve		(50,192)	(30,450)	(50,772)	(30,852)
Total taxpayers' equity		**121,358**	**138,519**	**120,778**	**138,117**

The notes form part of these accounts.

Name	Beverley Murphy
Position	Acting Interim Chief Executive
Date	**25 June 2025**

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

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**162,964**	**6,005**	**(30,450)**	**138,519**
Deficit for the year	-	-	(19,742)	**(19,742)**
Impairments	-	(720)	-	**(720)**
Revaluations	-	343	-	**343**
Public dividend capital received	2,958	-	-	**2,958**
Taxpayers' and others' equity at 31 March 2025	**165,922**	**5,628**	**(50,192)**	**121,358**

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

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**160,212**	**7,690**	**(13,490)**	**154,412**
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	(5,796)	**(5,796)**
Deficit for the year	-	-	(11,164)	**(11,164)**
Impairments	-	(1,851)	-	**(1,851)**
Revaluations	-	166	-	**166**
Public dividend capital received	2,752	-	-	**2,752**
Taxpayers' and others' equity at 31 March 2024	**162,964**	**6,005**	**(30,450)**	**138,519**

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

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**162,964**	**6,005**	**(30,852)**	**138,117**
Deficit for the year	-	-	(19,920)	**(19,920)**
Impairments	-	(720)	-	**(720)**
Revaluations	-	343	-	**343**
Public dividend capital received	2,958	-	-	**2,958**
Taxpayers' and others' equity at 31 March 2025	**165,922**	**5,628**	**(50,772)**	**120,778**

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

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**160,212**	**7,690**	**(13,448)**	**154,454**
Prior period adjustment	**-**	**-**	**-**	**-**
Taxpayers' and others' equity at 1 April 2023 - restated	**160,212**	**7,690**	**(13,448)**	**154,454**
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	**-**	**-**	**(5,796)**	**(5,796)**
Surplus/(deficit) for the year	**-**	**-**	**(11,608)**	**(11,608)**
Impairments	**-**	**(1,851)**	**-**	**(1,851)**
Revaluations	**-**	**166**	**-**	**166**
Public dividend capital received	**2,752**	**-**	**-**	**2,752**
Taxpayers' and others' equity at 31 March 2024	**162,964**	**6,005**	**(30,852)**	**138,117**

Information on reserves

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

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

Income and expenditure reserve
The balance of this reserve is the net accumulated value of the prior and current year surpluses and deficits of the group and trust.

Statements of Cash Flows

	Note	Group 2024/25 £000	Group 2023/24 £000	Trust 2024/25 £000	Trust 2023/24 £000
Cash flows from operating activities					
Operating deficit		(18,647)	(8,652)	(18,884)	(9,234)
Non-cash income and expense:					
Depreciation and amortisation	7.1	6,134	5,293	6,134	5,293
Net impairments	8	20,407	9,725	20,407	9,725
(Increase) / decrease in receivables and other assets		(2,625)	19,375	(3,006)	19,608
(Increase) / decrease in inventories		63	(430)	63	(430)
Increase / (decrease) in payables and other liabilities		605	(16,910)	662	(16,506)
Decrease in provisions		(2,645)	(4,279)	(2,645)	(4,279)
Tax (paid) / received		(59)	(138)	-	-
Net cash flows from operating activities		**3,233**	**3,984**	**2,731**	**4,177**
Cash flows from investing activities					
Interest received		3,242	3,787	3,242	3,787
Purchase of intangible assets		(593)	(2,522)	(593)	(2,522)
Purchase of PPE and investment property		(10,866)	(16,631)	(10,866)	(16,631)
Sales of PPE and investment property		-	11	-	11
Net cash flows used in investing activities		**(8,217)**	**(15,355)**	**(8,217)**	**(15,355)**
Cash flows from financing activities					
Public dividend capital received		2,958	2,752	2,958	2,752
Capital element of lease liability repayments		(2,057)	(2,110)	(2,057)	(2,110)
Capital element of PFI, LIFT and other service concession payments		(982)	(652)	(982)	(652)
Interest paid on lease liability repayments		(207)	(228)	(207)	(228)
Interest paid on PFI, LIFT and other service concession obligations		(925)	(919)	(925)	(919)
PDC dividend paid		(2,771)	(2,909)	(2,771)	(2,909)
Cash flows from other financing activities		-	3	-	1
Net cash flows from used in financing activities		**(3,984)**	**(4,063)**	**(3,984)**	**(4,065)**
Decrease in cash and cash equivalents		**(8,968)**	**(15,434)**	**(9,470)**	**(15,243)**
Cash and cash equivalents at 1 April - brought forward		**60,336**	**75,770**	**59,928**	**75,171**
Cash and cash equivalents at 31 March	18	**51,368**	**60,336**	**50,458**	**59,928**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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 (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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

Note 1.2 Going concern
These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have have confirmed they have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation
The group financial statements consolidate the financial statements of the trust and entities controlled by the trust (its subsidiary) and incorporate its share of the results of the wholly owned subsidiary. These are accounted for at cost in accordance with IAS 27. The financial statements of the subsidiary are prepared for the same reporting year as the trust. The materiality level of all of the entities controlled by the trust was considered in the determination to prepare consolidated financial statements.

The accounting policies of the trust as detailed in note 1 also apply to its subsidiaries unless otherwise specifically detailed.

Financial statements and notes have been presented to show both Group and trust totals. Where no split is shown, it is because the Group and trust totals are the same, i.e. no material impact from the consilidated subsidiary.

NHS Charitable Funds
The trust is the corporate trustee to Tees Esk and Wear Valleys NHS Trust General Charitable Fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund year end is 31 March 2025 and are produced in accordance with Financial Reporting Standard (FRS) 102 accounting standards, but the balances are not consolidated with the trust's accounts on the grounds of immateriality.

Other subsidiaries
Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the draft year end financial statements of the subsidiaries for the year.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The trust has two wholly owned subsidiary companies "Positive Individualised Proactive Support (PIPS) Limited", which prepares accounts under FRS102 (the balances of which are consolidated into Group accounts), and "TEWV Estates and Facilities Management Limited" (made dormant during 2019/20), which prepares accounts under FRS102 . The financial year end for PIPS Ltd was 31 March 2025.

Note 1.4 Revenue from contracts with customers

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

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

The majority of the group's revenue from contracts with customers is received from annual contracts with NHS commissioners. Cash is generally received monthly in twelfths, and performance criteria are met as the contracted services are provided.

Revenue from NHS contracts

The main source of income for the group is contracts with commissioners for health care services. Funding envelopes are set nationally at an Integrated Care System (ICS) level. The majority of the group's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to groups for NHS-funded secondary healthcare.

Aligned Payment and Incentive (API) contracts form the main payment mechanism under the NHSPS. Acute providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

The group also receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective acute hospital services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on acute hospital elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular Integrated Care Board is expected to be a low volume of activity (an LVA arrangement which has an annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

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 a multi-year contract. In these cases it is assessed that the group's interim performance does not create an asset with alternative use for the group, and the group 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 group recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Note 1.5 Other forms of income

Grants and donations

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

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 related training service. Where these funds are paid directly to an accredited training provider from the Trust's Apprenticeship Service Account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment
Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

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

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

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

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

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

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

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

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

A desktop MEA valuation was carried out on the trust's land and buildings at 31 March 2025, and the assets have been treated as prescribed in the GAM. All of the trust's MEA valuations at 31 March 2025 have been completed by Cushman and Wakefield Inc. (independent qualified valuer).

Depreciation

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

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

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

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

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

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

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

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

Donated and grant funded assets

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

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

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

PFI transactions which meet the International Financial Reporting Interpretations Committee (IFRIC) 12 definition of a service concession, as interpreted in HM Treasury's Financial Reporting Manual (FReM), are accounted for as 'on-Statement of Financial Position' by the group. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, 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.

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 group 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.

PFI Lifecycle Replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Initial application of IFRS 16 liability measurement principles to PFI

IFRS 16 liability measurement principles have been applied to PFI and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis has been 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.

Useful lives of property, plant and equipment

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

	Min life Years	**Max life Years**
Buildings, excluding dwellings	1	90
Plant & machinery	1	15
Information technology	1	7

Note 1.9 Intangible assets
Recognition

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

Software

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

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is reflective of expected life, this can be linked to a contract or a nominal expected life.

	Min life	**Max life**
	Years	**Years**
Software licences	1	20

Note 1.10 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Between 2020/21 and 2023/24, the group received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM, and applying the principles of the IFRS Conceptual Framework, the group has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Note 1.11 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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 group's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities
Recognition
Financial assets and financial liabilities arise where the group is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

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

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured at amortised cost.

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

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

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

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

The group adopts the simplified approach to impairments 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 calculated for non government funded organisations only, based on the level of risk attached to individual transactions.

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 group has transferred substantially all the risks and rewards of ownership.

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

Note 1.13 Leases

A lease is a contract, or part of a contract, that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of IFRS 16 Leases (previously IAS 17) 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 which in all other respects meet the definition of a lease. The group does not apply lease accounting to new contracts for the use of intangible assets.

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

The group as a lessee

Recognition and initial measurement

At the commencement date of the lease, this being when the asset is made available for use, the group 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 include fixed lease payments, variable lease payments dependent on an index or rate, and amounts payable under residual value guarantees. Lease payments also include 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 group'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 group 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, or where a total group right of use asset value is not material. Lease payments associated with these leases are expensed on a straight-line basis over the lease term, or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the group 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 group has employed the revaluation model for all right of use assets.

The group 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 group as a lessor

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

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

Finance leases

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

Operating leases

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

Note 1.14 Provisions

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

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

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

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

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme. The group 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 group. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the group is disclosed at Note 22.2, but is not recognised in the group’s accounts.

Non-clinical risk pooling

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

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in Note 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 32, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.16 Public dividend capital

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

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

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

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

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

Note 1.17 Value added tax

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

Note 1.18 Corporation tax

Positive Individual Personalised Support Ltd (PIPS Ltd) is a wholly owned subsidiary of Tees, Esk and Wear Valleys NHS Foundation Trust and is subject to corporation tax on its profits. Tax on the profit or loss for the year comprises current and any deferred tax. Tax is recognised in the Statement of Comprehensive Income except to the extent that it relates to items recognised directly to equity, in which case it is recognised in equity. Current tax is the expected tax payable or receivable on the taxable income or loss for the year, using tax rates enacted or substantively enacted at the Statement of Financial Position date, and any adjustment to tax payable in respect of previous years. Deferred tax is provided on temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. The following temporary differences are not provided for: the initial recognition of goodwill; the initial recognition of assets or liabilities that affect neither accounting nor taxable profit other than in a business combination, and differences relating to investments in subsidiaries to the extent that they will probably not reverse in the foreseeable future. The amount of deferred tax provided is based on the expected manner of realisation or settlement of the carrying amount of assets and liabilities, using tax rates enacted or substantively enacted at the Statement of Financial Position date.

Note 1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.20 Third party assets

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

Note 1.21 Losses and special payments

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

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

Note 1.22 Gifts

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

Note 1.23 Early adoption of standards, amendments and interpretations

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

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

The DHSC GAM does not require the following IFRS Standards 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.

GAM updates (non accounting standard changes)

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

Changes to subsequent measurement of intangible assets and Property, Plant and Equipment PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

• Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

• A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.

• Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed, but it is expected to have a material impact on the carrying values of property assets. Property and right of use assets currently subject to revaluation have a total book value of £129m as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £122m at 31 March 2025.

Note 1.25 Critical judgements in applying accounting policies

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

• The group has identified the valuation of the group's estate as a critical accounting judgement and a key source of uncertainty. Cushman and Wakefield Inc. provide third party assurance of the value of the estate, completing a full modern equivalent valuation exercise every 3 to 5 years. The Trust has made critical judgements in relation to the Modern Equivalent Asset (MEA) revaluation. Cushman & Wakefield as the Trust's valuer carries out a professional valuation of the modern equivalent asset required to have the same productive capacity and service potential as existing Trust assets. Judgements have been made by the Trust in relation to floor space, bed space, garden space, car parking areas and all areas associated with the capacity required to deliver the Trust's services as at 31st March 2025.

• On the grounds of materiality, as per guidance within the GAM, the group has not consolidated its Charitable Fund, or TEWV Estates and Facilities Management (TEWV EFM) services (now dormant), within the main accounts.

Note 1.26 Sources of estimation uncertainty

The valuation of assets is the only source of estimation uncertainty that has a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year. The carrying value at the year end is disclosed in note 14.1.

Valuations are undertaken by an independent external valuer. These values will therefore be subject to changes in market conditions and market values. The asset lives are also estimated by the independent valuer and are subject to professional judgement.

Cost data:
The valuer uses cost data (published by the RICS Building Cost Information Service) adjusted to reflect indexation changes since the original download date. Published price data is a forecast of the costs that would be incurred in constructing a modern equivalent asset and may differ to the costs that would actually be incurred in practice. If the cost data were 2.5% higher this would have an impact on the value of specialised properties recorded on the SoFP of an increase £2.6m.

Adjustments for obsolescence:
Once the build rates for constructing a modern equivalent asset has been determined an adjustment is made to reflect the difference between the modern equivalent and the actual asset being valued. This adjustment is made by the valuer based on his knowledge and experience, further to site survey and detailed discussion with the group, it takes into account physical obsolescence, functional obsolescence (including MEA considerations) and economic obsolescence. Had the adjustment for functional obsolescence been 2% higher than the valuer allowed, this would have an impact on the value of specialised properties recorded on the SoFP of a decrease of £2.3m.

Adjustments for modern equivalent asset (MEA):
The assets have been valued at MEA basis with deductions for physical deterioration and important forms of obsolescence taken into consideration for optimisation. The key assumption underlying the valuation is that the size of the new asset would be less than the existing total m² representing economies gained through increased efficiencies in occupation based on the group's MEA model. Had the adjustment for MEA been 2% higher than the valuer assumed, this would have an impact on the value of specialised properties recorded on the SoFP of an increase of £1.4m.

Note 2 Operating Segments

The group had no elements that required segmental analysis for the period ended 31 March 2025. The chief operating decision maker was identified as the Chief Executive, an Executive Director post within the group and trust; and on this basis the group has identified healthcare as the single operating segment.

Note 2.1 Performance against planned financial position

For the year ended 31st March 2025, the performance of NHS organisations was measured against delivery of their agreed planned financial position. Certain exceptional and technical revenue streams were excluded from the calculation of 'performance' to ensure true operational performance was measured.

The group and trust's planned operational performance, as confirmed formally through national plan submissions for 2024/25, and excluding technical adjustments, was to breakeven (i.e. no reported surplus or deficit). The group and trust reported an adjusted financial surplus position (excluding technical adjustments for Annually Managed Expenditure (AME) impairments and Statement of Comprehensive Income impact of peppercorn leases) of £617k, which was £617k ahead of plan i.e. target achieved. Inclusive of technical adjustments, the accounts show an unadjusted deficit of £19,742k.

A reconciliation of the group's performance against the agreed breakeven plan is shown below:

	2024/25 £000	2023/24 £000
Deficit for the year from SoCI	(19,742)	(11,608)
Add back net impairments	20,407	9,725
Remove I&E impact of peppercorn lease	19	20
Prior period adjustments to correct errors and other performance adjustments	402	-
Remove PFI revenue costs on an IFRS 16 basis	2,345	4,175
Add back PFI revenue costs on a UK GAAP basis	(2,814)	-
Add back PFI revenue costs on an IAS17 basis (2023-24 only)	-	(2,308)
Actual surplus for performance assessment	**617**	**4**
Required performance (planned surplus)	-	-
Performance ahead of required level	**617**	**4**

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Mental health services				
Income from commissioners under API contracts*	397,963	372,617	393,078	368,884
Services delivered under a mental health collaborative	52,065	49,884	52,065	49,884
Clinical income for the secondary commissioning of mandatory services	17,736	19,942	17,736	19,942
Other clinical income from mandatory services	2,711	2,320	2,711	2,320
All services				
National pay award central funding***	536	116	536	116
Additional pension contribution central funding**	24,798	15,388	24,798	15,388
Other clinical income	24,094	24,431	15,654	16,000
Total income from activities	**519,903**	**484,698**	**506,578**	**472,534**

*Aligned payment and incentive (API) contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

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

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

***Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions, which incrased in 2024/25 (to 23.7%, 2023/24: 20.6%) and the increased related NHS England funding (9.4%, 2023/24: 6.3%), have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
Income from patient care activities received from:	**£000**	**£000**	**£000**	**£000**
NHS England	35,881	24,388	35,881	24,388
Integrated care boards	405,152	383,675	400,267	379,942
Other NHS providers	54,776	52,204	54,776	52,204
NHS other	-	8	-	8
Local authorities	11,231	11,212	2,791	2,781
Non NHS: other	12,863	13,211	12,863	13,211
Total income from activities	**519,903**	**484,698**	**506,578**	**472,534**
Of which:				
Related to continuing operations	519,903	484,698	506,578	472,534

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)
The group had no income relating to overseas visitors (non-reciprocal, chargeable to the patient) (2023/24, £nil).

Note 4 Other operating income (Group)

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	2,687	-	**2,687**	2,663	-	**2,663**
Education and training	21,096	1,731	**22,827**	19,931	1,662	**21,593**
Non-patient care services to other bodies	2,517		**2,517**	2,338		**2,338**
Income in respect of employee benefits accounted on a gross basis	875		**875**	1,029		**1,029**
Charitable and other contributions to expenditure		-	**-**		16	**16**
Revenue from operating leases		645	**645**		846	**846**
Other income*	1,041	-	**1,041**	547	-	**547**
Total other operating income	**28,216**	**2,376**	**30,592**	**26,508**	**2,524**	**29,032**
Of which:						
Related to continuing operations			30,592			29,032

*The largest source of other income was £665k relating to income from serivce charges from property leases (non-rent) (2023/24, catering £229k).

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2024/25	2023/24
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	655	1,803

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2025	31 March 2024
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	759	655
Total revenue allocated to remaining performance obligations	**759**	**655**

Note 5.3 Income from activities arising from commissioner requested services

The group is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Income from services designated as commissioner requested services	519,903	484,698	506,578	472,534
Income from services not designated as commissioner requested services	30,592	29,032	30,592	29,032
Total	**550,495**	**513,730**	**537,170**	**501,566**

Note 6 Operating leases - Tees, Esk and Wear Valleys NHS Foundation Trust as lessor
This note discloses income generated in operating lease agreements where the group is the lessor.

The group has 8 leases, all for the rent of property, and the lessees comprise 7 NHS organisations and Thirteen Housing Group Ltd. Due to this there is minimal risk associated with contract default.

Note 6.1 Operating leases income (Group)

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	645	846
Total in-year operating lease income	**645**	**846**

Note 6.2 Future lease receipts (Group)

	31 March 2025	31 March 2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	466	837
- later than one year and not later than two years	106	105
- later than two years and not later than three years	106	105
- later than three years and not later than four years	106	105
- later than four years and not later than five years	106	105
- later than five years	1,865	1,957
Total	**2,755**	**3,214**

Note 7.1 Operating expenses (Group)

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,467	2,048	1,467	2,048
Purchase of healthcare from non-NHS and non-DHSC bodies	16,269	17,894	16,269	17,894
Staff and executive directors costs	448,978	409,242	436,634	398,270
Remuneration of non-executive directors	172	191	172	191
Supplies and services - clinical (excluding drugs costs)	4,191	3,577	4,187	3,576
Supplies and services - general	6,681	6,643	6,681	6,643
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	5,607	5,315	5,607	5,315
Consultancy costs	74	73	74	73
Establishment	4,425	4,857	4,213	4,726
Premises	28,159	25,879	27,781	25,508
Transport (including patient travel)	10,110	9,736	10,066	9,720
Depreciation on property, plant and equipment	5,772	5,277	5,772	5,277
Amortisation on intangible assets	362	16	362	16
Net impairments	20,407	9,725	20,407	9,725
Movement in credit loss allowance: contract receivables / contract assets	157	29	95	25
Change in provisions discount rate(s)	8	(217)	8	(217)
Fees payable to the external auditor				
audit services- statutory audit*	143	128	130	115
Internal audit costs	290	261	290	261
Clinical negligence	1,724	1,597	1,724	1,597
Legal fees	2,681	5,010	2,681	5,010
Insurance	480	406	480	406
Research and development	3,003	2,937	3,003	2,937
Education and training	7,828	8,190	7,735	8,112
Early retirements	-	242	-	242
Redundancy	-	100	-	100
Charges to operating expenditure for on-SoFP PFI schemes	866	746	866	746
Hospitality	51	90	51	90
Losses, ex gratia & special payments	11	15	11	15
Other services, eg external payroll	17	72	17	72
Other**	(791)	2,303	(729)	2,307
Total	**569,142**	**522,382**	**556,054**	**510,800**
Of which:				
Related to continuing operations	569,142	522,382	556,054	510,800

* Amount includes VAT

** Other includes the reversal of an unrequired accrual included in 2023/24 accounts for £1,600k.

Note 7.2 Other auditor remuneration (Group)

The group has not paid its auditors any additional remuneration for the period to 31 March 2025 (31 March 2024, £nil). Auditor's remuneration for statutory audit is shown in note 7.1.

Note 7.3 Limitation on auditor's liability (Group)

There is no limitation on auditor's liability for external audit work carried out for the financial years 2024/25 and 2023/24.

Note 8 Impairment of assets (Group)

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	20,407	9,725
Total net impairments charged to operating surplus / deficit	**20,407**	**9,725**
Impairments charged to the revaluation reserve	720	1,851
Total net impairments	**21,127**	**11,576**

The group realised impairments totalling £21,127k during 2024/25 following an independent valuation of its sites and right of use assets (2023/24, £11,576k).

Note 9 Employee benefits (Group)

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	346,036	314,296
Social security costs	32,770	31,830
Apprenticeship levy	1,611	1,563
Employer's contributions to NHS pensions*	62,838	50,623
Pension cost - other	370	324
Temporary staff (including agency)	11,555	18,701
Total staff costs	**455,180**	**417,337**
Of which		
Costs capitalised as part of assets	1,290	2,720

*The cost of employer's NHS Pensions contributions increased to 23.7% in 2024/25 (2023/24: 20.6%).

Note 9.1 Retirements due to ill-health (Group)

During 2024/25 8 early retirements from the group were agreed on the grounds of ill-health (8 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £720k (2023/24, £717k).

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

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Auto-enrolment

The trust opts all employees into the NHS pension scheme on its auto enrolment date (with the next auto enrolment being on 1 April 2025). In previous years some staff were ineligible for enrolment in the NHS pension scheme, and the trust established an alternative scheme with the National Employment Savings Trust (NEST). The NHS pension scheme is the default (mandated) auto enrolment offering however, where they choose to, staff have the alternative option to become a member of NEST. The NEST pension scheme is a defined contribution scheme, and as such the cost to the NHS Body of participating in the scheme is equal to the contributions payable to the scheme for the

PIPS ltd uses the NEST pension for all employees. Their next auto enrolment date is 1st February 2026.

Trust pension contributions

The NHS Foundation Trust estimates that its employer contributions into the scheme in 2025/26 will be £39,105k, which is based on the 14.38% contribution. The additional contributions from 14.38% to 23.7%, estimated to be £25,492k will be paid directly by NHS England on behalf of the NHS Foundation Trust during the financial year 2025/26.

Note 11 Finance income (Group)

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

	2024/25	2023/24
	£000	£000
Interest on bank accounts	3,242	3,787
Total finance income	**3,242**	**3,787**

Note 12 Finance expenditure (Group)

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

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on lease obligations	207	228
Finance costs on PFI arrangements:		
Main finance costs	925	919
Remeasurement of the liability resulting from change in index or rate	858	2,381
Total interest expense	**1,990**	**3,528**
Unwinding of discount on provisions	42	45
Total finance costs	**2,032**	**3,573**

Note 13 Intangible assets

The group's only intangible asset is a bespoke software system that has been created by the trust. Asset balances as at 31 March 2025 were £2,753k (31 March 2024, £2,531k).

Note 14.1 Property, plant and equipment - 2024/25

Group and trust totals are the same, as PIPS ltd has no non current assets. Due to this there is a single table included in the annual accounts.

Group and trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**11,622**	**120,379**	**3,987**	**3,245**	**10,558**	**149,791**
Additions	-	7,662	486	654	1,821	**10,623**
Impairments	(460)	(19,517)	-	-	-	**(19,977)**
Reversals of impairments	11	737	-	-	-	**748**
Revaluations	89	(2,890)	-	(219)	(532)	**(3,552)**
Reclassifications	-	3,987	(3,987)	-	-	**-**
Valuation/gross cost at 31 March 2025	**11,262**	**110,358**	**486**	**3,680**	**11,847**	**137,633**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**-**	**-**	**1,577**	**4,132**	**5,709**
Provided during the year	-	3,144	-	269	1,550	**4,963**
Revaluations	-	(3,144)	-	(219)	(532)	**(3,895)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**1,627**	**5,150**	**6,777**
Net book value at 31 March 2025	**11,262**	**110,358**	**486**	**2,053**	**6,697**	**130,856**
Net book value at 1 April 2024	**11,622**	**120,379**	**3,987**	**1,668**	**6,426**	**144,082**

Note 14.2 Property, plant and equipment - 2023/24

Group and trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**11,941**	**119,061**	**4,691**	**2,731**	**9,008**	**147,432**
Additions	-	8,740	3,987	514	1,550	**14,791**
Impairments	(371)	(16,466)	-	-	-	**(16,837)**
Reversals of impairments	7	7,272	-	-	-	**7,279**
Revaluations	56	(2,919)	-	-	-	**(2,863)**
Reclassifications	-	4,691	(4,691)	-	-	**-**
Disposals	(11)	-	-	-	-	**(11)**
Valuation/gross cost at 31 March 2024	**11,622**	**120,379**	**3,987**	**3,245**	**10,558**	**149,791**
Accumulated depreciation at 1 April 2023 - as previously stated	**-**	**-**	**-**	**1,345**	**2,929**	**4,274**
Provided during the year	-	3,029	-	232	1,203	**4,464**
Revaluations	-	(3,029)	-	-	-	**(3,029)**
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**1,577**	**4,132**	**5,709**
Net book value at 31 March 2024	**11,622**	**120,379**	**3,987**	**1,668**	**6,426**	**144,082**
Net book value at 1 April 2023	**11,941**	**119,061**	**4,691**	**1,386**	**6,079**	**143,158**

Note 14.3 Property, plant and equipment financing - 31 March 2025

Group and trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Owned - purchased	11,262	104,194	486	2,053	6,697	**124,692**
On-SoFP PFI contracts and other service concession arrangements	-	6,164	-	-	-	**6,164**
NBV total at 31 March 2025	**11,262**	**110,358**	**486**	**2,053**	**6,697**	**130,856**

Note 14.4 Property, plant and equipment financing - 31 March 2024

Group and trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Owned - purchased	11,622	114,323	3,987	1,668	6,426	**138,026**
On-SoFP PFI contracts and other service concession arrangements	-	6,056	-	-	-	**6,056**
NBV total at 31 March 2024	**11,622**	**120,379**	**3,987**	**1,668**	**6,426**	**144,082**

Note 14.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Group and trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Subject to an operating lease	135	4,171				**4,306**
Not subject to an operating lease	11,127	106,187	486	2,053	6,697	**126,550**
NBV total at 31 March 2025	**11,262**	**110,358**	**486**	**2,053**	**6,697**	**130,856**

Note 14.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

Group and trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total

	£000	£000	£000	£000	£000	£000
Subject to an operating lease	236	3,555	-	-	-	**3,791**
Not subject to an operating lease	11,386	116,824	3,987	1,668	6,426	**140,291**
NBV total at 31 March 2024	**11,622**	**120,379**	**3,987**	**1,668**	**6,426**	**144,082**

Note 15 Leases - Tees, Esk and Wear Valleys NHS Foundation Trust as a lessee

The group has 34 property leases accounted for under IFRS 16 as at 31 March 2025. Five new leases have been agreed, and two leases were extended, in 2024/25, which is reflected in the liability increase in note 29.1. Three leased properties were vacated during 2024/25. All leases relate to the trust, so the is no seperate note for trust only reporting.

Note 15.1 Right of use assets - 2024/25

Group	Property (land and buildings)	Total	Of which: leased from DHSC group bodies
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**9,397**	**9,397**	**2,730**
Additions	3,759	**3,759**	49
Remeasurements of the lease liability	(5)	**(5)**	(535)
Impairments	(3,312)	**(3,312)**	(518)
Reversal of impairments	1,414	**1,414**	1,143
Revaluations	(4,121)	**(4,121)**	(1,350)
Disposals / derecognition	(132)	**(132)**	(10)
Valuation/gross cost at 31 March 2025	**7,000**	**7,000**	**1,509**
Accumulated depreciation at 1 April 2024 - brought forward	**3,312**	**3,312**	**1,116**
Provided during the year	809	**809**	234
Revaluations	(4,121)	**(4,121)**	(1,350)
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**
Net book value at 31 March 2025	**7,000**	**7,000**	**1,509**
Net book value at 1 April 2024	**6,085**	**6,085**	**1,614**
Net book value of right of use assets leased from other NHS providers			39
Net book value of right of use assets leased from other DHSC group bodies			1,470

Note 15.2 Right of use assets - 2023/24

Group	Property (land and buildings) £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	**9,564**	**9,564**	**2,737**
Additions	1,919	**1,919**	-
Impairments	(2,035)	**(2,035)**	(12)
Reversal of impairments	17	**17**	5
Disposals / derecognition	(68)	**(68)**	-
Valuation/gross cost at 31 March 2024	**9,397**	**9,397**	**2,730**
Accumulated depreciation at 1 April 2023 - brought forward	**2,499**	**2,499**	**883**
Provided during the year	813	**813**	233
Accumulated depreciation at 31 March 2024	**3,312**	**3,312**	**1,116**
Net book value at 31 March 2024	**6,085**	**6,085**	**1,614**
Net book value at 1 April 2023	**7,065**	**7,065**	**1,854**
Net book value of right of use assets leased from other NHS providers			45
Net book value of right of use assets leased from other DHSC group bodies			1,569

Note 15.3 Revaluations of right of use assets

The group measures Right of Use (ROU) assets by applying the revaluation model in IAS 16. The MEA valuation of ROU assets was subject to an indexation review as at 31 March 2025. Cushman and Wakefield Inc. are the independent qualified valuer that completed the valuation.

Note 15.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the Statement of Financial Position. A breakdown of borrowings is disclosed in note 21.1.

	Group	
	2024/25	**2023/24**
	£000	**£000**
Carrying value at 1 April	**16,763**	**17,022**
Lease additions	3,759	1,919
Lease liability remeasurements	(5)	-
Interest charge arising in year	207	228
Early terminations	(132)	(68)
Lease payments (cash outflows)	(2,264)	(2,338)
Carrying value at 31 March	**18,328**	**16,763**

Lease payments for short term leases, leases of low value underlying assets, and variable lease payments not dependent on an index or rate, are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 15.5 Maturity analysis of future lease payments at 31 March 2025

	Group	
	Total	**Of which leased from DHSC group bodies:**
	31 March 2025	**31 March 2025**
	£000	**£000**
Undiscounted future lease payments payable in:		
- not later than one year;	2,510	867
- later than one year and not later than five years;	9,565	3,117
- later than five years.	7,955	2,226
Total gross future lease payments	**20,030**	**6,210**
Finance charges allocated to future periods	(1,701)	(209)
Net lease liabilities at 31 March 2025	**18,329**	**6,001**
Of which:		
Leased from other NHS providers		135
Leased from other DHSC group bodies		5,866

Note 15.6 Maturity analysis of future lease payments at 31 March 2024

	Group	
	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	2,262	929
- later than one year and not later than five years;	8,330	3,527
- later than five years.	7,443	3,251
Total gross future lease payments	**18,035**	**7,707**
Finance charges allocated to future periods	(1,271)	(351)
Net finance lease liabilities at 31 March 2024	**16,764**	**7,356**
Of which:		
Leased from other NHS providers		121
Leased from other DHSC group bodies		7,235

Note 16 Inventories

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Drugs	257	287	257	287
Consumables	966	999	966	999
Total inventories	**1,223**	**1,286**	**1,223**	**1,286**

Inventories recognised in expenses for the year were £1,286k (2023/24: £872k). Write-down of inventories recognised as expenses for the year were £0k (2023/24: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the group and trust received £16k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 17.1 Receivables

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Contract receivables	10,629	8,665	10,070	7,597
Allowance for impaired contract receivables / assets	(373)	(216)	(307)	(212)
Prepayments (non-PFI)	8,221	7,053	7,988	7,010
PFI lifecycle prepayments	-	477	-	477
PDC dividend receivable	925	400	925	400
VAT receivable	877	1,225	877	1,225
Other receivables	9	8	9	8
Total current receivables	**20,288**	**17,612**	**19,562**	**16,505**
Non-current				
Other receivables	403	406	403	406
Total non-current receivables	**403**	**406**	**403**	**406**
Of which receivable from NHS and DHSC group bodies:				
Current	8,603	4,325	8,043	4,325
Non-current	383	381	383	381

Note 17.2 Allowances for credit losses - 2024/25

	Group Contract receivables and contract assets £000	Trust Contract receivables and contract assets £000
Allowances as at 1 Apr 2024 - brought forward	**216**	**212**
New allowances arising	157	**95**
Allowances as at 31 Mar 2025	**373**	**307**

Note 17.3 Allowances for credit losses - 2023/24

	Group Contract receivables and contract assets £000	Trust Contract receivables and contract assets £000
Allowances as at 1 Apr 2023 - as previously stated	**6,232**	**6,232**
New allowances arising	29	**25**
Utilisation of allowances (write offs)	(6,045)	**(6,045)**
Allowances as at 31 Mar 2024	**216**	**212**

Note 18.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
At 1 April	**60,606**	**75,579**	**60,198**	**75,171**
Net change in year	(9,238)	(14,973)	(9,740)	(14,973)
At 31 March	**51,368**	**60,606**	**50,458**	**60,198**
Broken down into:				
Cash at commercial banks and in hand	1,026	502	116	94
Cash with the Government Banking Service	50,342	39,604	50,342	39,604
Deposits with the National Loan Fund	-	20,500	-	20,500
Total cash and cash equivalents as in SoFP	**51,368**	**60,606**	**50,458**	**60,198**
Bank overdrafts (GBS and commercial banks)	-	(270)	-	(270)
Total cash and cash equivalents as in SoCF	**51,368**	**60,336**	**50,458**	**59,928**

Note 18.2 Third party assets held by the trust

The group held cash and cash equivalents which relate to monies held by the trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts."

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Bank balances	752	755
Total third party assets	**752**	**755**

Note 19.1 Trade and other payables

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Trade payables	1,448	4,321	1,134	4,085
Capital payables	3,539	4,268	3,539	4,268
Accruals	31,173	29,234	30,938	28,871
Social security costs	4,931	4,266	4,819	4,160
VAT payables	264	99	264	99
Other taxes payable	4,328	4,155	4,171	3,928
Pension contributions payable	5,408	4,976	5,305	4,931
Total current trade and other payables	**51,091**	**51,319**	**50,170**	**50,342**

The Directors consider that the carrying amount of trade payables approximates to their fair value.

Note 20 Other liabilities

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Deferred income: contract liabilities	759	655	624	519
Total other current liabilities	**759**	**655**	**624**	**519**

Note 21.1 Borrowings

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Bank overdrafts	-	270	-	270
Lease liabilities	2,256	2,262	2,256	2,262
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	923	939	923	939
Total current borrowings	**3,179**	**3,471**	**3,179**	**3,471**
Non-current				
Lease liabilities	16,073	14,502	16,073	14,502
Obligations under PFI, LIFT or other service concession contracts	17,887	17,995	17,887	17,995
Total non-current borrowings	**33,960**	**32,497**	**33,960**	**32,497**

Note 21.2 Reconciliation of liabilities arising from financing activities (Group)

Group and trust totals are the same, as PIPS ltd has no financing activities. Due to this there is a single table included in the annual accounts.

Group and trust - 2024/25	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2024	**16,763**	**18,934**	**35,697**
Cash movements:			
Financing cash flows - payments and receipts of principal	(2,057)	(982)	**(3,039)**
Financing cash flows - payments of interest	(207)	(925)	**(1,132)**
Non-cash movements:			
Additions	3,759	-	**3,759**
Lease liability remeasurements	(5)	-	**(5)**
Remeasurement of PFI resulting from change in index		858	**858**
Application of effective interest rate	207	925	**1,132**
Early terminations	(132)	-	**(132)**
Carrying value at 31 March 2025	**18,328**	**18,810**	**37,138**

Group and trust - 2023/24	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2023	**17,022**	**11,409**	**28,431**
Cash movements:			
Financing cash flows - payments and receipts of principal	(2,110)	(652)	**(2,762)**
Financing cash flows - payments of interest	(228)	(919)	**(1,147)**
Non-cash movements:			
April 2023		5,796	**5,796**
Additions	1,919	-	**1,919**
Remeasurement of PFI resulting from change in index		2,381	**2,381**
Application of effective interest rate	228	919	**1,147**
Early terminations	(68)	-	**(68)**
Carrying value at 31 March 2024	**16,763**	**18,934**	**35,697**

Note 22.1 Provisions for liabilities and charges analysis (Group)

Group and trust totals are the same, as PIPS ltd holds no provisions. Due to this there is a single table included in the annual accounts.

Group	Pensions: injury benefits	Legal claims*	Other**	Total
	£000	£000	£000	£000
At 1 April 2024	**1,980**	**118**	**4,049**	**6,147**
Change in the discount rate	7	-	(3)	**4**
Arising during the year	145	46	319	**510**
Utilised during the year	(164)	(13)	(25)	**(202)**
Reversed unused	(91)	(30)	(2,855)	**(2,976)**
Unwinding of discount	41	-	20	**61**
At 31 March 2025	**1,918**	**121**	**1,505**	**3,544**
Expected timing of cash flows:				
- not later than one year;	151	121	39	**311**
- later than one year and not later than five years;	569	-	32	**601**
- later than five years.	1,198	-	1,434	**2,632**
Total	**1,918**	**121**	**1,505**	**3,544**

*Legal claims relate to employer / public liability claims notified by NHS Resolution.
**Other provision balances relate to potential contract payments and a provision for clinical pensions tax

Note 22.2 Clinical negligence liabilities

At 31 March 2025, £5,255k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Tees, Esk and Wear Valleys NHS Foundation Trust (31 March 2024: £5,600k).

Note 23 Contingent assets and liabilities

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	(183)	(240)	(183)	(240)
Net value of contingent liabilities	**(183)**	**(240)**	**(183)**	**(240)**
Net value of contingent assets	**-**	**-**		

Contingent liabilities relate to employer liability legal cases, all cases relate to NHS Resolution legal claims and are due within 1 year.

The Trust has a contingent asset (amount uncertain) linked to an ongoing legal case regarding a contract dispute that could result in a future cash inflow to the trust.

Note 24 Contractual capital commitments

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Property, plant and equipment	2,722	2,181	2,722	2,181
Total	**2,722**	**2,181**	**2,722**	**2,181**

Note 25 On-SoFP PFI arrangements

The trust has full control of clinical services provided from its PFI funded hospital (Lanchester Road), and full access and use of the buildings, which are maintained by the PFI project company as part of the PFI procurement contract.

The PFI project company provides services for “hard” facilities management including building maintenance and life cycle replacement programmes. A contractual commitment exists for the PFI project company to maintain the building at “category b” status for the contract life (30 years from commencement for Lanchester Road).

The contract can be terminated within the 30 year contract period if contractual obligations for service delivery (maintenance) and building availability are not met. This is controlled by a points-based payment deduction methodology within the standard PFI contract. The trust has the right to cease the contract early, subject to payment of a financial penalty.

Note 25.1 On-SoFP PFI arrangement obligations

The following obligations in respect of the PFI arrangements are recognised in the statement of financial position:

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Gross PFI, LIFT or other service concession liabilities	**25,384**	**26,109**	**25,384**	**26,109**
Of which liabilities are due				
- not later than one year;	1,802	1,824	1,802	1,824
- later than one year and not later than five years;	7,857	7,194	7,857	7,194
- later than five years.	15,725	17,091	15,725	17,091
Finance charges allocated to future periods	(6,574)	(7,175)	(6,574)	(7,175)
Net PFI, LIFT or other service concession arrangement obligation	**18,810**	**18,934**	**18,810**	**18,934**
- not later than one year;	923	939	923	939
- later than one year and not later than five years;	4,844	4,110	4,844	4,110
- later than five years.	13,043	13,885	13,043	13,885

Note 25.2 Total on-SoFP PFI arrangement commitments

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

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**49,530**	**53,125**	**49,530**	**53,125**
Of which payments are due:				
- not later than one year;	3,241	3,188	3,241	3,188
- later than one year and not later than five years;	13,797	13,571	13,797	13,571
- later than five years.	32,492	36,366	32,492	36,366

Note 25.3 Analysis of amounts payable to service concession operator

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

	Group		Trust	
	2024/25 £000	2023/24 £000	2024/25 £000	2023/24 £000

Unitary payment payable to service concession operator	**3,138**	**2,919**	**3,138**	**2,919**
Consisting of:				
- Interest charge	925	919	925	919
- Repayment of balance sheet obligation	982	652	982	652
- Service element and other charges to operating expenditure	866	746	866	746
- Capital lifecycle maintenance	365	602	365	602
Total amount paid to service concession operator	**3,138**	**2,919**	**3,138**	**2,919**

Note 26 Financial instruments

Note 26.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the trust has with Integrated Care Boards (ICBs) and the way those ICBs are financed, the trust is not exposed to the same degree of financial risk faced by business entities. Financial instruments also play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The trust has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the trust's internal auditors.

Currency risk
The group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The group has no overseas operations and therefore has low exposure to currency rate fluctuations.

Market risk
The main potential market risk to the group is interest rate risk. 100% of the group's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest (excluding interest received from cash held in bank accounts). The group is not, therefore, exposed to significant interest-rate risk.

Credit risk
Credit risk exists where the group can suffer financial loss through default of contractual obligations by a customer or counterparty.

Trade debtors include high value transactions with Integrated Care Boards and Foundation Trusts under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health. Consequently the credit risk exposure is not significant.

Credit risk exposures of monetary financial assets are managed through the group's investment policy which supports investment with Government Banking Service and National Loans Fund only for the Trust.

Credit risk exposures of monetary financial assets are managed through the Planning and Resources Committee (formerly named Strategy and Resources Committee), which is required to approve all methods used for investing cash balances. For the financial year 2024/25 main cash balances were held in Government Banking Service (GBS) accounts, with a small amount held in a Barclays current account to cover unpresented cheques etc.

Liquidity risk
The group's net operating costs are mainly incurred under legally binding contracts with Integrated Care Boards and NHS England as Commissioners, and from Foundation Trusts, all of which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream, which significantly reduces the group's exposure to liquidity risk.

Note 26.2 Carrying values of financial assets (Group)

All of the group's financial assets are carried at amortised cost. Fair value is not considered to be significantly different from book value.

Carrying values of financial assets as at 31 March 2025	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	10,256	**10,256**
Cash and cash equivalents	51,368	**51,368**
Total at 31 March 2025	**61,624**	**61,624**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	7,385	**7,385**
Cash and cash equivalents	60,606	**60,606**
Total at 31 March 2024	**67,991**	**67,991**

Note 26.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2025	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	9,763	**9,763**
Cash and cash equivalents	50,458	**50,458**
Total at 31 March 2025	**60,221**	**60,221**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	7,385	**7,385**
Cash and cash equivalents	60,198	**60,198**
Total at 31 March 2024	**67,583**	**67,583**

Note 26.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	-	**-**
Obligations under leases	18,329	**18,329**
Obligations under PFI	18,810	**18,810**
Trade and other payables excluding non financial liabilities	32,502	**32,502**
Provisions under contract	121	**121**
Total at 31 March 2025	**69,762**	**69,762**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost £000	Total book value £000
Obligations under leases	16,764	**16,764**
Obligations under PFI	18,934	**18,934**
Other borrowings	270	**270**
Trade and other payables excluding non financial liabilities	33,309	**33,309**
Provisions under contract	118	**118**
Total at 31 March 2024	**69,395**	**69,395**

Note 26.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care		**-**
Obligations under leases	18,329	**18,329**
Obligations under PFI	18,810	**18,810**
Trade and other payables excluding non financial liabilities	31,953	**31,953**
Provisions under contract	121	**121**
Total at 31 March 2025	**69,213**	**69,213**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care		**-**
Obligations under leases	16,764	**16,764**
Obligations under PFI	18,934	**18,934**
Other borrowings	270	**270**
Trade and other payables excluding non financial liabilities	33,309	**33,309**
Provisions under contract	118	**118**
Total at 31 March 2024	**69,395**	**69,395**

Note 26.5 Maturity of financial liabilities

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

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
In one year or less	36,935	37,783	36,386	37,783
In more than one year but not more than five years	17,422	15,524	17,422	15,524
In more than five years	23,680	24,534	23,680	24,534
Total	**78,037**	**77,841**	**77,488**	**77,841**

Note 26.6 Fair values of financial assets and liabilities

It is the group's opinion that book value is a reasonable approximation of the fair value of financial assets and liabilities.

Note 27 Losses and special payments

Group and trust totals are the same, as PIPS ltd made no special payments. Due to this there is a single table included in the annual accounts.

	2024/25		2023/24	
Group and trust	**Total number of cases Number**	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Losses				
Cash losses	1	-	3	2
Total losses	**1**	**-**	**3**	**2**
Special payments				
Ex-gratia payments	32	6	35	11
Total special payments	**32**	**6**	**35**	**11**
Total losses and special payments	**33**	**6**	**38**	**13**
Compensation payments received				

Note 28 Related parties

Tees, Esk and Wear Valleys NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Department of Health and Social Care is regarded as the parent department, and a related party. During the period the group and trust has had a significant number of material transactions with entities for which the Department is regarded as the parent department, or a related party.

The main entities that the group and trust has dealings with are its commissioners, namely;

NHS North East and North Cumbria ICB

NHS Humber and North Yorkshire ICB

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (Provider Collaborative)

NHS England

The group and trust also has material expenditure with the following:

NHS Pension Scheme

HM Revenue & Customs

The related parties disclosure below includes organisations the group and trust has a joint venture, subsidiary or other partnership arrangement with. The trust is not required to report other public bodies as related parties.

The trust has two subsidiary companies, Positive Individualised Proactive Support Ltd (consolidated in these accounts), and TEWV Estates and Facilities Management Ltd (made dormant in 2019/20 financial year). The trust is also sole corporate trustee for the Tees Esk and Wear Valleys NHS Trust General Charitable Fund.

During the period none of the Board members, members of the key management staff, or parties related to them, have undertaken any material transactions with the group and trust, or any subsidiary companies or charities.

Note 29 Events after the reporting date

The group and trust have no events after the reporting period to disclose.

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** If you would like additional copies of this report please contact:

The communications team

Email: tewv.enquiries@nhs.net

Our chairman, directors and governors can be contacted through the Trust secretary's office by emailing: tewv.ftmembership@nhs.net

For more information about the Trust and how you can get involved please visit our website www.tewv.nhs.uk

Tees, Esk and Wear Valleys
NHS Foundation Trust

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Gavin Barker
Audit Director
Forvis Mazars LLP
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26 Mosley Street
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NE1 1DF

27 June 2025

Dear Gavin,

Tees, Esk and Wear Valleys NHS Foundation Trust and Group - audit for year ended 31 March 2025

This representation letter is provided in connection with your audit of the financial statements of Tees, Esk and Wear Valleys NHS Foundation Trust (the Trust) and Group, for the year ended 31 March 2025 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with the DHSC Group Accounting Manual 2024/25 (the GAM).

I confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy ourselves that I can properly make each of the following representations to you.

My responsibility for the financial statements and accounting information

I believe that I have fulfilled my responsibilities for the true and fair presentation and preparation of the financial statements in accordance with the GAM, and relevant legislation and International Financial Reporting Standards (IFRS) as adapted and adopted by HM Treasury.

My responsibility to provide and disclose relevant information

I have provided you with:

- access to all information of which I am aware that is relevant to the preparation of the financial statements such as records, documentation and other material;
- additional information that you have requested from us for the purpose of the audit; and

- unrestricted access to individuals within the Trust and Group you determined it was necessary to contact in order to obtain audit evidence.

I confirm as Accountable Officer that I have taken all the necessary steps to make me aware of any relevant audit information and to establish that you, as auditors, are aware of this information.

As far as I am aware there is no relevant audit information of which you, as auditors, are unaware. We confirm that there is no information provided to you as part of the audit that we consider legally privileged.

Accounting records

I confirm that all transactions that have a material effect on the financial statements have been recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all Board and relevant committee meetings, have been made available to you.

Accounting policies

I confirm that I have reviewed the accounting policies applied during the year in accordance with GAM and International Accounting Standard 8 and consider these policies to faithfully represent the effects of transactions, other events or conditions on the Trust‘s and Group’s financial position, financial performance and cash flows.

Accounting estimates, including those measured at current and / or fair value

I confirm that the methods, significant assumptions and the data used by the Trust and Group in making the accounting estimates, including those measured at current and / or fair value, are appropriate to achieve recognition, measurement or disclosure that is in accordance with the applicable financial reporting framework.

Contingencies

There are no material contingent losses including pending or potential litigation that should be accrued where:

- information presently available indicates that it is probable that an asset has been impaired or a liability had been incurred at the balance sheet date; and
- the amount of the loss can be reasonably estimated.

There are no material contingent losses that should be disclosed where, although either or both the conditions specified above are not met, there is a reasonable possibility that a loss, or a loss greater than that accrued, may have been incurred at the balance sheet date.

There are no contingent gains which should be disclosed.

All material matters, including unasserted claims, that may result in litigation against the Trust or Group have been brought to your attention. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with the GAM and relevant legislation and IFRSs as adapted and adopted by HM Treasury.

Laws and regulations

I confirm that I have disclosed to you all those events of which I am aware which involve known or suspected non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

The Trust and Group have complied with all aspects of contractual agreements that would have a material effect on the accounts in the event of non-compliance.

Related party transactions

I confirm that all related party relationships, transactions and balances, have been appropriately accounted for and disclosed in accordance with the requirements of the GAM and relevant legislation and IFRSs.

I have disclosed to you the identity of the Trust and Group's related parties and all related party relationships and transactions of which I am aware.

Fraud and error

I acknowledge my responsibility as Accountable Officer for the design, implementation and maintenance of internal control to prevent and detect fraud and error and I believe I have appropriately fulfilled those responsibilities.

I have disclosed to you:

- all the results of my assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- all knowledge of fraud or suspected fraud affecting the Trust and Group involving:
    - management and those charged with governance;
    - employees who have significant roles in internal control; and
    - others where fraud could have a material effect on the financial statements.

I have disclosed to you all information in relation to any allegations of fraud, or suspected fraud, affecting the Trust and Group financial statements communicated by employees, former employees, analysts, regulators or others

Impairment review

To the best of my knowledge, there is nothing to indicate that there is a permanent reduction in the recoverable amount of the property, plant and equipment, right of use assets and intangibles below their carrying value at the balance sheet date. An impairment review is, therefore, not considered necessary.

Charges on assets

All the Trust and Group's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

Future commitments

The Trust and Group has no plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

Subsequent events

I confirm all events subsequent to the date of the financial statements and for which the GAM, relevant legislation and IFRSs, require adjustment or disclosure have been adjusted or disclosed.

Should further material events occur after the date of this letter which may necessitate revision of the figures included in the financial statements or inclusion of a note thereto, I will advise you accordingly.

Reinforced Autoclaved Aerated Concrete (RAAC)

I confirm that I have revisited my assessment of potential impact of Reinforced Autoclaved Aerated Concrete on the Trust, and in particular whether there are indications of a need for an impairment of the Trust's property, plant and equipment balances. I confirm there are no such indications of impairment in those assets.

Impacts of Russian Forces entering Ukraine

I confirm that I have revisited my assessment of the potential impact of Russian Forces entering Ukraine on the Trust and Group, including the impact of mitigation measures and uncertainties, and that there are no disclosures required in the financial statements.

Tariffs

I confirm that I have carried out an assessment of the potential impact of changes in US trade policy in respect of tariffs, including the impact of reciprocal tariffs by other countries, including the impact of mitigation measures and uncertainties and there are no disclosures required in the financial statements.

Going concern

To the best of my knowledge there is nothing to indicate that the Trust and Group will not continue as a going concern in the foreseeable future. The period to which I have paid particular attention in assessing the appropriateness of the going concern basis is not less than twelve months from the date of approval of the financial statements.

Annual Governance Statement

I am satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust's risk assurance and governance framework, and I confirm that I am not aware of any significant risks that are not disclosed within the AGS.

Annual Report

The disclosures within the Annual Report and Remuneration and Staff Report fairly reflect my understanding of the Trust's financial and operating performance over the period covered by the financial statements.

Arrangements to achieve economy, effectiveness and efficiency in the use of resources (Value for Money arrangements)

I confirm that I have disclosed to you all findings and correspondence from regulators for previous and on-going inspections of which I am aware. In addition, I have disclosed to you any other information that would be considered relevant to your work on value for money arrangements.

Yours faithfully,

Accountable Officer

Tees, Esk and Wear Valleys
NHS Foundation Trust

Meeting of:	**Board of Directors**
Date:	**25 June 2025**
Title:	**Quality Account 2024/25**
Executive Sponsor(s):	**Beverley Murphy, Acting Interim Chief Executive**
Author(s):	**Phil Bellas, Company Secretary** **Leanne McCrindle, Associate Director of Quality Governance, Compliance and Quality Data**

Report for:				
	Assurance	✓	***Decision***	
	Consultation		***Information***	

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
10	Regulatory Compliance	Under its Provider License, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the License, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Executive Summary:

Purpose: The purpose of this report is to seek the Board's approval of the Quality Account 2024/25.

Proposal: The Board is asked to:
(1) Approve the Quality Account 2024/25.
(2) Authorise its submission to the Department of Health and Social Care and publication on the Trust's website.

Overview: Quality Accounts are annual reports, prepared under the Health Act 2009 and in accordance with regulations made by the Secretary of State for Health and Social Care, to inform the public about the quality of services delivered by providers of NHS services.

They are aimed at encouraging boards and leaders of healthcare organisations to assess quality across all the healthcare services they offer; to demonstrate their commitment to continuous, evidence-based quality improvement; and to explain progress.

The draft Quality Account for 2024/25 is attached to this report.

Under the Regulations, key stakeholders (Integrated Care Boards, Health Overview and Scrutiny Committees, local HealthWatch, etc) are provided with an opportunity to comment on the Quality Account before it is published. This is to support confidence in the accuracy

of the data and conclusions drawn by the Trust.

Stakeholder feedback received is included as Appendix 3 to the document. Where appropriate comments have been reflected in the document.

In addition:

- A presentation on the draft Quality Account was provided to:
  - Middlesbrough Council: People Scrutiny Panel, 12.05.25
  - Darlington Special Health and Housing Scrutiny Committee, 13.05.25
- Presentations on progress against the Trust's Quality Priorities have also been provided to a number of other Local Authorities during 2024/25.

The Quality Account is required to be approved by the Board by 30 June 2025.

The Board is asked to note that the Quality Account is no longer subject to a limited (scope) review by the External Auditors.

Prior Consideration and Feedback

Quality Assurance Committee – 5 June 2025 -

The Committee considered that the Quality Account 2024/25 provides a fair, balanced and understandable description of the quality of services.

Audit and Risk Committee – 21 June 2025

The Committee considered that:

(1) A robust process has been followed in preparing the Quality Account 2024/25.

(2) The document provides a fair, accurate and understandable assessment of the quality of Trust's services during 2024/25 and future Quality Priorities.

Implications:

The Trust is required to establish and implement processes and systems to identify risks and guard against their occurrence.

Failure to do so would be a breach of the provider licence.

Recommendations:

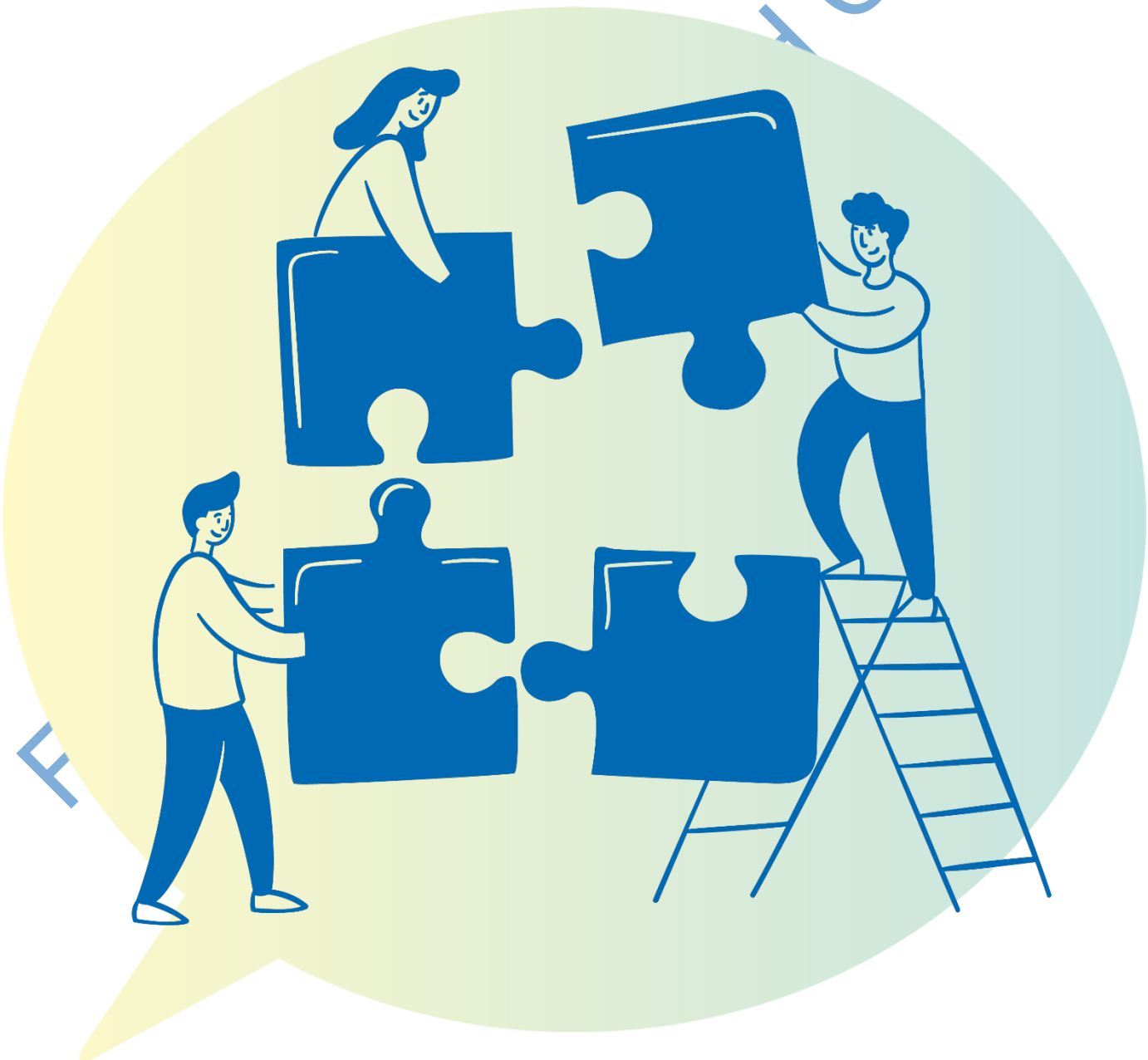
The Board is asked to:

(1) Approve the Quality Account 2025/25.

(2) Authorise its submission to the Department of Health and Social Care and publication on the Trust's website.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Quality Account 2024/25



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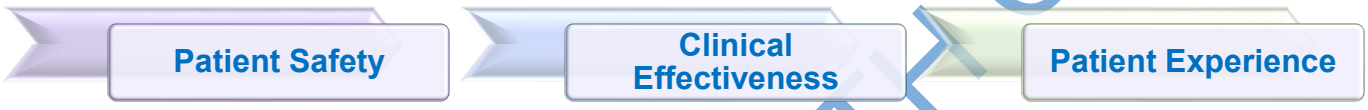
Part One: Introduction and context

1.1 Welcome to the Quality Account and its Purpose

A Quality Account is an annual report describing the quality of services provided by an NHS healthcare organisation. Quality accounts aim to increase public accountability and drive quality improvements in the NHS. All NHS healthcare providers are required to produce an annual Quality Account to provide information on the quality of services they deliver.

This report aims to give a true and fair representation of the quality of our services, including information that is meaningful, relevant and understandable. We hope that the information is useful and demonstrates our commitment and intention to provide high quality and safe services, which is the Trust's highest priority and at the heart of everything we do.

Like all NHS healthcare providers, we focus on three different aspects or domains of quality:



The structure of this Quality Account is in line with guidance published by the Department of Health and NHS England, and contains the following information:

- **Part 1:** Introduction and context
- **Part 2:** Information on how we have improved in the areas of quality we identified as important for 2024/25, our priorities for improvement in 2025/26 and the required statements of assurance from the Board
- **Part 3:** Further information on how we have performed in 2024/25 against our key quality metrics and national targets and the national quality agenda

We would value your feedback on this document so that we can improve next year's Quality Account. If you have any comments or would like more information, please contact us using the details below:

By email: tewv.communications@nhs.net

By telephone: 0300 200 0010

1.2 Chief executive's statement on quality

Everything we do is about people, and we are committed to providing safe and kind care for the communities we serve.

Reflecting on the last year, we've seen so many examples of positive change, driven by our colleagues, working alongside our partners and involving our patients and carers. These changes have had a real and meaningful impact on the quality and the safety of the care we provide.

You can read more about this throughout this report. However, some of the highlights include the work we've done in our inpatient services, such as culture of care, and work to further reduce restrictive interventions. In the last 12 months we've switched our crisis service over to NHS 111 (select the mental health option) and worked with partners to introduce Right Care, Right Person, which aims to give people in our communities the most appropriate support to meet their needs when in a crisis.

There also continues to be a huge amount of work to support people in our communities. Earlier this year, Hartlepool was mentioned as an example of best practice at a Parliamentary Health Select Committee on community mental health transformation. We're incredibly proud of this partnership work and the positive impact it has had - and there are many other examples of this across our trust.

In February, the Care Quality Commission (CQC) published its report into our mental health crisis services and health-based places of safety. We were rated 'good' which means we retained our previous rating and that the service is performing well and meeting the CQC's expectations.

This was another important step in Our Journey to Change. It demonstrated our continuous improvement and the positive impact that this has had on people's experience of our trust. This service supports some of our most vulnerable patients, so maintaining our 'good' rating is incredibly important.

Looking ahead, there continues to be change across the health and social care sector. And we expect more change. Last year saw the publication of the Darzi Report, and we await the publication of the 10-year plan for the NHS. What we do know is that there will be three key areas of focus - hospital to community care, analogue to digital and from treating sickness to preventing it.

The work we've done during 2024-25 fundamentally supports these shifts. Importantly they are also a key focus of our own future plans, and the next stage of Our Journey to Change. This will ensure that we continue to improve the services we provide – with an unwavering commitment to safe and kind care.

Underpinning all of this, is the hard work and dedication of our colleagues, our partners, and the patients and families that we work with to co-create these continued improvements. Thank you to everyone involved.

Beverley Murphy
Acting Interim Chief Executive

1.3 About our Trust and the services we provide

We are the Mental Health, Learning Disability and Autism NHS Foundation Trust for County Durham and Darlington, Teesside, North Yorkshire, York and Selby.

From education and prevention, to crisis and specialist care - our talented and compassionate teams work in partnership with our patients, communities and partners to help the people of our region feel safe, understood, believed in and cared for.

TEWV was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust. In 2008 our Trust became the first mental health Foundation Trust in the North and since then, it has expanded both geographically and in the number and type of services provided. Our Trust now has around 8,100 staff, who work out of more than 90 sites, and an annual income of over £500 million.

We operate across two care group boards – one covering Durham, Tees Valley and Forensic services and one for North Yorkshire, York and Selby.

Across our care group boards, we deliver care under six clinical directorates:

- Adult mental health services
- Mental health services for older people
- Children and young people's mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

As a Foundation Trust we are accountable to local people through our Council of Governors and are regulated by NHS England and the Care Quality Commission

Figure 1: Map of the Trust footprint

1.4 Our Journey to Change

In August 2020 we launched **Our Big Conversation** - the biggest listening exercise in the history of our Trust. Over 2,100 people shared 35,800 ideas, comments, and votes, exploring what could be possible if we got everything right and what we must do to achieve this. From the rich conversations and feedback we received from Our Big Conversation, we developed big ideas for change and a new strategic direction called Our Journey to Change.

It sets out why we do what we do, the kind of organisation we want to be and how we will get there by delivering our three goals and living our new values of respect, compassion, and responsibility all the time.

The big goals we have committed to deliver over the next five years are:

- to co-create a great experience for patients, carers, and their families
- to co-create a great experience for our colleagues
- to be a great partner

Our Journey to Change is at the forefront of everything we do.

There has been a huge amount of work since the launch of Our Journey to Change - we're a very different organisation. We continue to make significant progress, with a focus on providing safe and kind care and improving people's experience of our Trust. This was acknowledged in our latest Care Quality Commission (CQC) well led report.

Since the launch of Our Journey to Change 2021, we've seen the positive impact that it's had on people's experience of our Trust. Whilst we know there is more work to do, we are continuing to build on our progress and make further improvements to make sure the communities we serve get the mental health and learning disability services they need and deserve.

Our Journey to Change: The Next Chapter

In July 2024, we once again held Our Big Conversation where we asked four key questions based on:

- Our journey so far
  - **What are the things we've done well over the last few years to improve the experience we provide to people in our care, families and carers, our colleagues and our partners?**
- Improving the experience of people in our care and their families and carers
  - **What big things should we start, stop or change to deliver an exceptional experience to people in our care, their families and carers?**
- Improving the experience of our colleagues
  - **What big things should we start, stop or change to deliver an exceptional experience to our colleagues?**
- Improving the experience of our partners
  - **What big things should we start, stop or change to be a great partner?**

Our Big Conversation 2024 closed on Friday 9th August 2024 and aimed to strengthen existing intelligence about the impact work has had since the Trust's strategic framework was approved back in January 2021.

990 people took part in this, including 752 Trust staff, 143 people with lived experience (service users / ex-service users and family members), and 95 people in partner organisations. The Board also held a strategy

focussed board workshop on 14 September 2024 which considered the feedback from the Big Conversation and changes in our strategic and operational environment such as the Darzi Report (see part 3.3 of this Quality Account document for further information).

Since that September 2024 workshop, an iterative process to develop a revised set of words for Our Journey to Change has taken place. This has included a further Board workshop discussion, reports to the Council of Governors, continued engagement with the lived experience reference group, discussions with the Trust's leadership and management network members and a 'check and challenge' internal and external stakeholder survey.

This process produced ***Our Journey to Change: The Next Chapter***.

The main differences between the Board's ***next chapter*** and the 2021 Our Journey to Change are:

- Much shorter, more memorable vision statement which does not duplicate other parts of OJTC.
- Goal 1 now has a broader quality focus, partly due to lived experience reference group feedback that the outcomes of treatment need to be good as well as the experience of being treated by our Trust, and that they expect our staff to be knowledgeable and competent as well as working in line with our values and offering good "customer service".
- In Goal 2, the main change is the inclusion of the objective, "Feel safe to challenge, innovate and celebrate". This reflects both the national agenda (e.g. freedom to speak up) but also a view that after several years of progress it is important to celebrate excellent practice to both support staff morale, aid recruitment, and support share and spread of successes.
- Goal 3's revised objectives recognise the increased national emphasis on neighbourhood-level integration and on reducing health inequalities compared to 2021. We also recognise our role as a major employer or "anchor institution".
- The behaviours attached to the responsibility value place more emphasis on staff doing their duties well and recognise the need for staff to be productive and support innovation and change. The emphasis on openness, accountability and reliability was particularly important to the lived experience reference group (as is the importance of not just listening but acting on what is heard in the compassion value), while productivity is now a national NHS priority.

Delivery and implementation of the Trust's strategy will continue to be via the implementation of Care Group and corporate plans, including transformation programmes.

1.5 Co-creation

We are embracing patient and carer experience and using their insights to continually improve, working in close partnership with patients, families and carers to provide the best possible experience and outcomes.
We also work together with our partners and regulators to ensure we understand what good looks like, so we bring meaningful change to the care we provide. We refer to this partnership-style of working as co-creation. It is at the heart of Our Journey to Change and is fundamental to how we improve the care we provide to the communities we serve.
We want co-creation to run through everything we do, so that it becomes the normal way of doing things.
Including:

- Care plans written in partnership, where patients and families have choice about their care and make shared decisions with their clinician.
- A thriving and diverse involvement community that supports co-creation across all areas of our Trust, such as policy, research, recruitment, and quality improvement.
- A growing and diverse peer workforce across all services, underpinned by peer values and driven by peer leadership.
- Innovative and diverse methods to really hear the experience of all patients and families and understand the relationship between patient experience, complaints and serious incidents.
- Lived experience leadership roles supporting transformation and culture change. By lived experience we mean people who have experience of mental illness as a patient or carer and who are using their experiences and insights to help others.

We have made sustained progress in this area and we have two Lived Experience Directors who joined the organisation in 2022. Throughout 2024/25 they have established themselves across both of our Care Boards, offering a lived experience lens, insight and challenge across strategic decision making in our trust. We are now the first Trust in the country to have a strategic lived experience leadership team, including four strategic lived experience roles working across peer support, co-creation and our two Lived Experience Directors.

The strategic lived experience leadership team have broadened the lived experience input across the organisation, by establishing two Co-creation Boards that work closely with our Care Boards and are shaping how we deliver services - putting patient and carer voice at its heart. As well as leading on big transformational pieces of work across the Trust, including the transition from the Care Programme Approach to Personalised Care Planning, Culture of Care Programme and Patient Safety Partner development, in line with our updated Patient Safety Incident Response Framework (PSIRF).

This year, we have also launched our Co-creation Framework, which has been co-developed over several months with the aim of giving clear definitions, co-creation values and types of co-creation that we can use across the Trust and with our partners.

We also employ Peer Support Workers, who have lived experience of mental illness either themselves or as a carer and these roles are continuing to grow. The quality of our peer work implementation has been recognised as a national example of positive practice. The service has demonstrated that it has the experience and expertise to implement into new service areas across the Trust.

Examples of co-creation and lived experience in action:

- The launch of our Co-creation Framework and next steps.

- The co-creation and co-delivery of training to staff and students by patients at Ridgeway.
- Co-designing and developing our approach to patient safety partners under the Patient Safety Incident Response Framework.
- Launching our staff Lived Experience Network.
- A number of co-creation groups have been established and are working with staff on major transformation projects across the Trust, including Community Transformation in Adult Mental Health Services and the Personalised Care Planning approach.
- Service users and carers have joined our Patient-led Assessments of the Care Environment (PLACE) inspections of our wards to offer a lived experience perspective of the wards.
- Service users and carers are involved in the recruitment of staff across the Trust from Board level to community-based teams.

1.6 Patient stories

Anem

A 19-year-old with a passion for advocating children's mental health is committed to using her own lived experience to make "a real difference" to the lives of others. Anem Sharif, an involvement member with the Trust, is determined to play her part in shaping the future of mental health care across the North East.

"I'm confident in my ability to stand up for what's important, ensuring that children's voices are heard, and their mental health is treated as a priority,"
"My goal is to build a career in a child mental health setting, where I can actively contribute to improving services and creating a more supportive environment for young people."
"I aim to inspire young people to overcome challenges, embrace their strengths, and navigate life with resilience and hope."

Anem, from Middlesbrough, first became involved with Child and Adolescent Mental Health Services (CAMHS) at the age of 15. At the time she was used to bottling up her feelings but, after working with "an amazing psychologist", she learned that talking and writing about your feelings really helped.

"My biggest challenge I faced was accepting how I felt – mainly because I was always made to seem like I was dramatic or overthinking," said Anem.
"But the dialectic behaviour therapy (DBT) programme I took part in really helped me to process how I felt – and understand how I felt was valid and totally acceptable."
"As a young person, I know this skill made me more confident within myself, as well as being able to provide reassurance to others when facing difficult times."
"I would definitely encourage other young people to participate in DBT, as it can help shape life in a positive and rewarding way, as well as impacting life in a hopeful way."

Anem's experience with CAMHS has given her great insight into the importance of building resilience – and the need to get back up when you have fallen down.

She said: *"A relapse does not have to mean the end of the journey – when there's someone in recovery there is bound to be urges which may end up leading to a relapse.*
"However, just because there was a relapse doesn't mean it is a reason to give up on yourself and how far you have come. Try and try till you reach your full potential and recover.
"Acknowledge your progress, acknowledge what is going right and acknowledge your strengths."

Anem has collected many hints and tips on her own mental health journey as to how young people can help support each other, which she is keen to share – including:

- Validate each other's feelings
- Be by each other's sides during the difficult times as well as the easier times

- Accept how someone is feeling, even if you cannot understand why that is. By doing so you are encouraging others to process feelings as well as experience emotions and learn how to face them without the fear of judgment.
- Understand that your feelings are valid – but that so are the feelings of others, even if the overall opinion on the topic is different.

Anem said: “My goal is to heal young people. I acknowledge it is never easy, but being in that patient setting and having that lived experience I feel makes me stronger for the role.

“I want to empower and guide young people to realise their full potential and view life through a positive lens.”
“By offering support, encouragement, and practical tools for personal growth, I want to help create a generation that not only believes in their worth but also uses that belief to create meaningful, impactful lives.”
“Ultimately, my goal is to be a source of light, helping young people transform their mindset and approach to the world, paving the way for them to succeed and thrive.”

Anem won the Involvement Member of the Year award at our Star Awards last year, for her work with CAMHS to develop a Dialectical Behavioural Therapy Group for young people.

Niki

An inspirational Redcar mum who felt “on the scrap heap” after struggling with her mental health is now looking forward to a brighter future – thanks to the support of Trust staff.

Niki Wass was in “a dark place filled with pain” when she was admitted to Roseberry Park Hospital in Middlesbrough in 2022, after attempting to take her own life.

“I was convinced my family would be better off without me,” she recalls. *“But somehow, I survived, and being in hospital gave me the pause in life I needed to reflect on things.”*

Niki, 45, suffered from bouts of depression as an adult, but managed to balance running her own care business with her role as a mum-of-three – until a difficult breakup in 2019.

Just a year later she was diagnosed with fibromyalgia and IBS and, as she grappled with family issues, so her anxiety and depression grew progressively worse.

Eventually, she had to step back from her business and was signed off work. Then, COVID-19 hit. As the lockdowns began, so Niki’s mental and physical health spiralled downwards.

“I felt worthless, lost all my self-respect, felt lost without a job to be proud of and was in a lot of physical pain too,” she said. *“It was a very dark time in my life.”*
“My admission to hospital brought the support I needed. But, as time went on, I realised that getting up and doing something would be the key to my recovery – I wanted to help others.”

Just three months after her discharge, Niki was back on the wards of Roseberry Park – this time as a volunteer. Her dream of helping others was starting to come true.

Then, when the Trust's Involvement and Engagement (I&E) Team reached out to volunteer services for some administrative support, Niki offered to help – a move which "changed her life".

"Volunteering with the involvement staff gave me a lot of confidence and helped me regain my self-worth," she said. *"I realised I still had something to offer within the workplace."*

After several months of volunteering, involvement staff – including Dawn Teeley and Jess Wilkinson, Niki was encouraged to study for specialist administrative courses and apply for paid jobs.

Within weeks she was offered two posts, and now works as an Outreach Support Co-ordinator with a mental health team – helping others as she has always hoped to do.

"I firmly believe the support I received from the involvement team and volunteer service has been essential to my recovery, and that it's the reason I now have my dream job," she said.

Ann Bridges, Executive Director of Corporate Affairs and Involvement at the Trust, said: "*Niki's inspiring story shows the power of co-creation in supporting the wellbeing of people. By working together with staff, partners and patients, we can really help make a difference to people's lives as part of their recovery, giving them the confidence to take that next step*."

1.7 Our CQC ratings

The CQC's current ratings for our Trust overall and for each key domain is as follows:

Overall, our current CQC rating is **Requires Improvement**

For each key domain our Trust is rated as follows:

Safe	**Requires Improvement**
Effective	**Good**
Caring	**Good**
Responsive	**Requires Improvement**
Well-led	**Requires Improvement**

Further information is provided within section 2.13: What the Care Quality Commission (CQC) says about us.

1.8 What we have achieved in 2024/25

We're making progress on our goals and working together to co-create a great experience for patients, carers and families, for colleagues and to be a great partner.

How we're co-creating a great experience for patients, carers and families

- CQC rated our Mental Health Crisis Services, Health Based Places of Safety and Liaison Services as good following an inspection in June 2024.
- NICHE undertook a Phase 2 Assurance Review of Practice and Governance which focused on patient safety incidents, complaints and safeguarding events. NICHE found that our CAMHS services had implemented and sustained the recommended improvements in practice.
- Hospitality Assured rated the Trust as 'world class' hospitality – the highest standard of customer service quality standard accreditation that can be achieved.
- Teesside Crisis Assessment Suite (CAS) is shortlisted in the Seni Lewis Award category of the Health Service Journal (HSJ) Patient Safety Awards.
- Services have implemented the national OPEL (Operational Pressures Escalation Levels) Framework, which has improved bed occupancy, sustainability of reduced out of area placements and internal governance of patient flow.
- Implemented NHS 111 (select mental health option 2) service, which has improved response times for people needing to access services.
- Introduced York and North Yorkshire Mental Health Treatment Requirement (MHTR) Team to support people sentenced to a community order and who have a mental health need.
- Implemented the Durham Community Reorganisation Plan for MHSOP (mental health services for older people) with significant benefits such as reduced waiting times and enhanced the quality of care.
- Actively engaged with the Culture of Care Programme, backed by NHS England, to help improve the experience of those in our care.
- Delivered trust-wide workshops with clinical and operational colleagues to explore moving from a risk-based culture to one that focuses on therapeutic benefits and outcomes - implementing the GIRFT (Getting it Right First Time) principles across our services.
- Worked with the family of a patient who sadly died in our care to create the Chris's Voice Campaign, which aims to help improve involvement of patients and families in our care delivery.
- The Personalised Care Planning Policy has been developed, ratified and is moving into implementation.
- 600 patients have been supported with their paid employment aspirations and achieved 300 paid employment outcomes.
- 849 concerns have been managed locally at ward or team level (local issue resolution). Complaints were managed as an early resolution complaint (385 in total) and 116 were managed as a formal complaint, ensuring concerns are addressed promptly.
- Increased the number of complaints responded to within our originally agreed timeframes by 15%.
- Secure Inpatient Services held an equality inclusion event at Ridgeway with awareness sessions and the launch of AQA (Assessment and Qualifications Alliance) training for patients to gain a qualification in EDI (equality, diversity and inclusion) and race.
- Launched a dedicated CAMHS (child and adolescent mental health services) web section on our trust website – this was co-created by children and young people, their parents and carers, and staff, and is a fantastic resource for everyone.
- 420 patients participated in research approved by a Research Ethics Committee across 29 NIHR (National Institute for Health Research) portfolio research studies (patients receiving relevant health service provided or sub-contracted by our Trust in 2024/2025 that were recruited during that period).
- Successfully contributed to several successful NIHR applications, including a £1.8m NIHR Work and Health Programme Award.
- Promoted PRES (Patient Research Experience Survey) and helped secure hundreds of new sign-ups to Join Dementia Research.
- The Trust were joint fourth place nationally for the number of recruiting 'interventional' mental health research studies.

- The peer workforce increased by 24% meaning more people with lived experience of mental health difficulties are using their experiences and specialist training to support patients, carers and families.
- Launched a 360-degree virtual tour of the Dalesway Unit, Roseberry Park Hospital, to relieve anxiety for first time visitors to the service.
- Significantly reduced our use of IS (independent sector) beds.
- Wellbeing in Mind (North Yorkshire school support service) now supports 64 schools within Hambleton and Richmond, Selby, Scarborough and Ryedale, and Harrogate and York.
- A new six-week course co-designed by veterans for veterans was launched by the ARCH Recovery College.
- Delivered c£2m life cycle expenditure to improve and maintain the Trust's property portfolio to a high standard, aligned with CQC Quality Standards.
- There have been improvements and new facilities at Lanchester Road Hospital, Roseberry Park Hospital and Worsley Court.
- Refurbishment works have started at the One Life Centre in Hartlepool (to be completed by June 2025), providing a much-improved environment for those accessing our services currently at Stewart House.
- Works have started on Jesmond House to provide a multi-speciality hub for the teams in Harrogate and an increased capacity for clinical appointments.
- The agreement for lease has been signed for the new Combined Care Centre at Catterick, providing purpose designed accommodation for community teams, currently based in Colburn, with an increased capacity for clinic appointments.
- A new, co-produced three year positive and safe strategy has been launched which will impact on reducing restrictive interventions.
- Successful bids against national sustainability funds have been achieved for LED lighting, solar panels, and BMS (building management systems).
- Awarded new solar panel funding, saving of £157,000 a year which is supporting investment into patient care.

How we're co-creating a great experience for colleagues

- Achieved the Better Health at Work Award Gold status and are now working towards 'continuing excellence' in 2025.
- A Leadership and Management Academy has been rolled out across the trust to strengthen the skills of current and future leaders and empower colleagues to be the best they can be.
- Over 550 colleagues have been helped by the Reasonable Adjustments Team and have reclaimed £65,452.32 from Access to Work.
- There were 492 nominations received for our annual staff awards (Star Awards), celebrating colleagues who do amazing work and go the extra mile.
- Launched our new staff lived experience network and established co-creation groups to work with staff on major transformation projects across the trust.
- Employed a peer lead for Culture of Care in inpatient services to provide leadership to inpatient peer support workers and support the trust's drive to implement Culture of Care standards.
- Co-created a Co-creation Policy, which includes a clear and robust processes. We have also established 27 Co-creation Champions trained and inducted so far with expansion planned.
- Confirmed funding to establish Peer Worker roles across DTVF (Durham Tees Valley Forensic) Crisis Teams.
- Increased volunteers by 17% (moving from 237 in 2023 to 277 in 2024).
- 59 people attended the Step Towards Employment Programme in 2024, with an average rating for usefulness of the course of 4.6 (out of 5).
- There have been measurable improvements in January 2025 from the NQPS (National Quarterly Pulse Survey), which helps us understand employee experience and support decision making and actions for improvement.
- A full review of mandatory and statutory training has been undertaken aligned to national priorities.

- Personalised care planning training has been implemented and is a mandatory in-person training model with top-ups every three years. We have also recruited to three involvement members to support communication, training, and policy implementation.
- Five positive and safe care trainers have successfully completed a moving and handling train the trainer course to increase the team capacity – work is ongoing to increase the number of trainers who can also train colleagues in Resuscitation.
- Improved clinical supervision recording continues following embedding of the TEWVision system.
- In-person events have resumed for our trust's welcome inductions, delivering two per month.
- Demonstrated a reduction in vacancies, which has had a positive impact on care delivery.
- Reduced use of agency staff within inpatient and community services from 32% (April 2024) to 10% (March 2025).
- Introduced a three-week Ridgeway Welcome Programme at Roseberry Park Hospital for all new Ridgeway staff and increased the staff retention rate to 88%.
- Outsourcing timeframes have reduced to ensure that shifts remain with the bank giving bank workers increased opportunities to fill shifts. Successfully recruited to the bank, via recruitment campaigns, which increased the bank fill rate from 48% to 72%.
- Pre-employment checks moved back in-house (from NHS Business Services Authority) and improved completion time from an average of 59 days to 24 days.
- There has been an extensive review of our Managing Concerns Procedure in collaboration with Staffside (union representatives), further embedding our Just and Learning Culture.
- The first TEWV 10K run took place at York Racecourse in April 2024 with another planned for 2025.
- The first TEWV 5K run took place in and around HMP Kirklevington Grange in March 2025.
- The staff-led Health and Wellbeing Council received 91 bids for charitable funding and approved 42 of them, with services and teams awarded £99,000 for local initiatives.
- Increased health and wellbeing champions from 304 to 349 (+14.8%).
- Launched sexual safety in the workplace toolkit and domestic abuse toolkit to guide managers and colleagues.
- A new Medical Strategy has been developed, following stakeholder involvement, as part of Our Journey to Change, which focused on training the future generation, optimising recruitment of medical staff, being an attractive place to work and having a strong engaged workforce.
- There has also been a new TEWV Charter for the Medical Workforce to ensure high standards of support and professional development for colleagues.
- A Medical Directorate Equality Group has been established to consider issues affecting the experiences of medical students and doctors within our trust including gender, race, LGBTQ+, disability and religious practice and expression.
- The Faculty of Medical Education hosted its annual, internal educational audit visit to enhance quality monitoring and assurance for all postgraduate and undergraduate activity within the trust.
- Team and service-level Workforce Plans have been developed to support services to plan for the future workforce that they need, with support put in place for leadership teams including online training modules, guidance and templates and a Community of Practice (a group of people who share a common concern, a set of problems, or an interest in a topic and who come together to fulfil both individual and group goals).
- Introduced recruitment for 16 and 17-year-olds through apprenticeships, T-levels, volunteering and work experience placements across a variety of roles and specialties.
- Received 50 requests for work experience placements and sourced placements for 36 (73% success rate).
- 184 staff started an apprenticeship and 130 staff completed an apprenticeship.
- Gained a new contract for Liaison and Diversion Services for Durham and Cleveland Police Force areas.
- Gained CQC Registration and established the mental health services for the new HMP Millsike.
- The Lived Experience Manager for Learning Disability and Neurodiversity has been honoured with the Outstanding Contribution to Positive Behaviour Support Award by the British Institute of Learning Disabilities (BILD).

- The Trust has won a total of five awards and several highly commended accolades at the National Positive Practice in Mental Health Awards (PPiMH) 2024.
- Nurses, Sue Sargeant and Claire Donnelly, were awarded Learning Disability Nurses of the Year at British Journal of Nursing (BJN) Awards in London following national recognition for their work to stop the over medication of people (STOMP) with a learning disability, autism or both.
- Dr Jennifer Gilligan won Specialty Doctor / Associate Specialist of the Year at the Royal College of Psychiatry (RCPsych) Awards.
- The Volunteer Service Co-ordinator, Kelly Conway, and her therapy dog Ruby, won the animal award at the BBC Make a Difference Awards.
- The NEPACS (North East Prison and Criminal Justice Network) award was won by a member of our SOTT (secure outreach transitions team) and a certificate of excellence was awarded to another STOTT colleague.
- The Health and Justice Mental Health Treatment and Review Team were recognised with a certificate of excellence at NEPACS. The Ruth Cranfield Awards also celebrated exceptional work for rehabilitating prisoners into society and helping cut the risk of re-offending.

How we're working with our partners

- Systemwide, Peer Support Worker Networks have been established in County Durham and York in collaboration with local VCSE (voluntary, community and social enterprise).
- The Co-creation Framework, which has been co-developed over several years has been launched and aims to give clear definitions, co-creation values and types of co-creation that we can use across the trust and with our partners.
- The Trust joined the Yorkshire and Humber Perinatal Mental Health Provider Collaborative, working with seven other providers in Yorkshire and Humber to improve perinatal mental health care.
- The Distress Brief Intervention (DBI) service has been expanded across County Durham, along with partners at Everyturn, following the success of the initial programme in Derwentside.
- Enhanced Health in Care Homes Service, working in partnership with primary care colleagues and carers was awarded Highly Commended at the Yorkshire and Humberside Great British Care Awards 2024.
- We are transforming our services. Personalised care planning, working with partners across the public and voluntary community and social enterprise sector, is transforming the way people with mental illnesses are supported within their local community.
- We have worked with partners to open a new Wellbeing Hub, in Wellington Square, Stockton to support the wellbeing of local people and the Tees Valley Community Mental Health Transformation Programme.
- Forums for learning disabilities have been established, working with North Yorkshire York and Selby Improving Together and Durham Tees Valley and Forensics Group, People with Power to make changes for people with learning disabilities.
- A transitions pilot is being developed with three VCSEs organisations, in partnership with urgent care and peer leaders in our trust – this is a one year pilot to support 18 to 25-year-olds admitted to our wards with intentional lived experience roles.
- We have commenced conversations with CNTW (Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust) to share good practice in the learning and development contract.
- Over 200 people attended our trust's AGM (annual general meeting) in Darlington, which this year showcased our collaborative approach with valued partners to improve the lives of people in our local communities.

Living our values

Our Journey to Change sets out why we do what we do and the kind of organisation we want to become. It also sets out how we'll get there by living our values, respect, compassion and responsibility – all of the time.

It's important that we recognise and celebrate when we're truly living our values, and we encourage people to share examples of this. Each month we hold a living our values award, recognising colleagues who are living our values and the positive impact it has on the experience for people in our care, families and carers, colleagues and our partners. In 2024/25, there was an increase in nominations from patients, carers, partners and colleagues.

1.9 National awards – won and shortlisted

In addition to our Trust achievements listed above, external bodies have recognised the work of individuals or teams through the award shortlisting, or award wins listed in the table below.

Award	Awarding status	Name / category of award	Team / individual
Skills for Health Awards	Winner	Best Healthcare Workforce Collaboration	Reconnect team
Teesside Healthwatch Star Awards	Winner	Excelling in support to others Award	Sue Sargeant
Positive Practice in Mental Health Awards	Winner	Forensic Mental Health Services (including criminal justice, inpatient, liaison & diversion and prison mental healthcare)	Integrated Support Unit, HMP Durham
Positive Practice in Mental Health Awards	Winner	Outstanding Leadership for Band 7 and 8 staff – Individual Award	Richard Hand
Positive Practice in Mental Health Awards	Winner	All Age Eating disorders Services for Adults or Children and Young People	Teesside Children and Young People Community Eating Disorder Service
Positive Practice in Mental Health Awards	Winner	Older adult functional mental health services and/or dementia care	County Durham and Darlington Care Home Liaison Hub
Positive Practice in Mental Health Awards	Winner	Addressing mental health inequalities	The REACH team, Scarborough
Positive Practice in Mental Health Awards	Highly Commended	Innovation in Community Mental Health (including Primary Mental Health Care)	The REACH team – Scarborough
Positive Practice in Mental Health Awards	Highly Commended	Perinatal and maternal mental health	North Yorkshire and York perinatal team
Positive Practice in Mental Health Awards	Highly Commended	Suicide prevention services with a focus on initiatives which encourage multiagency working (LA / PH / NHS / Police / Third sector)	Familiar Faces
Positive Practice in Mental Health Awards	Highly Commended	Outstanding Leadership for Band 7 and 8 staff – INDIVIDUAL AWARD	Karla Shariff
Positive Practice in Mental Health Awards	Highly Commended	Mental Wellbeing of the Workforce	Kestrel Kite ward
Positive Practice in Mental Health Awards	Highly Commended	Mental Wellbeing of the Workforce	Employee Support Service
Positive Practice in Mental Health Awards	Highly Commended	Innovation in Digital Mental Health Care	Recovery College Online

Award	Awarding status	Name / category of award	Team / individual
Positive Practice in Mental Health Awards	Highly Commended	Non-Clinical Team of the Year (inc. admin, facilities, finance, housekeeping etc.)	Employee support services
Positive Practice in Mental Health Awards	Highly Commended	Complex mental health needs, including services working with people with a diagnosis of personality disorder	Wellbeing Unit: Regional Enhanced Mental Health Unit – HMP Hull
Positive Practice in Mental Health Awards	Highly Commended	Specialist Services (including, Veterans, Substance Misuse, Addictions, Housing, Education and Employment)	Individual Placement and Support (IPS) team
British Institute of Learning Disabilities International Positive Behavioural Support conference	Awarded	Outstanding Contribution to Positive Behaviour Support	Debbie Austin
Teesside University: Student Nursing Associate Awards	Winner	Champion for patient/service user care	Danielle Calvert
Teesside University: Student Nursing Associate Awards	Winner	Outstanding care and compassion in patient/service user care	Martin Young
The Learning Disabilities and Autism Awards	Highly Commended	Learning Disability Nurse of the year	Sue Sargeant and Claire Donnelly
Healthcare Financial Management Association (HFMA)	Winner	Unsung Hero of the Year	Emma Cruttenden
Healthcare Financial Management Association (HFMA)	Winner	Finance team of the year	Finance team
Healthcare Financial Management Association (HFMA)	Winner	Lifetime Achievement Award	Drew Kendall
Cavell Star Awards	Winner	Awarded	Hayley Hawksby
NEPACS Ruth Cranfield Award	Winner	Awarded	Stephen Harding
HSJ Patient Safety Awards	Winner	Staff Wellbeing Initiative of the Year	Humber and North Yorkshire Resilience Hub
BBC Radio Tees Make a Difference Awards	Winner	The Animal Award	Kelly Conway and Ruby
RC Psyche Awards 2024	Winner	Specialty Doctor/Associate Specialist of the Year	Jennifer Gilligan

Award	Awarding status	Name / category of award	Team / individual
Great British Care Awards	Highly Commended	Social care nurse of the year	Enhanced Health in care Homes service
Bright Ideas in Health Awards 2024	Winner	Research for Local Health Needs	Increasing Access to Healthy, Affordable Food for Adults Living with Severe Mental Illness in Teesside – Teesside University
Cavell Star Awards	Winner	Awarded	Shelley Glover
Woman Achieving Greatness in Social Care awards	Winner	Outstanding Partner Award	Claire Donnelly & Sue Sargeant, Primary Care Liaison Nurse & Advanced Nurse Practitioner, Tees, Esk & Wear Valleys NHS Foundation Trust
Better Health at Work Award	Awarded	Gold Award	Trustwide wellbeing service
British Journal of Nursing (BJN) Awards	Winner	Learning Disability Nurses of the Year	Sue Sargeant and Claire Donnelly

Part Two: Quality priorities for 2024/25 and required statements of assurance from the Board

2.1 Introduction – purpose of this section

In part two of our Quality Account, we outline our planned quality improvement priorities for 2024/25 and provide a series of statements of assurance from the Board on mandated items as required by NHS England.

In this section, we also review the progress we have made in relation to the quality priorities we set ourselves.

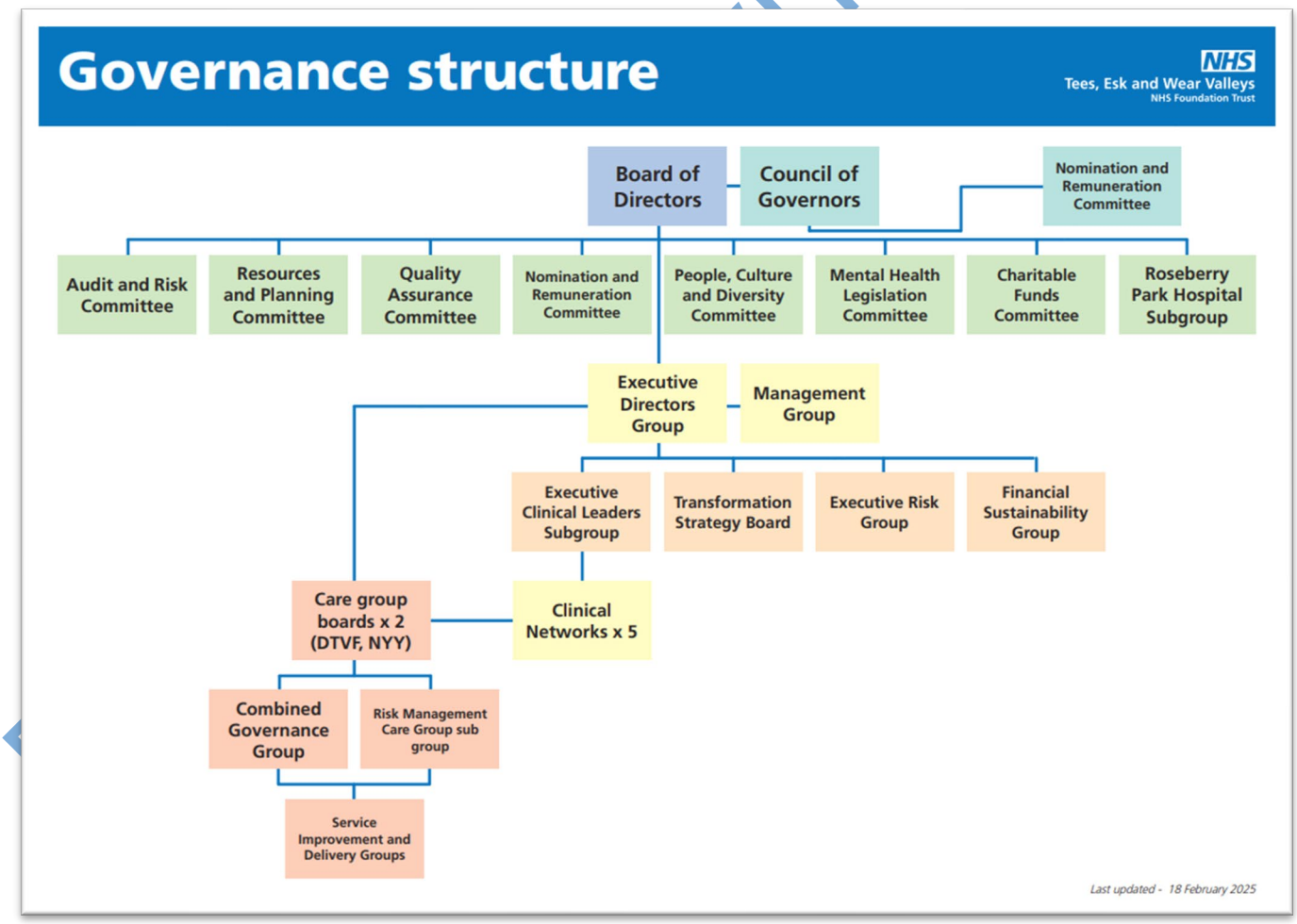
2.2 Our approach to quality governance and improvement

Our Trust has a robust governance infrastructure. Our governance structure is focused on clear oversight and accountability and is supported by the Trust's Accountability Framework.

The governance structure supports the delivery of Our Journey to Change by making sure that we are:

- Clinically led and operationally enabled.
- Better able to align around the regional changes in the form of the two Integrated Care Systems in which we provide services.
- Able to deliver on individual and collective system wide accountability effectively and consistently, by making all roles clearer and manageable for post holders.
- Organised in a more simple, less complex way formally incorporating patient leadership into our structures.

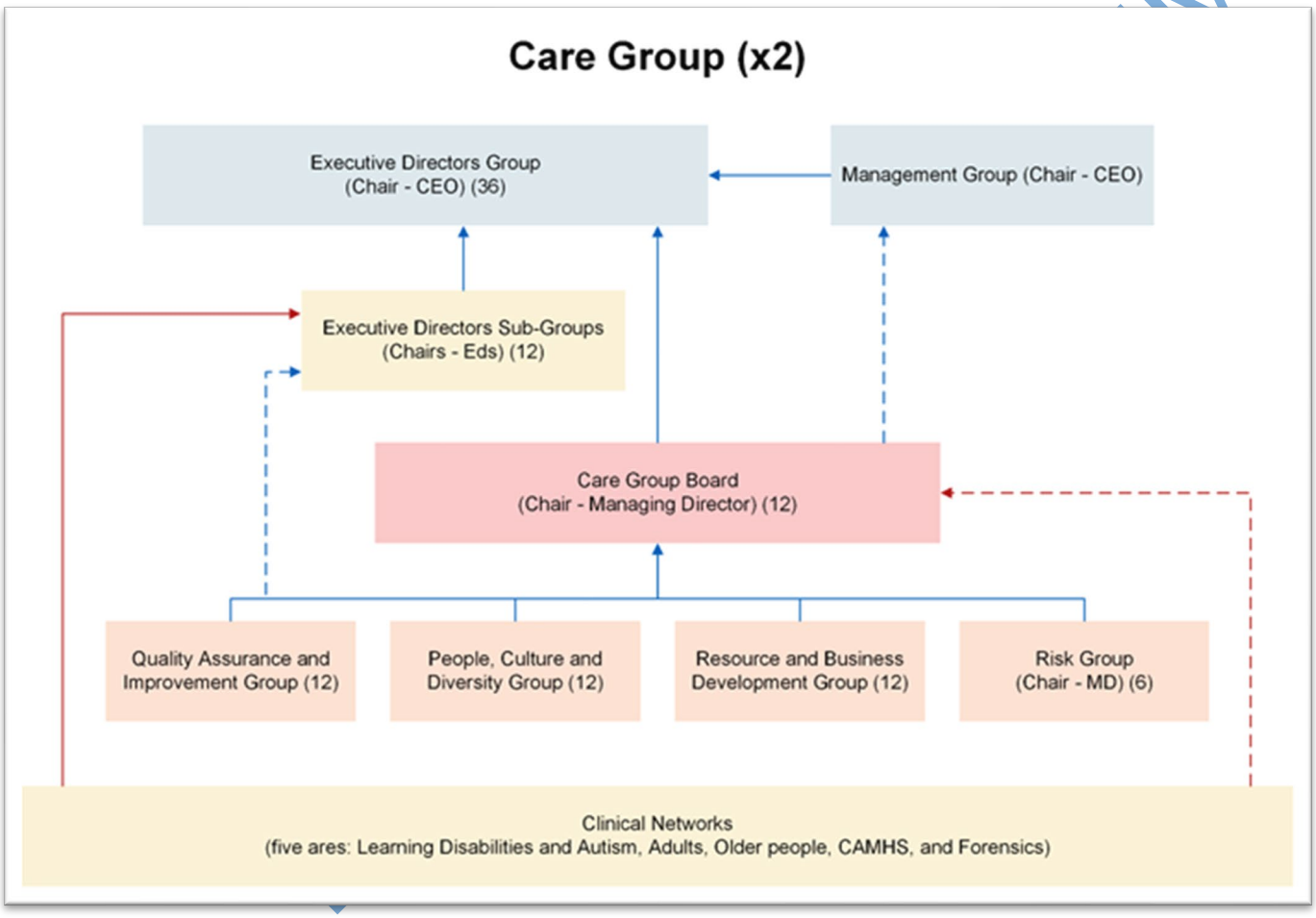
The governance structure in place during 2024/25 is shown in the figure below:



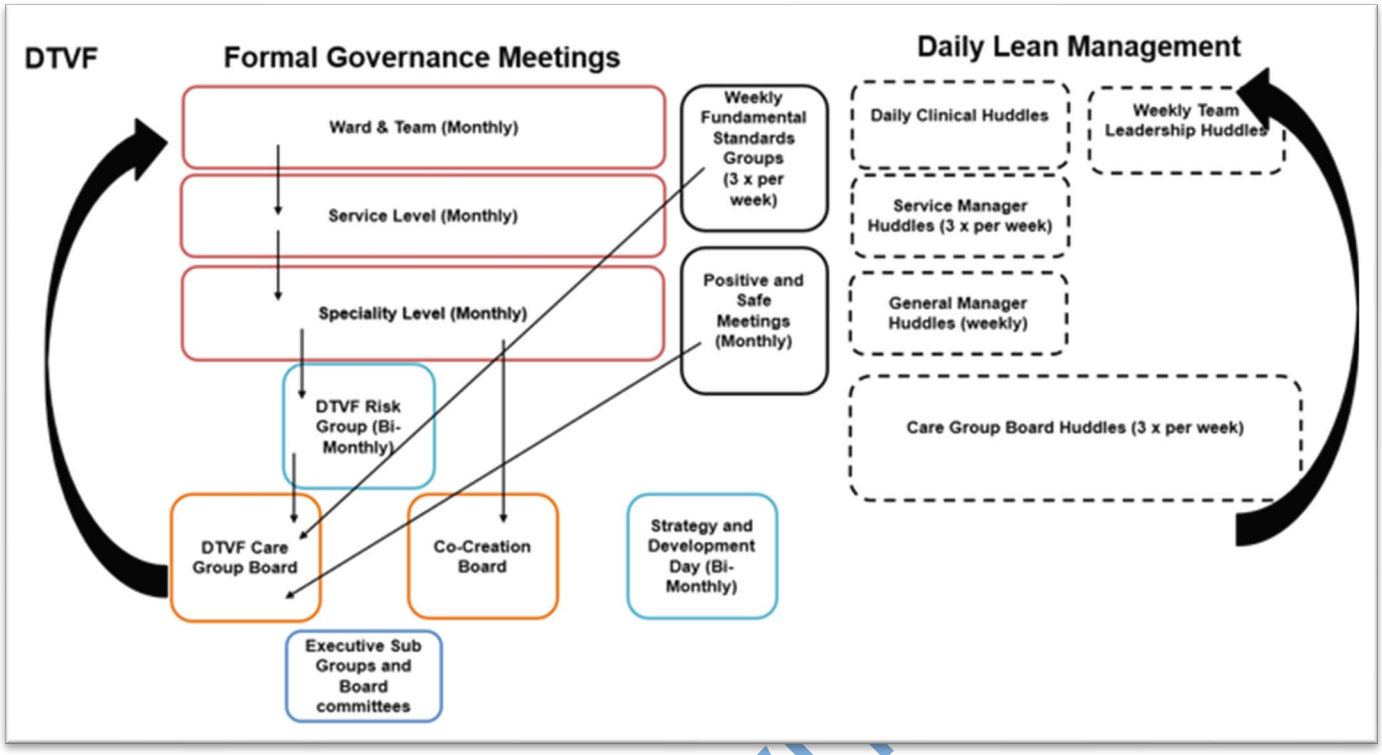
Our Trust Board ensures robust quality governance through the Quality Assurance Committee, a Committee of the Board.

The Quality Assurance Committee is chaired by a Non-Executive Director. Its strategic purpose is to provide assurance to the Board on the quality, safety and effectiveness of clinical and operational services through effective systems, structures and processes.

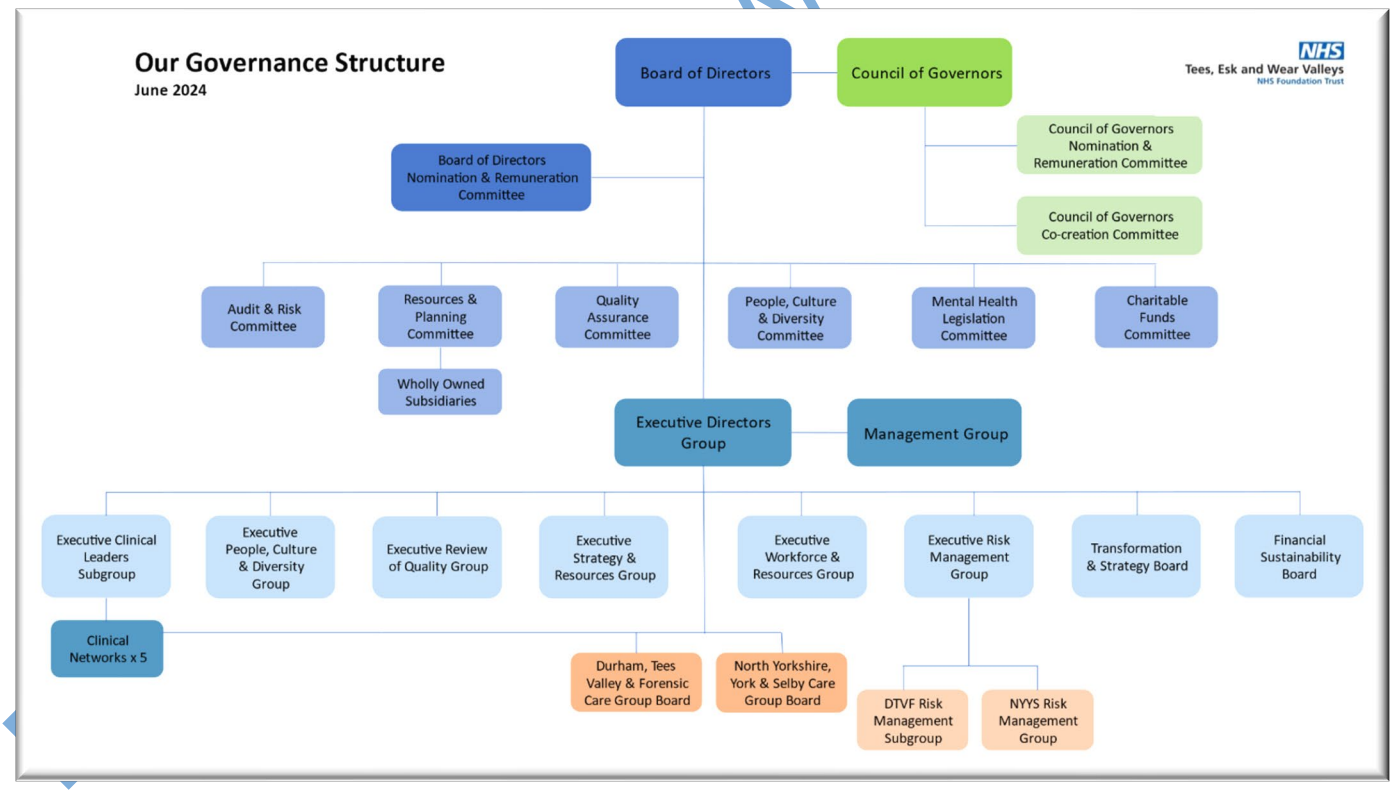
Care Groups:
Each Care Group has quality governance arrangements to address the key elements of quality and safety. These are outlined in the figure below. Each Care Group reports directly to the Executive Directors Group monthly, on quality performance issues that require executive oversight and/or escalation. Each Care Group is also required to provide assurance to the quality assurance committee regarding how it is improving the quality of services.



Durham Tees Valley and Forensic Care Group:



North Yorkshire, York and Selby Care Group:



Quality Assurance and Improvement

Our well established and embedded Quality Assurance and Improvement Programme continues to be used as a system to help us focus on key quality and safety issues. It has supported us to make improvements including to patient care documentation, recognising that high quality documentation is an enabler of high-quality patient care.

The programme comprises of a range of quality assurance tools that are used to gain a holistic assessment of the quality of patient care. These tools have been reviewed during 2024/25 and continue to be updated to ensure that they are informed by current areas of risk, where further assurance is required. The Programme includes Quality Reviews, Peer Reviews and Leadership Walkabouts.

The Quality Assurance and Improvement Programme is an effective method of monitoring compliance against key standards of care related to patient safety, clinical effectiveness and patient experience. It has facilitated significant sustained practice improvements and provides the organisation with both quantitative and qualitative assurance evidence. To further strengthen and streamline clinical audit processes including data collection and oversight of key quality and risk areas reviewed, the Trust has started to integrate some of the Quality Assurance tools into the new InPhase Applications. This will be further developed and expanded into 2025/26, using bespoke dashboards within the InPhase App.

The Quality Assurance and Improvement Programme continues to be reported into the Trust governance structure via the Executive Director's Group and the Quality Assurance Committee.

2.3 Our progress on implementing our 2024/25 quality improvement priorities

As part of the Trust's ongoing commitment to co-creation, it was agreed that from 2024/25, development of the Quality Account Quality Priorities would be led by people with lived experience (and those currently working with Involvement Networks and other community organisations). This approach enables the voice of service users, relatives and carers to be at the heart of quality improvement across the organisation.

The Strategic Fundamental Standards Group have supported the new approach adopted for the development of the 2024/25, co-created priorities and have reviewed proposed measures that align to the priorities.

The Co-Creation Boards have developed the quality priorities for 2024/25 and these were endorsed by the Quality Assurance Committee 4 April 2024:

The following progress can be observed for each of these Quality Priorities:

Quality Priority 1: Patient Experience: Promoting education using lived experience

Why it is important:

This priority is focused on improving accessibility of services and early intervention. Through the identification and review of themes of patient feedback regarding access to services; the use of the Recovery College and patient stories will establish a cycle of learning, which will be shared with key Partners.

What we said we would do and what we did for this Quality Priority:

Our Lived Experience Directors and Involvement Team have experience of developing training sessions for clinical and non-clinical colleagues. The sessions include people with lived experience sharing their experience to support others learning from a lived experience perspective.
The Lived Experience Focus Group and Co-creation Boards told us that it was particularly important for clinical staff in Urgent Care services (including Accident and Emergency, and Primary Care) to understand what is important to patients who present at these services and how they can help to improve patient experience.

The following measures were developed to help us deliver this Quality Priority:

1) We will develop a programme of training that could be offered. This will include facilitating training sessions as well as some formal workshops, in addition to referring to online resources accessible via the Trust Intranet page and other associated communications. We will ensure that the personalised care training is delivered both internally and externally.

A Training Lead has been recruited to the Involvement and Engagement Team and commenced in post October 2024. Their role is focused on consolidating existing training packages that the Trust currently use about lived experience and coproduction. This review will incorporate training on personalised care planning. Another function of the Training Lead role is supporting the training roll out across the Trust.

The Trust Safeguarding and Public Protection Team have been working with groups of young people via Participation Groups and schools to look at what young people think about feeling safe. The voice of the young people will be collated and used in Safeguarding Training and other key work in relation to the impact of parental mental health on children to increase awareness and support early identification of needs for families.

2) We will deliver the identified training programme throughout Quarter 3 and Quarter 4 to internal and external colleagues and Partners (considering voluntary services)

Training and development sessions have now been co-created on the new 'Co-creation Framework' and are available to all teams.

The induction and training programme for Involvement and Engagement members has been re-designed and rolled out. Work continues into the new year to co-create a development programme for Involvement and Engagement members.

Partnerships with local acute Trusts have been strengthened and a range of training opportunities have been made available to enhance care for patients. Health and Justice also continue to deliver training to HMPs and Partner organisations.

Priority Two: Patient Safety: Relapse Prevention

Why it is important:

This priority is focused on timely and proactive access to support for patients who experience relapse in order to minimise harm, particularly through the effective use of patient's safety and care plans.

What we said we would do and what we did for this Quality Priority:

1) We will review how patient's safety and care plans are used for people in community services, and establish best practice standards for these plans

A review of safety and care plans has been undertaken and further work continues on best practice examples for people using community services.

Relapse prevention has been further supported through the implementation of the new Personalised Care Planning Policy which was fully revised following an extensive consultation period and was published January 2025. A communication and engagement campaign has been initiated to embed the new Policy. This policy works interdependently with the new Safety and Risk Management (previously Harm Minimisation) Policy which was published in October 2024.

Outline guidance for the content of patient's safety and care plans is also available for all staff via the 'Ask Cito' robot along with gold standard examples.

2) We will co-create an audit tool to review the plans

The Quality Assurance and Improvement Programme tools include regular review of patient's safety plan and its co-production with the patient (or significant person involved in their care where they are unable to). This is where wellbeing and relapse prevention needs are documented on the electronic patient record.

Over 2024/25, the Quality Assurance and Improvement Programme has demonstrated:

- For Inpatient Services – improvement in 6 of the 7 relevant metrics, including the metric on co-production, with one metric remaining consistent.
- For Community Services – improvement in 5 of the 6 relevant metrics, including the metric on co-production, with one reducing by one percentage point (with good standards of practice still noted)
- Robust oversight is maintained through our Trust's governance structures.

Priority Three: Clinical Effectiveness: Improving Personalisation in Urgent Care

Why it is important:

This priority is focused on improving the effective use of the 'my story once' approach. The priority will be linked with the community transformation work and also aims to improve patient experience when accessing urgent care services.

What we said we would do and what we did for this Quality Priority:

The following measures have been developed to help us deliver this Quality Priority:

1) The 'My Story Once' principles will be incorporated into the new Personalising Care Planning Policy. This will be circulated for consultation

The 'My Story Once' principles have been incorporated into the Personalising Care Planning Policy and the approach is modelled in the training that has been developed.

The Policy was circulated for Trust wide and external consultation and was formally launched January 2025 (supported by communication and training campaigns).

2) We will review and update the associated online training pack which is currently named 'CPA (Care Programme Approach) Module' (which will include the 'My Story Once' approach)

The Personalised Care Planning training package has been reviewed and updated.

3) Staff will have undertaken the online training module on personalising care planning

Planning of the training programme has commenced including a face-to-face training day. This is instead of the online training module on personalising Care Planning previously delivered. The new face-to-face training will reflect the interdependency of the policies mentioned previously and will include training on the new Safety and Risk Management Policy, Personalising Care Planning Policy and Working with People being in distress.

Roll out of the training programme will continue into 2025/26 for all applicable staff.

2.4 Our quality journey

We have continued to focus on five areas to support Our Journey to Change strategy and have worked with patients, carers, partners and colleagues to create our strategy made up of five journeys:

The five journeys are:

- **Clinical** – how we will provide high quality, safe, kind, effective and personalised clinical care to the people we support.
- **Quality and Safety** – how we will make our services safer and improve patient experience through evidence-based care.
- **Co-creation** – how we will seek out and act upon the voices of the people we work with to improve care.
- **Infrastructure** – how the places we work, such as our hospitals and offices, the equipment we use, the information we gather and the systems and processes we put in place will support excellent patient care.
- **People** – how we will ensure everyone who works and volunteers with us has a great experience, whether they're permanent employees, people working as bank staff or through an agency, students or volunteers.

These journeys have set out specific ambitions and principles that support the mission, values and goals of Our Journey to Change and have been progressed alongside a programme of works as part of the 2024/25 delivery plan.

It is our ambition is that by 2028, we will achieve the specific aims and measurable improvements set out in our quality journey, through continuous learning and improvement using a range of tools and enablers. This journey has been shaped by our other journeys; clinical, co-creation, people and infrastructure.

In relation to our **Quality and Safety Journey**, the following progress has been made (as presented to the April 2025 Management Group):

- **Personalised Care Planning:** There are 7 key deliverables within this piece of work and currently the following 5 have been achieved:
    a) We have developed and implemented a strategy to increase access to evidence based psychological therapies.
    b) The Trust Policy for Personalised Care Planning has been ratified and published.
    c) We have rolled out DIALOG to enhance co-produced care planning following the launch of Cito.
    d) We have established a Workforce Development Group to support the delivery of transformation.
    e) We have ensured that there is a comprehensive communications plan in place so that all stakeholders are aware of developments and the related implications
- There are 2 deliverables in progress which relate to continuing to work with ICBs to establish effective interoperability between systems and this work will progress as business as usual into 2025/26.

- **Physical Health:** There are 4 deliverables within this piece of work and currently 3 are complete:
    a) We have scoped recommendations to inform our Clinical Advisory Groups with overarching plans in place.
    b) We have established the Clinical Advisory Group priorities, workplan and targets with oversight via our Trust Physical Health Group.
    c) The approach to physical health for people using our services was presented and endorsed by our Executive Directors and Quality Assurance Committee
- The one area which remains in progress relates to the communication plan being developed with subsequent engagement. This work has been completed on our Trust Intranet and empathy mapping took place during January 2025, however further planning is being undertaken as part of a wider internal communications campaign throughout 2025/26 therefore this will continue to the next year as business as usual activities.

- **Improved patient safety**: There are 5 deliverables within this piece of work and currently the following 4 are complete:
    a) We have fully implemented PSIRF and introduced meetings including the Organisational Learning Group (OLG).
    b) We have integrated Suicide Prevention Leads to patient safety
    c) The Trust Positive and Safe Leads have commenced within both Care Groups
    d) We have reviewed priorities and agreed further key patient safety milestones
- The one remaining deliverable remains on track which involves implementing further InPhase Modules and this will be completed by the end of June 2025.

2.5 Our priorities for 2025/26

The quality priorities outlined in this document will be sustained and carried forward over a three-year timeline to ensure sustained continuous improvement and a steadfast commitment to delivering of high quality care. These are some of the most important priorities for people who use our services and we are therefore committed to supporting a strategic approach that aims to embed these priorities over the next 3 years, within our operational framework.

Key areas which we will continue to improve upon to support the Quality Priorities include:

- Assessing the embeddedness and quality of patient's Safety and Care Plans. This includes reviewing the findings from the established Peer Quality Reviews which are undertaken throughout the year and includes measures for the plans in place and their quality.

- Extensive roll out of new training requirements related to Safety and Risk Management, Personalising Care Planning, as well as training in Being with Distress.

- Assessment of the training to review the impact of improvements in personalisation in urgent care, including evaluating the quality of patient experience feedback.

2.6 Statement of assurances from the Trust

In this section of the Quality Account, our Trust is required to provide statements of assurance in relation to a number of key performance indicators which are as follows:

- Review of services provided by or contracted our Trust
- Our 2024 Community Mental Health Survey results
- Our 2024 National NHS Staff Survey results
- Clinical Audit: participation in clinical audits and national confidential inquiries
- Participation in Clinical Research
- What the Care Quality Commission (CQC) says about us
- Information governance
- Freedom to Speak Up
- Community Transformation
- Learning from deaths
- Local Resolution and Complaints
- Data quality
- Mandatory quality indicators

2.7 Review of services provided by or contracted by our Trust

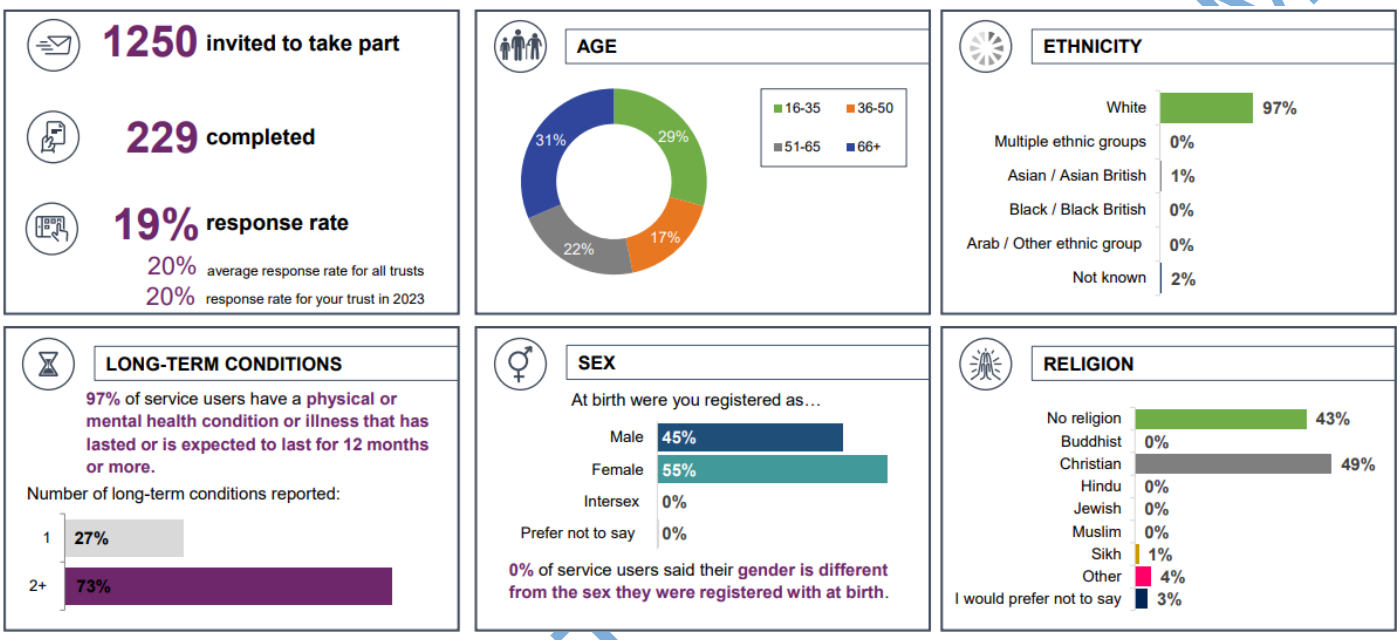
During 2024/25 our Trust provided and/or subcontracted 20 relevant health services. Our Trust reviewed all the data available to us on the quality of care in 20 of these relevant health services.

The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of relevant health services by our Trust for 2024/25.

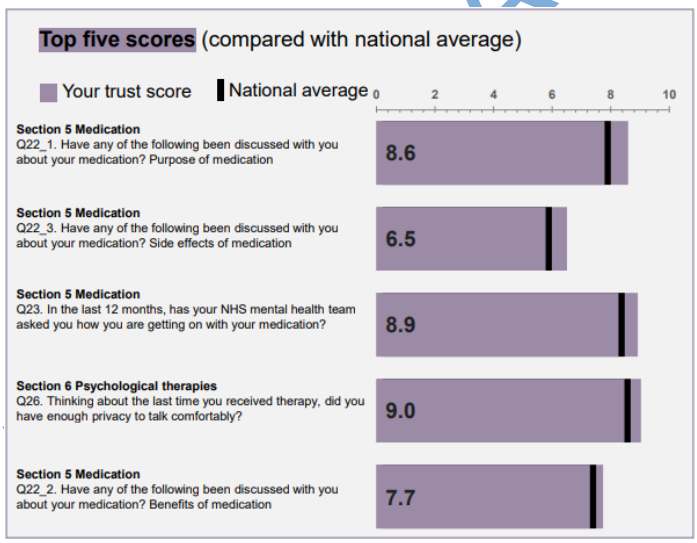
2.8 Our 2024 Community Mental Health Survey results

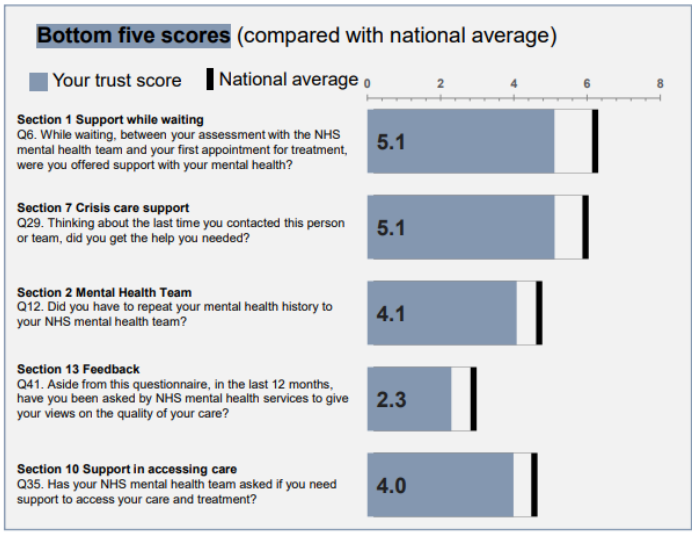
Results of the 2024 Community Mental Health Survey were published 04 April 2025. Feedback was shared from people who received treatment for a mental health condition between 01 April and 31 May 2024. Participants 16 years and older were offered the choice of responding online or via a paper-based questionnaire.

There were 229 completed surveys returned within our Trust for the 2024 Community Mental Health Survey, a response rate of 19%. This is within the same range as to the national average response rate (20%). The following image illustrates the population of our patients who took part in the survey.



The following top five and bottom five scores (compared with the national average) are illustrated as follows:





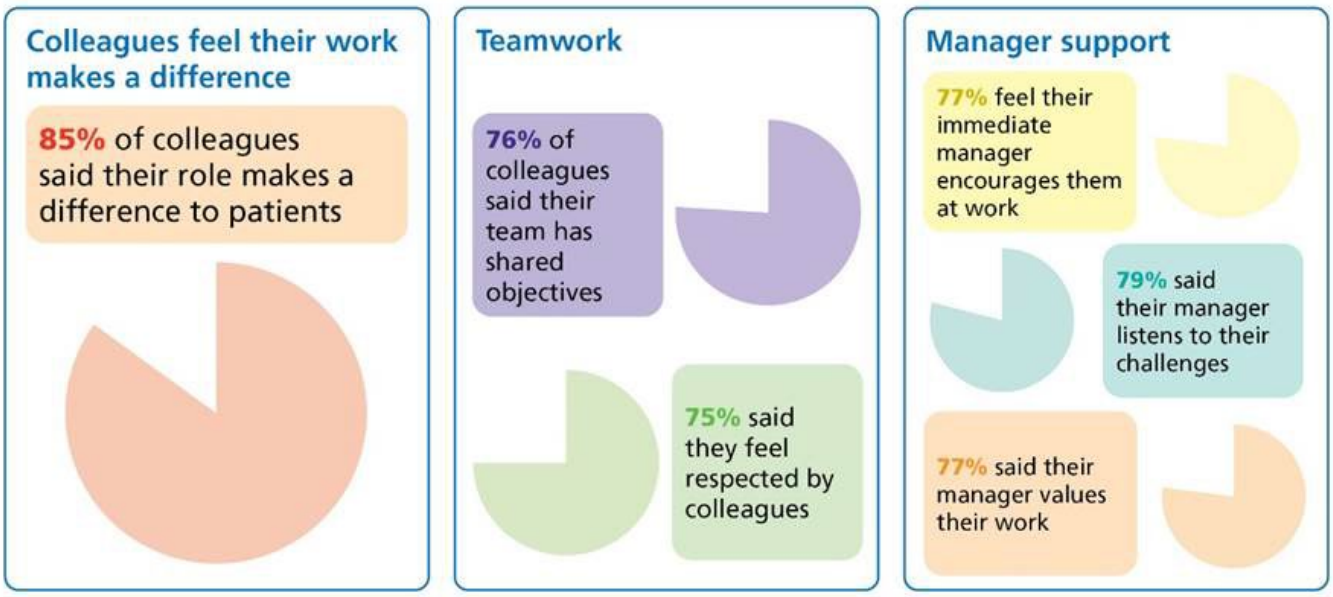
Full results of the survey for our Trust can be found at:
https://www.cqc.org.uk/search/site?fulltext=Mental%20Health%20Survey

2.9 Our 2024 National NHS Staff Survey results

The NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. Each autumn NHS staff in England are invited to take part in the survey. It offers a snapshot in time of how people experience their working lives, gathered at the same time each year. Its strength is in capturing a national picture alongside local detail, enabling a range of organisations to understand what it is like for staff across different parts of the NHS and work to make improvements.

Our results for the 2024 NHS National Staff Survey were published 13 March 2025 and the following highlights were achieved from receiving 3521 responses:

This year's highlights



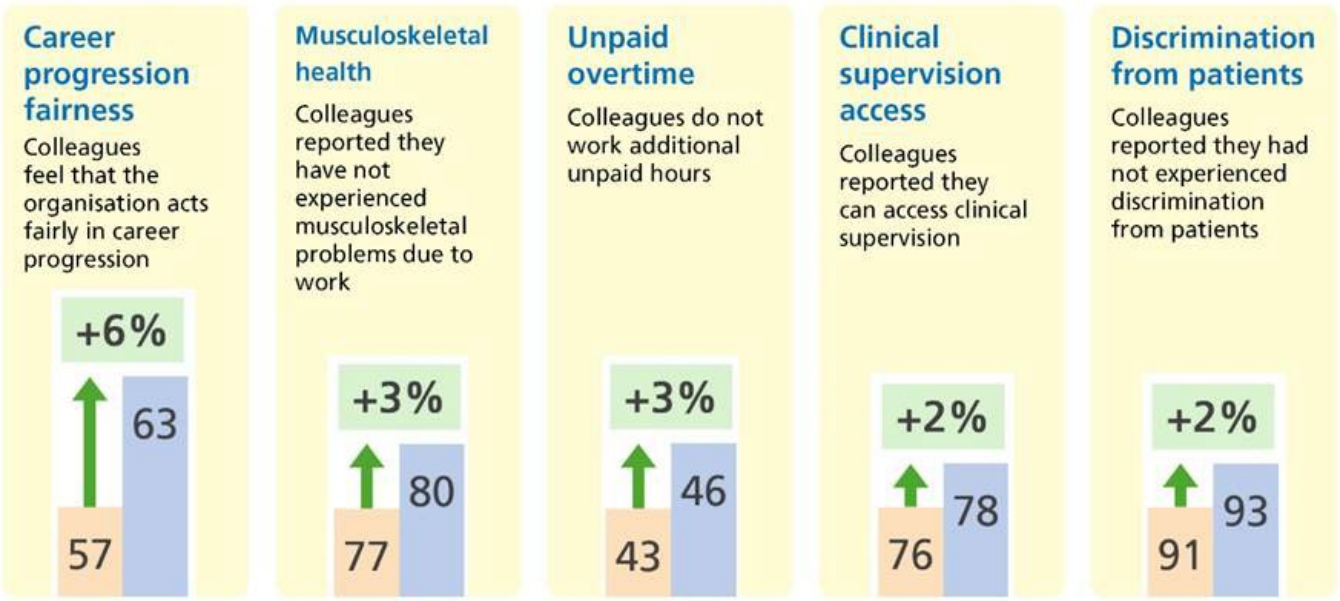
Patient care: colleagues feel their work makes a real difference to patients.
Teamwork: staff say their team has shared objectives and they feel respected by colleagues.
Manager support: staff feel encouraged by their managers, believe their managers listen to their challenges, and feel valued.

Where we're most improved

We've made meaningful progress in several important areas:

- Appraisals
- Reasonable adjustments
- Enough staff to do the job properly
- People feel respected
- Fewer colleagues working unpaid hours

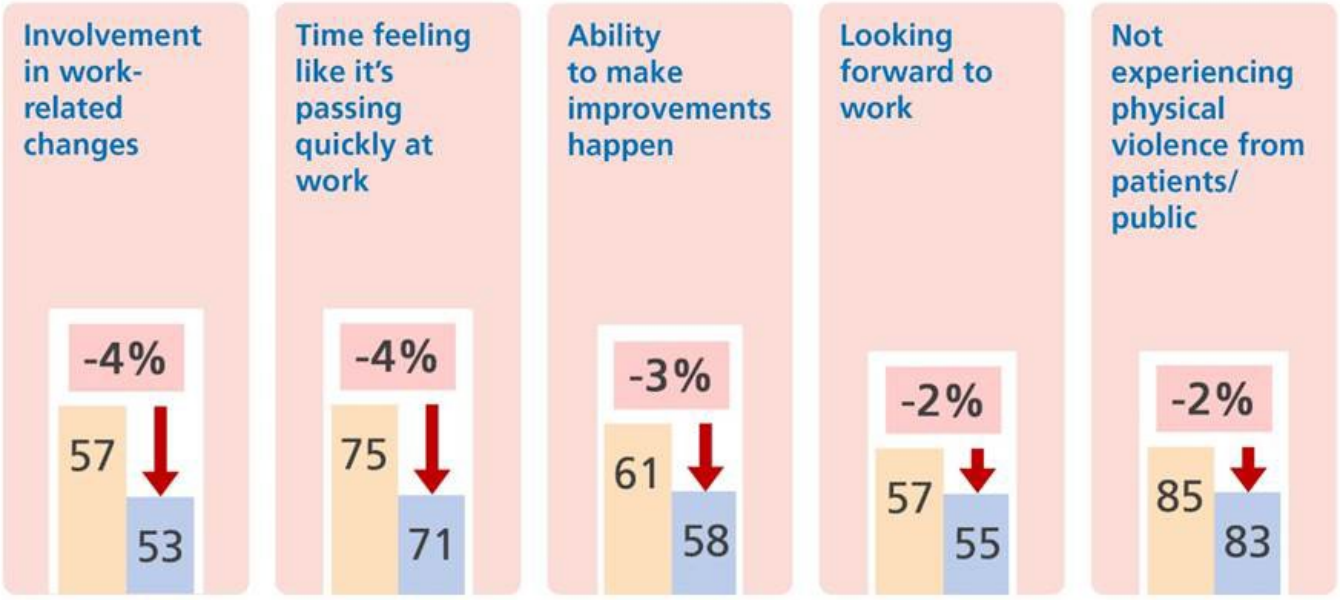
Where we're performing better than the national average



We're proud to be outperforming national averages in key areas:

- Fairness in career progression
- Prioritising health and wellbeing with less staff experiencing musculoskeletal issues due to work
- Reductions in unpaid overtime
- Access to clinical supervision
- Fewer people experiencing discrimination from patients

Where we need more focus



While we're proud of our achievements, we recognise there's still work to do to support you and your team to:

- Feel involved in work-related changes and able to make improvements happen.
- Feel like time passes quickly at work and looking forward to coming into work.
- Feel safe as the number of colleagues not experiencing physical violence from patients or the public has reduced slightly.

What we achieved together following the results of last year's survey

We took significant steps to address staff feedback and several projects have made meaningful changes across our Trust. This included:

- Training reforms: Streamlining mandatory and statutory training to reduce the load and ensure relevance to your roles.
- Health and wellbeing: Achieving Better Health at Work Award Gold status and launching initiatives through a staff-led health and wellbeing council.
- Support for staff: Expanding our reasonable adjustments program, benefiting over 550 colleagues, and launching toolkits for sexual safety and domestic abuse.
- Operational improvements: Reducing recruitment times by 20 days, enhancing digital processes, and establishing a Leadership and Management Academy.

Following the results of this 2024 survey, teams have been asked to review their results and complete Team Worksheets in order to identify areas for improvement and celebrate successes.
Our significant area of focus for 2025/26 is a new suite of management training for all managers (corporate and operational) and clinical leaders in line with the national 'expectations of people managers' framework.

2.10 Clinical Audit: Participation in clinical audits and national confidential inquiries

During 2024/25, **6** national clinical audits and **1** national confidential enquiry covered NHS services that Tees, Esk and Wear Valleys NHS Foundation Trust provides.

During that period, Tees, Esk and Wear Valleys NHS Foundation Trust participated in **100%** national clinical audits and **100%** national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiry that Tees, Esk and Wear Valleys NHS Foundation Trust was eligible to participate in during 2024/25 are as follows:

- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (NAD)
- National Clinical Audit of Psychosis (NCAP)
- POMH Topic 16c: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour
- POMH Topic 21b: The use of Melatonin
- POMH Topic 24a: Opioid Medications in Mental Health Services
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The national clinical audits and national confidential enquiries that Tees, Esk and Wear Valleys NHS Foundation Trust participated in during 2024/25 are as follows:

- National Audit of Dementia (NAD)
- National Audit of care at the end of life (NACEL)
- National Clinical Audit of Psychosis (NCAP)
- POMH Topic 16c: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour
- POMH Topic 21b: The use of Melatonin
- POMH Topic 24a: Opioid Medications in Mental Health Services
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The national clinical audits and national confidential enquires that Tees, Esk and Wear Valleys NHS Foundation Trust participated in, and for which data collection was completed during 2024/25, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

Audit Title	Cases Submitted	% of number of registered cases required
POMH Topic 16c: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour	Sample provided: 43	**100%**
POMH Topic 21b: The use of Melatonin	Sample provided: 186	**100%**
POMH Topic 24a: Opioid Medications in Mental Health Services	Sample provided: 85	**100%**

Audit Title	Cases Submitted	% of number of registered cases required
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	112 questionnaires sent to the Trust with 71 returned	**63%**

The reports of the **3** national audits were reviewed by the provider in 2024/25 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- The anti-cholinergic medication prescription will be reviewed through the internal webinar.
- The summary of 'Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services' audit findings, along with relevant information and advice to support improved prescribing will be shared via the Medicines Optimisation newsletter.
- A directory has been created on the trust intranet, providing staff with access to relevant palliative care contact details as needed.
- Inpatient nursing staff of Mental Health Services for Older People are being encouraged to complete the online 'End of Life Care' training modules, and this is monitored by the End of Life Care clinical advisory group (CAG) which forms as a working group of the Trust wide Physical Health Group.

The reports of **126** local clinical audits were reviewed by the provider in 2024/25 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- The Trust Procedure for bed rails and bed grab handles was reviewed in light of the findings from clinical audit of bedrails.
- Bespoke MAPPA awareness sessions were delivered to all staff across the Trust. Additionally, a voice over presentation was made available to all staff in the trust intranet page.
- A new mattress audit tool was developed by IPC team for wards to use when self-auditing their patients' mattresses.
- A series of brief online sessions will be delivered to all staff by the Trust Safeguarding team over a six month period, to identify and protect children, vulnerable adults or adults at risk of significant harm.
- The Adult Safeguarding Lead will establish a meeting forum with partner agencies to produce a safeguarding incident reporting flow chart/protocol for prison mental health teams.
- All infection, prevention and control (IPC) audits are continuously monitored by the IPC team and any required actions are rectified collaboratively by the IPC Team and ward staff. Assurance of implementation of actions is monitored by the clinical audit and effectiveness team via the clinical audit action monitoring database. A total of **98** IPC clinical audits were conducted during 2024/25 across inpatient areas, prison teams, and applicable community teams where there are clinic facilities. 66% (65/98) of clinical areas achieved standards between 90-100% compliance. Local clinical audit action plans were implemented in collaboration with the IPC team and the clinical team members to mitigate any areas of noncompliance.

In addition to those local clinical audits reviewed (i.e., those that were reviewed by our quality assurance committee and quality assurance and improvement group), we undertook a further **66** clinical audits in 2024/25 including clinical effectiveness projects by trainee doctors, consultants and other professionals, in addition to those by directorates/specialty groups. These clinical audits were led by the services and individual members of staff to support service improvement and professional development and were reviewed by specialties.
The Clinical Audit and Effectiveness Team is continuing to implement and embed a new electronic application - **InPhase**. This will enhance the efficiency of clinical audits and streamline the process for teams. This platform will allow teams to review their clinical quality information in real time, enabling them

to make informed changes to improve practice. Ultimately, this aims to enhance the quality of care and the experience of patients and their families.

We continued to implement an extensive Quality Assurance and Improvement Schedule during 2024/25. This provides ongoing assurance that key quality and risk issues identified are addressed. Significant improvements in practice and patient safety continue to be facilitated through this programme.

2.11 Participation in clinical research

Our Trust participates in research activity to help provide new knowledge with the potential to be valuable in improving care for patients. It is important such research is open to critical examination and open to all that would benefit from it.

The number of patients receiving relevant health service provided or sub-contracted by our Trust in 2024/2025 that were recruited during that period to participate in research approved by a research ethics committee was **420** across **29** National Institute for Health Research (NIHR) Portfolio research studies. The Trust is fourth place nationally for the number of recruiting 'interventional' mental health research studies.

The Trust recently secured external funding to support a wider range of communities in accessing research participation opportunities. Alongside carrying out research studies, our research team have actively promoted the Patient Research Experience Survey (PRES) and helped secure hundreds of new sign-ups to 'Join Dementia Research'.

As well as acting as a research site and participant identification centre for many studies, our Trust sponsors research including NIHR grant-funded studies. As part of this role, our research and development team actively supports a wide range of researchers and completes governance activities such as conducting monitoring visits, distributing monies, and reviewing and reporting on performance.

During 2024/2025, our Trust successfully contributed to several successful NIHR grant applications including a £1.8m NIHR Work and Health Programme award. We have also created a new regular report to celebrate and help disseminate the outcomes of concluded research studies. We concluded several studies, such as the DREAMS START project for instance which evaluated an intervention for sleep difficulties for those with dementia and their carers; initial results of which showed definitive evidence of clinical effectiveness (click here for the link to the paper).

Alongside this, we have carried out a major overhaul of our research website to include a much wider range of resources and information to assist both researchers and service users.

We continue to work closely with the NIHR Research Delivery Network North East and North Cumbria to support large scale national portfolio research studies, and to measure patient research experience when taking part in studies with feedback and any actions reported to our research governance group. We continue to collaborate with a wide range of universities and other NHS providers to deliver large multi-site research studies for the benefit of our service users, carers, and staff.

2.12 Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

There were no 2024/25 CQUIN requirements.

2.13 What the Care Quality Commission (CQC) says about us

The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with safe, effective, compassionate and high-quality care, and encourages these services to improve. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care.

Tees, Esk and Wear Valleys NHS Foundation Trust is required to register with the CQC and its current registration status is registered without conditions for services being delivered by the Trust. The Trust is therefore licensed to provide services.

The CQC has not taken enforcement action against Tees, Esk and Wear Valleys NHS Foundation Trust during 2024/25.

Tees, Esk and Wear Valleys NHS Foundation Trust is subject to periodic reviews by the CQC and the last review was on 29 March 2023 to 02 June 2023. The CQC's assessment of the Tees, Esk and Wear Valleys NHS Foundation Trust following that review was an overall rating of **requires improvement**.

Our Trust's CQC inspection took place 29 March 2023 to 02 June 2023 and the results of the latest trust wide inspection were published on 25 October 2023. Details of the improvements made were listed within the previous Quality Account (2023/24).

In addition, the CQC inspected our AMH Crisis, Acute Liaison Services and Health Based Places of Safety (HBPOS) in June 2024. This was a targeted inspection. The outcome of the inspection was subject to the new Single Assessment Framework (SAF) scoring system and the CQC published the results of this focused inspection on its website 06 February 2025. The service received a rating of Good overall and in 4 of the 5 domains.

The CQC report highlights that staff shared a vision and culture, worked with capable and compassionate leaders and there were sound structures in place for staff to speak up.

- **People were treated as individuals** and offered independence, choice and control.
- There was evidence of a **good learning culture**, and people using the services told the CQC that they **felt safe**.
- **People were safeguarded** by the staff caring for them.
- People had their **needs assessed** and most people said they were involved in the planning of their care and that their **care was regularly reviewed**.
- The CQC saw **staff supporting people** with their mental health needs and the **physical health monitoring**.
- **People received evidenced based care and treatment** and there were regular multidisciplinary meetings where learning could be shared and staff at all levels attended various meetings.
- **People are included** in their care and treatment choices with **carers being involved** where appropriate.
- **People's preferences** were considered when deciding on appropriate treatment options.
- **Carers were included** at assessment stage and throughout.

- There was a **strong quality improvement culture**, and leaders were encouraged to develop themselves and the services.
- Staff told the CQC that the recent move to the 111 service was having a **positive impact**.

Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following action to address the points made in the CQC's assessment:

- Since the inspection in June 2024, a number of improvement actions have been undertaken and collaborative events were held 14 and 24 April 2025. The events helped to develop the formal Improvement Plan with Care Group colleagues and specialty/ directorate leads focusing on any areas of improvement from the inspection report requiring further action.
- The Trust CQC improvement plan was formally submitted to the CQC on 01 May 2025 after approval by our Executive Chief Nurse.
- Actions were developed following the Crisis Improvement Planning events including exploring the use of the Urgent Care tracking Application to capture wider information about patients and practices with our Section 136 Suites, reviewing the training offer to assist with staff understanding of Patient Rights, and strengthening the processes involved in recording the outcomes following Safeguarding Local Authority referrals.
- The quality governance team continue to maintain the evidence repository to provide assurance of completion and implementation of improvement actions. Delivery progress for the CQC improvement plan will continue to be formally reported to the Executive Directors Group and Quality Assurance Committee, noting where actions are implemented and embedded.

Tees, Esk and Wear Valleys NHS Foundation Trust has made the following progress by 31st March 2025 in taking such action:

- The Trust has achieved closure of the 2023 CQC Improvement Plan following the Core Service and Well-led inspection.

Tees, Esk and Wear Valleys NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

2.14 Information governance

The NHSE Data Security and Protection Toolkit (DSPT) reporting year runs from 1st July to 30th June each year.

For the DSPT reporting year 2023/24, Tees, Esk and Wear Valleys NHS Foundation Trust achieved **Standards Met**.

ODS	Organisation name	Status	Published
RX3	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	23/24 Standards Met	28/06/2024

2.15 Freedom to Speak Up

There are a number of routes through which staff can raise concerns:

- Through their own management or professional structures.
- Through the Freedom to Speak Up team. This is as confidential as the person asks for it to be. Concerns are addressed in agreement with the person who spoke up. We have recently started directing the request for review to the senior leadership team, where appropriate. This has enhanced the process and increased the sense of service ownership and satisfaction from those who spoke up. However, we still offer an independent review for those who feel speaking outside their service is preferrable or want to ensure a level of confidentiality. We also signpost to other services such as employee support services or human resources. Feedback is given to the person on a regular basis, in line with our revised process. As much feedback is given as appropriate although, by the nature of some concerns and investigations, full feedback is not always possible.
  We have a monthly speaking up forum where we share soft intelligence, agree proactive work and agree what information is to be shared with the people and culture committee, the board, and each care group board so that we can triangulate feedback from reviews, service action plans, and share outcomes.
- The online raising concerns form where people could previously complete anonymously has been discontinued.
- Through our safeguarding team or directly to the CQC.
- Through our formal HR processes, the timescales of which vary and are laid out in the relevant policy.
- Through the employee support service who will signpost and provide guidance on how to make best use of the options available.
- Through any trade union of which they are a member.

We have a process for addressing any concerns of detriment or demeaning treatment, in line with national guidance. In addition, concerns are passed to our associate director for operations and resourcing, who share themes with our non-executive director for speaking up on a quarterly basis.

With regard to the medical workforce, the role of Guardian of Safe Working for resident doctors within our Trust sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The work of the Guardian is subject to external scrutiny of doctors' working hours by the CQC and by the continued scrutiny of the quality of training by Health Education England.

The Guardian is required to levy a fine against a department(s) if a resident doctor:

- Works on average over 48 hours/week
- Works over 72 hours in seven days
- Misses more than 25% of required rest breaks
- On non-residential on call (NROC) does not have a minimum of continuous rest of five hours between 10pm and 7am
- Does not have the minimum eight hours total rest per 24-hour non-resident on-call (NROC) shift
- Has more than the maximum 13-hour residential shift length
- Does not have the minimum 11 hours rest between resident shifts

The Guardian of Safe Working for resident doctors within our Trust produces quarterly and annual reports to the Board that focus on gaps in medical rotas, exception reports and safety issues.

The Guardian's annual report for 2024/25 was presented to the Board and the main reasons for locum cover out of hours during were due to sickness (short or long term) and vacancies on the rotas. It should be noted that there were periods of industrial action during this period and there were also a few occasions were locum cover was needed due to maternity or paternity leave.

Exception reports received related mostly to claiming additional hours whilst on NROC, having to stay later than normal working hours or shift end time or missing teaching/training due to staff shortages. Discussions on these issues have taken place at the relevant forums and additional staffing put in place where possible.

2.16 Community transformation

The aims of the Community Mental Health Transformation Framework were to redesign and reorganise core community mental health teams which are place based and to create a core mental health service which is aligned with Primary Care Networks, local authority and voluntary care sector organisations.
Key achievements made as part of the ongoing community mental health transformation work in line with the NHS England five-year programme and next steps and key areas of delivery for the next 12 months are detailed as below:

Durham, Tees Valley Care Group

Key achievements:

- Our lived experience forums are now in place across Durham and Tees Valley boroughs.
- 22% increase in capacity for psychological therapies within community teams.
- Collaborative upskilling all system partners through VCSE led 'learning together' sessions.
- Hubs established in population centres and pop-up hubs in community facilities in more rural areas.
- Trusted assessment process developed collaboratively with VCSE, Social Care, CMHT and Talking therapies and service users – piloting in Middlesbrough ahead of wider role out.
- Significant increase in the number of patients receiving at least 2 contacts in a 12-month period.
- 91% improvement in year-on-year changes in caseloads – caseload increase of 1821 in 2022 has reduced to 165 in 2024.
- 59% reduction in patients waiting for assessment, reduced from 3500 in January 2023 to 1428 in March 2025.
- Over 40,000 appointments in primary care (per annum) by TEWV MH Nurse practitioner or Mental Health and Wellbeing Practitioners in 2024 (Additional Roles Reimbursement Scheme); additional appointments in primary care through GP Aligned team (Durham).
- Only 948 (2.5%) of ARRS (Additional Roles Reimbursement Scheme) patients were stepped up to secondary care services; 14.8% of GPA patients stepped up.
- 15%-20% reduction in secondary care referrals, at a time when we expected secondary care MH referrals to increase (Pandemic impact on Mental Health and Wellbeing and impact of increasing Neuro referrals).

Next steps:

- Resolving ongoing commissioning/Service Development Funding and contracting challenges for system (i.e. within and beyond statutory services contract settlements)
- Improve reporting – from TEWV and from the wider system (activity, outcomes etc).
- Shift from mobilising to embedding and supporting local ownership.
- Address identified areas for more work from Healthwatch stocktakes of progress.
- Continue to extend and embed lived experience forums, roles and infrastructure.
- More robust focus on communications – for staff/ organisations and for people needing support/the public (including websites etc).
- Specific focus on increasing evidence-based interventions, utilising outcomes and effective caseload management.
- Complete recruitment to outstanding schemes (e.g. peer support within TEWV, and Procurement of a Tees valley wide peer support service to work at PCN level).
- Mobilising the remaining "physical" mental health hubs, acknowledging the estate challenges in Durham).
- Improving pathways at place for people with concurrent mental health and substance misuse needs.

North Yorkshire, York and Selby Care Group
Key Achievements:

- Community Mental Health Hub operational at 30 Clarence Street, York. Phased roll out continues to include self-referrals. Pop-up hubs across City of York aligned to 30 Clarence Street.
- 24/7 Crisis Hub Pilot planned to go live in June 2025 (National Pilot Site). Hub will offer round the clock alternatives to a place of safety and aligned closely with Crisis services, VCS and Social Care Services.
- Further MH Hub planned for the East of the City later this year.
- MH Hubs planned across North Yorkshire with an expectation that they will all become operational by the Spring of 2026.
- Procurement process underway for VCS input into hubs (Coordinated by NYC).
- 18 of the 19 PCNs have 1 or more First Contact Mental Health Practitioners (some want more than 3) providing timely access to MH support (average wait 1-2 weeks).
- Improved relationships and communication between Primary Care and Secondary Care services
- Over 30,000 appointments in primary care (per annum) by TEWV First Contact MH Practitioners cross 19 PCNs in North Yorkshire & York Places.
- Just over half were new referrals.
- 15% referred on to Talking Therapies.
- Between 2% and 3% referred on to Secondary Care Services.
- Only 2% required an additional appointment with their GP.
- 3% referred to Social Prescribers.
- MDT meetings within Primary Care including Community MH Team Practitioners and VCS services.
- Complex Emotional Needs Practitioners in post across NY providing expertise, supervision and support for the VCS, Primary Care and the MH Hubs. Further post agreed to cover York.
- New Hybrid Roles created (2 in post, further 2 planned) working in Harrogate and Ripon, between Primary Care, Secondary Care and the new hubs. These roles are designed to more closely align and integrate Primary Care and Secondary Care and to improve patient flow.
- New Eating Disorder Consultants now in post and looking to establish FREED (First Episode Rapid Intervention for Eating Disorders) Champions across NYY.
- Developing leadership capabilities for the MH workforce is a key priority of the national trauma-informed organisational strategy. These are a key priority in our community transformation offer in North Yorkshire & York.
- Listening Exercises in our CMHT's have been started forming the foundation for an understanding of the transformation & Trauma Informed agenda. Supporting a wider system context & relational Trauma Informed repair where required
- We have started to support our CMHT's & partners to creatively maximise the service users experience through examining current capacity & functioning, whilst visioning & planning for improved efficiencies in future delivery.
- We have started to interweave Trauma Informed practice & leadership training & skill & communication awareness training across our CMHT's & system partners. Thus, developing skills & an emotional awareness for our leaders & staff. Already trained NY Police, NYC, Primary Care, CYC.
- Internally, we have established new Transformation Delivery Groups in each Neighbourhood across NYY. These groups will coproduce the local place-based plans for the transformation of the Trust Specialist Services across NYY. These groups develop and implement these plans covering the new models, estates, finance and workforce implications/opportunities and are aligned to the Care Groups Combined Governance Group and the Trusts Transformation Delivery Group. These groups are also aligned to the new MH, LD &A Partnerships in the York and NY Places and the Local Care Partnerships.

Next steps:

- Looking to resolve ongoing commissioning/Service Development Funding and contracting challenges for system (i.e. within and beyond statutory services contract settlements).
- Improve reporting – from TEWV and from the wider system (activity, outcomes etc) through single information system in MH Hubs.
- Working with Ardens to improve information capture for First Contact Mental Health Practitioners into System One and CITO.
- Continue to progress Commitment Plan developed in partnership with NY Healthwatch across partners in NY.
- Continue to extend and embed lived experience forums, roles and infrastructure

- More robust focus on communications – for staff/ organisations and for people needing support/the public (including websites etc).
- Specific focus on increasing evidence-based interventions, utilising outcomes and effective caseload management.
- Complete recruitment to outstanding schemes (e.g. peer support, Social Prescribing and Carer support within the Mental Health Hubs).
- Continue to Mobilise the remaining “physical” mental health hubs with our partners across NYY and explore potential pop-up and virtual solutions for the rural areas across NYY.
- Improving pathways at place for people with concurrent mental health and substance misuse needs.

2.17 Learning from deaths

During 2024-25, 1,744 deaths were reported to the Trust's incident reporting system, with the majority of these considered to be from natural causes. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

Quarter 1	Quarter 2	Quarter 3	Quarter 4
499	574	408	263

Of the 1,744 deaths, in line with the national guidance on learning from deaths, 379 deaths fit the criteria for further review of which 186 were case record reviews. This comprised of the following number of case record reviews and investigations which were completed in each quarter of the reporting period:

Quarter 1	Quarter 2	Quarter 3	Quarter 4
130	102	91	56

In mental health and learning disability services we have a number of older people who are cared for in the community and their needs are such they only require minimal contact with us. Many of these people, who die, do so through natural causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further. To support staff in their decision making regarding the investigation of deaths, staff have clear policy guidance, setting out criteria for categories and types of review.

During the reporting period there were 0 deaths that were subjected to both a case record review and an investigation.

Of the 1,744 patient deaths during the reporting period 1.31% are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of 14 representing 2.80% of the number of deaths which occurred in the first quarter; 7 representing 1.21% of the number of deaths which occurred in the second quarter; 2 representing 0.49% of the number of deaths which occurred in the third quarter. There were 0 deaths that occurred during quarter 4 which are judged to me more likely than not have been due to problems in the care provided to the patient.

29 case record reviews and 84 investigations completed after 31/03/2024 related to deaths which took place during the previous reporting period. This meant we undertook a total of 492 case record reviews and investigations. This is a significant decrease on the 601 case record reviews and investigations completed in the 2023/2024 period and reflects the work that was undertaken to close the previous backlog of reviews. Of the 29 case record reviews and 84 investigations completed after 31/03/2024 relating to deaths which took place during the previous reporting period, 13% are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been based on the information contained within Structured Judgement Reviews, After Action Reviews and Patient Safety Incident Investigations carried out under the Learning From Deaths policy and the national Patient Safety Incident Response Framework (PSIRF) which the Trust implemented from 29th January 2024.

During 2024/25 the number of learning points identified from case record reviews and investigations were as follows: 218 in the first quarter, 218 in the second quarter, 190 in the third quarter, and 161 in the fourth quarter.

All learning in the Trust is referred to as actionable learning and supports our approach towards a just and learning culture in line with Our Journey to Change and a systems-based approach to learning as advocated by PSIRF. All learning from patient safety incident investigations is themed and informs key workstreams to address any identified quality and safety issues.

Actionable learning continues to be monitored against the Trust's 12 current learning themes which were identified during 2022/23 and 2023/24, agreed by the Trust Organisational Learning Group. These are:

Our quality assurance and improvement programme is regularly updated to reflect learning from patient safety incidents. It provides assurance that improvements are being made in relation to risk assessment, risk management, care plans and patient and carer involvement and that these improvements are being sustained in both inpatient and community settings. Ongoing quality assurance processes where specific learning themes have been highlighted have been presented through a monthly system wide quality meeting.

Our Trust continues to strengthen arrangements for organisational learning via the Organisational Learning Group which has had a full review of its membership and terms of reference, resulting in multi-disciplinary and executive level membership. The group's role is:

- Develop and maintain processes to learn and improve after patient safety incidents, complaints, safeguarding, leadership visits, investigations etc.

- To alert the Trust of systemic areas for improvement and / or safety issues.
- To ensure the group escalates or delegates concerns or issues to the appropriate forums / workstreams.
- To ensure the organisation has a structure that supports learning and improvement with strong triangulation and governance through:
- Clear collation of information
- Transparent processes to explore and investigate issues based in the PSIRF principles of Just Culture.
- Work with care groups and clinical networks to identify and theme learning opportunities.
- Ensure governance structure that will implement and monitor any identified changes.
- Disseminate learning and developments through a variety of identified solutions.
- Proactively seek out best practice and provide guidance to fundamental standards, clinical networks and care groups to ensure that safe high-quality care remains at the forefront of service delivery.
- To invite identified work streams to feedback areas of development and positive practice to update and share progress.
- Review and raise awareness of wider system learning from across a range of organisations or publications for discussion.

The Organisational Learning Group now has a 12 month work plan based on the 12 themes identified. Learning and good practice identified from case record reviews and investigations can be discussed within the Organisational Learning Group. Learning will be disseminated via clinical networks, fundamental standards, briefings where appropriate, to ensure that learning feeds into existing improvement work.

During 2024/25, themes explored in this forum included Clinical Effectiveness, Record Keeping, Infrastructure, Legislation and Policy Compliance, Safeguarding, Risk Assessment and Patient, Carer and Family involvement and experience.

38 patient safety briefings have been circulated trust wide during 2024/25 as a result of learning.
Examples of these briefings include:

- Raising awareness of risks associated with illicit substances
- Information related to safe practice of manging sharps
- Raising awareness of environmental risks
- Information related to the functionality of CITO (Electronic Care Record system) and recording information
- Raising awareness of risks associated with the use of sanitary bins in unsupervised patient areas
- Recording of third party information within Safety Summary documentation
- Emollients and fire risk

The briefings circulated are specific about any assurance required from services. On receipt of completed actions these are documented in the local safety alert and learning database.

The Environmental Risk Group receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm. Any urgent learning from this group is disseminated Trust-wide via patient safety briefings. Environmental surveys with multi-professional input from estates, health and safety and clinical services continue to be undertaken.

Suicide Prevention training and Being with Distress workshops, continues, as well as our mandatory harm minimisation training. The training considers completion of documentation/record keeping, patient/carer involvement and the importance of multi-agency working. Bespoke training sessions in hot spot areas are available on request.

The learning from deaths policy has recently been reviewed to align to PSIRF. It is aligned to Our Journey to Change and will ensure carers and families receive compassionate care following the loss of a loved one. We continue to work in line with national frameworks and programmes to facilitate shared learning/good practice and valid comparisons with other trusts.

2.18 Local Resolution and Complaints

All complaints are managed in line with national guidance, and we are committed to providing opportunities for our patients, their carer, or their families to seek advice or information, raise concerns or make a complaint about the services that the trust provides. Our complaints policy outlines how they can do this and to feel confident that they will be listened to, and their issues taken seriously.

The Trust's approach to Complaints Handling ensures that we get the right process for those who use our services that gives them the best possible outcome in the least amount of time. Our approach fulfils the expectations set out by the Parliamentary and Health Service Ombudsman (PHSO) for NHS Complaint Standards (2022).

We are encouraging people to discuss any issues or concerns they have with staff who are directly involved in the patient's care, as we may be able to sort the issue out to their satisfaction quickly and without the need for them to make a complaint. This process is known as a Local Issue Resolution, and we ask that these are resolved either at the time that they are made or longer than 10 working days. This level of feedback is recorded electronically using InPhase that not only captures the nature of the concerns but also includes the outcome, any actions taken, and any learning identified.

We recognise that we cannot always resolve issues or concerns as they arise and that sometimes people will want to make a complaint. All complaints are managed utilising a pathway approach of either an 'Early Resolution Complaint' or as a 'Formal Complaint' which is locally determined by the Complaints Team. We work on the principle of 'investigate once and investigate well' with the complainant receiving an open and honest written response that outlines any learning to demonstrate how we have listened and taken seriously their complaint.

We recognise that all complaints give a vital and direct insight into the quality of services that we provide. Our Ward and Team Managers have full visibility of all concerns and complaints which they use within their governance discussions for learning purposes. In addition, they are able to triangulate the learning with other sources of intelligence e.g., patient safety incidents etc. Furthermore, all learning is shared with the Trust's Organisational Learning Group.

Our activity in 2024/25 can be summarised as follows:

Financial Year	Local Issue Resolution	PALS	Complaints	Total
2024/25	849	N/A	501	1,350
2023/24	206	1,773	498	2,477
2022/23	N/A	2,446	338	2,784

849 concerns were managed locally at ward or team level whilst the complaints were managed as an Early Resolution Complaint (385 in total) and 116 were managed as a Formal Complaint. This reflects the profile that we had envisaged following our new ways of working and ensures that concerns are addressed timely.

The highest reported themes from those Local Issue Resolutions and Complaints received include aspects of the individuals Care and Treatment, followed by Assessment and Communication Issues. We are unable to compare this data from the previous year following the introduction of the new InPhase system and a change to how we categorise all concerns and complaints.

We have also seen an increase in the number of complaints that have been responded to within our originally agreed timeframes (54% in 2023/24 compared to 69% in 2024/25).

The Complaints Team have received a number of positive feedback following the complaints handling, examples are as follows:

Thank you so much for your support today, I really appreciate having you both there especially going through some not nice things. I am really thankful that I was made to feel at ease and able to get my point across and actually be heard without defensive and trying to shift the blame. Patient/Carer

Just an email to thank you so much for your continued support in this matter. And to thank you so much for being there for us today. It was a good outcome we thought and hopefully things will start and get better for patients on the ward. Although we can't undo what has happened, we are hopeful this will bring some closure and **** can start and move forward with their life. Family Member

Thank you for listening to **** which they had really appreciated your time and felt that you were passionate about your role. **** felt lucky to have someone like you in their corner and felt they were disregarded by staff, and I was made to feel that my concerns were valid and appreciated. Patient

I've read through your letter this morning and have to congratulate you for a very balanced and considerate document. I'd also like to say thank you for dealing with this as you have in such a sensitive way. Staff Member

It was excellent to meet yesterday – I so appreciate all the time you gave me. You were both professional and empathetic, which helps very much in my situation. Family Member

I have to say **** having seen the complaints I think your response is really impressive, I don't know how you do it. Staff Member

I just want to thank you and compliment you on being excellent at your job. I wonder sometimes about why the excellent people with finely honed skills seem to end up in complaints resolution these days when it might be a better idea to have them training people? Patient

**** had recently made a complaint to yourselves. They reported that they were pleased with the response from this and feels that they were listened to. **** tells me that the ward has provided extra support for them and others, and they have been offered psychological support and use of an alarm should they need this. Patient

2.19 Data quality

The latest published Data Quality Maturity Index (DQMI) score is **94%**. This is for November 2024.

Tees, Esk and Wear Valleys NHS Foundation Trust did not submit records during 2024/25 to the secondary uses service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

Tees, Esk and Wear Valleys NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2024/25 by the Audit Commission. We have had our annual external clinical coding audit for the data security and protection toolkit. The results were 93% correct for primary diagnosis and 85.1% correct for secondary diagnosis.

We stopped making commissioning data sets submissions that go to secondary uses service and HES approximately six years ago as the data was duplicated with the Mental Health Services Data Set. The Mental Health Services Data Set data quality for NHS number and GP practice from the Data Quality Maturity Index publication for November 2024 were 99.7% and 100% respectively.

2.20 Mandatory quality indicators

Since 2012/13, all NHS foundation trusts have been required to report performance against a core set of indicators:

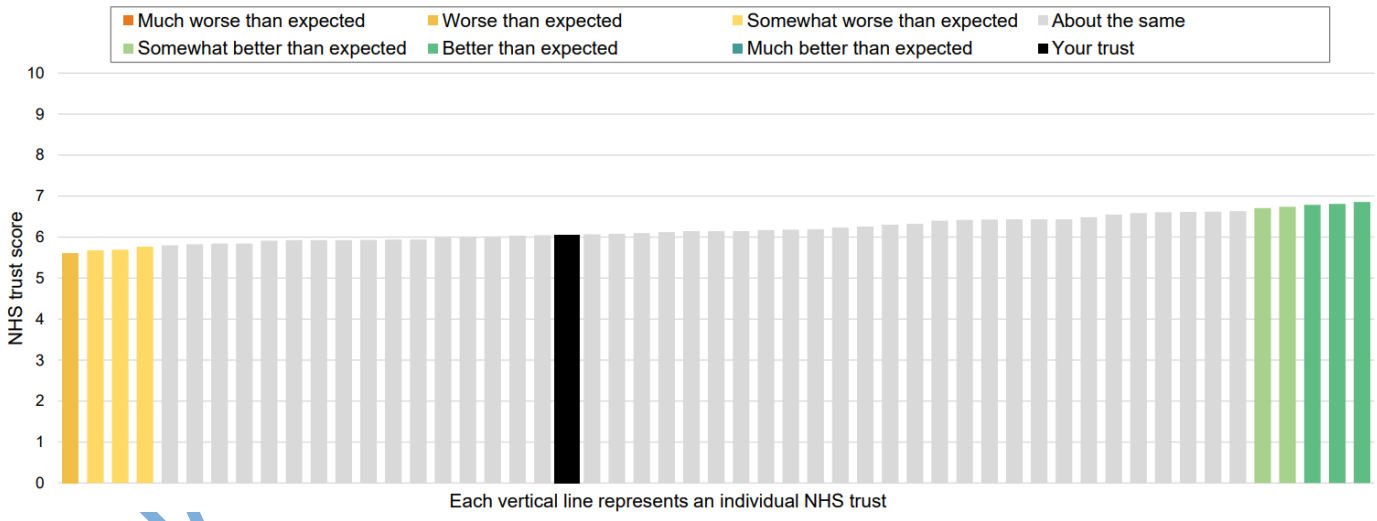
Inpatients that are discharged are followed up within 72 hours
The 72-hour measure is the percentage of people discharged from a CCG-commissioned adult mental health inpatient setting, that were followed up within 72 hours. This includes all people over the age of 18 years.

Of our commissioned services, 2975 patients were discharged between 1 April 2024 and 31 March 2025, of those:

- 2562 (**86.12%**) were followed up
- 413 were not followed up within 72 hours between April 2024 and March 2025.

The introduction of any new Electronic Patient Record has a negative impact on Data Quality. Following the introduction of Cito in February 2024, data quality issues have impacted several patient-based measures across the organisation. To support data quality and to provide oversight that our patients are safe and have been followed up in a timely manner, a thorough, manual validation has been in place through 2024/25. Whilst there are 413 patients **reported** as not receiving a follow up contact within 72 hours; only 154 of these were not actually followed up.

Patients' experience of mental health teams
For 2024, we have reported the mental health section score of the NHS Community Mental Health Survey Benchmark. The Trust has reported a score of 6.1 which is indicated below as 'about the same' compared to all other NHS trusts.



The section score is compiled from the results of the following survey questions below.

Question	TEWV mean score 2024	National average 2024	TEWV mean score 2023	TEWV mean score 2022	TEWV mean score 2021
Were you given enough time to discuss your needs and treatment?	**6.7**	**6.9**	6.9	7.7	7.5
Did you feel your NHS mental health team listened to what you had to say?	**6.9**	**7.0**	*Question updated from 2024*	-	-

Question	TEWV mean score 2024	National average 2024	TEWV mean score 2023	TEWV mean score 2022	TEWV mean score 2021
Did you get the help you needed?	**6.0**	**5.9**	6.0	*Question updated from 2023*	-
Did your NHS mental health team consider how areas of your life impact your mental health?	**6.5**	**6.5**	6.7	*Question updated from 2023*	-
Did you have to repeat your mental health history to your NHS mental health team?	**4.1**	**4.6**	4.7	*Question updated from 2023*	-

National patient safety incident reports

The National Learning from Patient Safety Incidents (LFPSE) system, which the Trust began reporting into at the end of October 2023 is now fully in place and NHS England have developed a reporting dashboard. The 'Reported Data Dashboard' (RDD) draws together all of the nationally reported patient safety incident data and provides a full overview, whether at national, regional or organisational level. Whilst this is now available to organisations within the dataset, this is still being validated prior to being made available on a public website. Local validation has been undertaken to ensure organisational data is accurate to the local system records and this will continue to be undertaken periodically and as any changes are introduced.

Part Three: Further information on how we have performed in 2024/25

3.1 Introduction to part 3

Part 3 of this document contains further information which the legal guidance requires us to include. This includes statutory statements. As with Part 2, this helps to develop an overall picture of quality at our Trust.

3.2 Our performance against our quality metrics

The Quality Account has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

Quality metrics:

Patient Safety indicators	Target	Whole Trust 24/25	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark (where available)	Further comments
Percentage of patients who report 'yes, always' or 'yes quite a lot' to the question 'do you feel safe on the ward?'	75.00%	**80.66%**	78.63%	55.57%	65.30%	64.66%	Not measured nationally	The end of 2024/25 position was **80.66%** which relates to 1847 out of 2290 surveyed. This is 5.66% above our standard 75.00%.
Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	**0.073**	0.10	0.28	0.17	0.13	The Royal College of Physicians discourage any benchmarking or comparisons due to the high number variables that exist that makes comparison unreliable.	This year's figure equates to 17 Moderate, Severe or Fatal Falls incidents against the 231,992 Occupied Bed Days.
The number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	**27.68**	29.2	33.27	28.84	20.9	N/A	This year's figure equates to 6422 incidents where restrictive intervention was used, against the 231,992 Occupied Bed Days.
The number of medication errors with a severity of moderate harm and above	2.5	**4**	11	13	12	7	N/A	There is no official benchmark for this indicator, as the greater the overall reporting, the more open and psychologically safe the culture can be said to be. A decrease in the more severe incidents can be observed to be a positive finding.
The number of Patient Safety Investigation Incidents (PSII) reported on STEIS	-	**27**	126	144	141	142	N/A	The Trust implemented the National Patient Safety Incident Response Framework (PSIRF) in January 2024 which replaced the National Serious Incident Framework (2015). PSIRF enables organisations to undertake a considered and proportionate response to patient safety incidents. Incidents that would have previously been reported on STEIS and reviewed via the Serious Incident investigation process are reviewed through a multidisciplinary After Action Review (AAR) process. AARs support teams to take a system-based approach to understanding what happened and identifying learning. For those incidents that require further investigation following completion of an AAR, these are

Patient Safety indicators	Target	Whole Trust 24/25	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark (where available)	Further comments
								reviewed under the Patient Safety Incident Investigation (PSII) process are reported on STEIS. In line with PSIRF, the term Serious Incident is no longer used.

Clinical Effectiveness Indicators	Target	Whole Trust 24/25	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National Benchmark
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours	85%	**86.12%**	81.93%	88%	*Previously reported indicator: (Existing percentage of patients on Care Programme Approach who were followed up within 72 hours after discharge from psychiatric inpatient care)*		-
Adults with a long length of stay over 60 for adult admissions	N/A	**10.02%**	12.47%	N/A	12%	N/A	According to the NHS Oversight Framework System Benchmarking as at March 2024, national rank 3 out of 50 mental health providers and are performing within the highest performing quartile (a positive position).
Older adults with a long length of stay over 90 days for older adult admissions	N/A	**35.11%**	58.04%	35%	N/A	N/A	According to the NHS Oversight Framework System Benchmarking as at March 2024, national rank 6 out of 52 mental health providers and are performing within the highest performing quartile (a positive position).

Patient Experience indicators	Target	Whole Trust 24/25	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	National benchmark
Percentage of patients who reported their overall experience as very good or good	92%[1]	**93%**	92.17%	92.16%	94.34%	87%
Percentage of patients that report that staff treated them with dignity and respect	94%	**87.6%**	87.00%	86.69%	84.72%	-
Number of complaints raised	-	**501**	498	338	257	-

Additional supporting comments on areas for improvement

The number of medication errors with a severity of moderate harm and above:
The Electronic Prescribing Medication Administration (EPMA) has been fully implemented on all wards (with the exception of respite wards), including integration work with CITO allowing discharge prescriptions to populate CITO transfer letters. During the first part of the 24/25 financial year, the EPMA Team scoped the use of EPMA within the community teams; looking at FP10 prescription forms, depot and clozapine processes. A number of enhancements to the system were proposed that would allow future implementation of EPMA to community. For the remaining months of the project, the EPMA Team worked on improving and embedding EPMA processes on the inpatient wards, delivering an update that brought group administration, increased the number of regimens and piloted leave generation on EPMA.

[1] Previous target was 94% changed December 2023 to 92%

3.3 Other external reviews/ publications

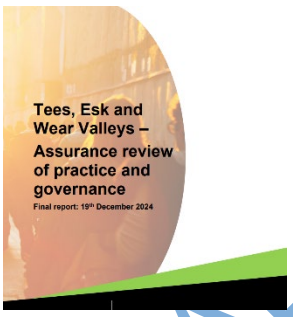
Special review of mental health services at Nottinghamshire Healthcare Foundation Trust
Following the conviction of Valdo Calocane in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar, and Barnaby Webber, the Secretary of State for Health and Social Care commissioned the CQC to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under Section 48 of the Health and Social Care Act 2008.

In March 2024, the CQC published the first part of the review on the findings of their assessment of patient safety and quality of care provided by NHFT, and progress made at Rampton Hospital since their last inspection in July 2023.
In August 2024, published the second part of their review. The issues identified in NHFT were noted as not unique to this Trust. The CQC found systemic issues with community mental health care and they made recommendations relevant to all providers. NHS England will commission an independent homicide review; the review may result in further recommendations.

All NHS mental health services were asked to complete a stock take to understand the gaps and risks in their services. The assessment framework can be found here:
https://www.england.nhs.uk/publication/guidance-on-intensive-and-assertive-community-mental-health-treatment/

Summaries of both parts of the reviews were considered within the Trust Management Group, Executive Clinical Leaders, Adult Mental Health Clinical Network and the reports were shared with both Care Group Leaders. The Community Mental Health Service Review ICB (Integrated Care Board) Maturity index self-assessment was submitted by each Care Group to the relevant ICBs. The Durham Tees Valley and Forensic (DTV&F) Care Group met with NENC (North East North Cumbria) ICB and developed an action plan based on the outcomes of the self-assessment. The North Yorkshire and York (NYY) Care Group also developed an action plan and shared this with the HNY ICB. There remains ongoing work to develop the capability to easily identify patients that meet the Assertive and Intensive criteria within the electronic patient recording system.

Assurance Review of Practice and Governance



A report was published in January 2025 which followed a review of our services and focused on where we are currently as an organisation, specifically the experiences of young people in our care. Alongside the report a shorter summary document called Lessons Learned Bulletin was also published. The independent investigation reports page of the NHS England website shows the publications.

This was a rigorous and independent review carried out by Niche Health and Social Care Consulting. It took place last year (2024). The review was commissioned by NHS England to assess whether, and to what extent, the care we provide is compliant with current standards and expectations. It is the final report following the publication in 2023 of a system-wide independent investigation into our CAMHS inpatient provision, and in 2022 reports that reviewed the care of three young women who sadly died in our care.

The findings show that we have made great improvements across our Trust and provides NHS England with good assurance that we are delivering safe and kind care every day to patients. There will be no further independent reviews in relation to the recommendations included in the earlier reports.

In particular the findings show:

- A good level of assurance that clinical practice within CAMHS offered to patients who present with complex cases is now compliant with expected standards.
- A good level of assurance that the governance of quality concerns within these services is now compliant with expected standards.

- A good level of assurance that the overall governance of quality within these services is now compliant with expected standards.

Lord Darzi Independent Investigation of the NHS in England
In July 2024, the Secretary of State for Health and Social Care commissioned Lord Darzi to conduct an immediate and independent investigation of the NHS.
Lord Darzi's report provides an expert understanding of the current performance of the NHS across England and the challenges facing the healthcare system. Lord Darzi has considered the available data and intelligence to assess:

- patient access to healthcare
- the quality of healthcare being provided
- the overall performance of the health system

In line with the terms of reference of the investigation, Lord Darzi has only considered the state of the NHS in England. UK-wide analysis is occasionally used when making international comparisons.

The 160-page report concluded that the NHS is in "serious trouble" financially and operationally and how it has failed to deliver on key obligations to the public since 2015, such as tackling health inequalities, record-long waiting times, workforce pressures and budget deficits.
As a result, millions have been deprived of access to quality care and patient satisfaction is at an all-time low. The report also highlighted how the UK health sector has continuously lagged behind other countries in several key areas, including digital transformation, capital investment, workforce capacity and pandemic response.

We have considered the Darzi report as we developed the Trust's Strategic Framework - **Our Journey to Change: The Next Chapter**. After the Darzi report was published in September 2024, it was discussed within the Executive Directors Group, a Board of Directors Workshop and in our Lived Experience Strategy Reference Group so that this was in mind as they developed the revised version of Our Journey to Change.

Following on from the Darzi report there was an opportunity to take part in the "Change NHS" consultation to inform the drafting of the government's NHS 10 year plan. The Trust successfully submitted a response using the "NHS organisations" template on 29 November 2024.

3.4 External audit

Under guidance from NHS England, the Quality Account 2024/25 is not subject to review by external audit.

3.5 Our stakeholders' views

Our Trust recognises the importance of the views of our partners as part of our assessment of the quality of the services we provide and to help us drive change and improvement.

How we involve and listen to what our partners say about us is critical to this process. We continue to listen and learn from the people we support, their carers and families, our colleagues and our partners.

In line with national guidance, we circulated our draft Quality Account for 2024/25 to the following stakeholders:

- NHS England
- North East and North Cumbria Integrated Care Board
- Humber and North Yorkshire Integrated Care Board
- Local Authority Overview and Scrutiny Committees
- Local Authority Health & Wellbeing Boards
- Local Healthwatch organisations

All the comments we have received from our stakeholders are included verbatim in Appendix 3.

Comments received will support the Trust in achievement of its Strategic Goals and will inform delivery of the Trust's Quality Priorities for 2025/26. Stakeholder comments will also inform key learning for the development of the next year Quality Account.

Appendix 1: 2024/25 Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Accounts/Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Account/Report.

In preparing the Quality Account/Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Account is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2024 to March 2025
  - Papers relating to quality reported to the Board over the period April 2024 to March 2025
  - Feedback from the Commissioners (see Appendix 3)
  - Feedback from Overview and Scrutiny Committees (see Appendix 3)
  - Feedback from Health and Wellbeing Boards (see Appendix 3)
  - The Trust's complaints information reported to its Quality Assurance Committee of the Board of Directors, which will be published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The latest community mental health survey published 04 April 2025
  - The latest national staff survey published 13 March 2025
  - CQC inspection report dated 06 February 2025
- The Quality Account/Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Account/Report is reliable and accurate There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Account regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account/Report.

By order of the Board.

Bev Reilly
Interim Chair
25 June 2025

Beverely Murphy
Acting Interim Chief Executive
25 June 2025

Appendix 2: Glossary

Adult Mental Health (AMH) Services: Services provided for people aged between 18 and 64 – known in some other parts of the country as 'working-age services'. These services include inpatient and community mental health services. In practice, some patients younger than 64 may be treated in older people's services if they are physically frail or have Early Onset Dementia. Early Intervention in Psychosis (EIP) teams may treat patients less than 18 years of age as well as patients aged 18-64.

Audit: An official inspection of records; this can be conducted either by an independent body or an internal audit department.

Autism: This describes a range of conditions typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases cognitive delays. People with autism are sometimes known as neuro-diverse. Autism cannot be cured, but the mental illnesses which are more common for people with autism can be treated.

Board/Board of Directors: Our Trust is run by a Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is responsible for ensuring accountability to the public for the services in manages. It is overseen by a Council of Governors and monitored by NHS England. It also:

- Ensure effective dialogue between our Trust and the communities we serve
- Monitors and ensures high quality services
- Is responsible for our financial viability
- Appoints and appraises our executive management team

Business plan: A document produced once a year to outline what we intend to do over the next three years in relation to the services that we provide.

Care Planning/ Care Programme Approach: Refer to Personalised Care Planning definition.

Care Quality Commission (CQC): The independent regulator of health and social care in England. They regulate the quality of care provided in hospitals, care homes and people's own homes by the NHS, Local Authorities, private companies, and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.

Child and Adolescent Mental Health Services (CAMHS): Mental Health Services for children and young people under the age of 18 years old. This includes community mental health services, inpatient services and learning disability services.

Cito: An information technology system which overlays the Trust's patient record system (PARIS) which makes it easier to record and view the patient's records.

Clinical Commissioning Groups (CCGs): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England.

Clinical Supervision: a supportive mechanism which involves clinicians meeting regularly to reflect on practice, with the intention of learning, developing practice and providing high quality, safe care to patients.

Commissioners: The organisations that have responsibility for purchasing health services on behalf of the population in the area they work for.

Commissioning for Quality and Innovation (CQUIN): A payment framework where a proportion of NHS providers' income is conditional on quality and innovation.

Community Mental Health Survey: a survey conducted every year by the CQC. It represents the experiences of people who have received specialist care or treatment for a mental health condition in 55 NHS Trusts in England over a specific period during the year.

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about factors which contributed to the inability of the NHS to prevent each suicide of a patient within its care. National reports and recommendations are then produced.

Co-production/Co-creation: This is an approach where a policy or other initiative/action is designed jointly between our staff and patients, carers, and families.

Council of Governors: Made up of elected public and staff members and includes non-elected members such as the prison service, voluntary sector, acute trusts, universities and local authorities. The Council has an advisory, guardianship and strategic role including developing our Trust's membership, appointments and remuneration of the non-executive directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Crisis Resolution & Home Treatment (CRHT) Team: Provide intensive support at home for individuals experiencing an acute mental health crisis. They aim to reduce both the number and length of hospital admissions and to ease the pressure on inpatient units.

Dashboard: A report that uses data on a number of measures to help managers build up a picture of operational (day-to-day) performance or long-term strategic outcomes.

Data Protection and Security Toolkit: A national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

Data Quality Strategy: A strategy which sets out clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality data. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

Department of Health: The government department responsible for health policy.

DIALOG+: A clinical tool that allows for assessment, planning, intervention, and evaluation in one procedure and allows more personalised care planning.

Forensic Adult and Mental Health and Learning Disability Services: Work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to a secure hospital from a prison or court, where their needs can be assessed and treated.

Formulation: When clinicians use information obtained from their assessment of a patient to provide an explanation or hypothesis about the cause and nature of the presenting problems. This helps in developing the most suitable treatment approach.

Freedom to Speak Up Guardian: Provides guidance and support to staff to enable them to speak up safely within their own workplace.

Friends and Family Test (FFT): A survey put to service users, carers and staff that asks whether or not they would recommend a hospital/community service to a friend or family member if they need treatment.

Gatekeeper/gatekeeping: Assessing the service user before admission to hospital to consider whether there are alternatives to admission and the involvement in the decision-making processes that result in admission.

General Medical Practice Code: The organisation code of the GP Practice that the patient is registered with. This is used to make sure a patient's GP code is recorded correctly.

Guardian of Safe Working: Provides assurance that rotas and working conditions are safe for doctors and patients.

Harm minimisation: Our way of working to minimise the risks of sometimes multiple and conflicting harm to both service users and other people.

Health and wellbeing boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system (i.e., local authorities and the NHS) would work together to improve the health and wellbeing of their local population and to reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities, and encourage commissioners to work in a more joined-up way.

HealthWatch: Local bodies made up of individuals and community groups, such as faith groups and resident's organisations associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

Home Treatment Accreditation Scheme (HTAS): Works with teams to assure and improve the quality of crisis resolution and home treatment services for people with acute mental illness and their carers.

Hospital Episode Statistics (HES): The national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

Improving Access to Psychological Therapies (IAPT): An NHS initiative to increase the provision of evidence-based treatments for common mental health conditions such as depression and anxiety by primary care organisations.

Integrated Information Centre (IIC): Our system for taking data from the patient record (PARIS) and enabling it to be analysed to aid operational decision making and business planning.

Intranet: This is our Trust's internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures.

Learning Disability Services: Services for people with a learning disability and/or mental health needs. We have an Adult Learning Disability (ALD) service in each Care Group and also specific wards for Forensic LD patients. We provide child LD services in Durham, Darlington, Teesside, and York but not in North Yorkshire.

LeDeR: The learning from deaths of people with a Learning Disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a Learning Disability and reduce health inequalities.

Local authority Overview and Scrutiny Committee (OSC): Statutory committees of each local authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the local authority area. All local authorities have an OSC that focusses on health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar and Cleveland councils have a joint Tees Valley Health OSC that performs this function.

Local Issue Resolution (LIR): A recent concern raised that can be explored together with the team or ward in a timely manner

Mental Health Act (1983): The main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. In most cases when people are treated in hospital or in another mental health facility they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old with a mental health problem. They can be treated for functional illness, such as depression, psychosis, or anxiety, or for organic mental illness (conditions usually associated with memory loss and cognitive impairment) such as dementia. The MHSOP Service sometimes treats people less than 65 years of age with organic conditions such as early-onset dementia.

Mortality Review Process: A process to review deaths, ensuring a consistent and coordinated approach, and promoting the identification of improvements and the sharing of learning.

Multi-Disciplinary: This means that more than one type of professional is involved, for example, psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacists all working together in a Multi-Disciplinary Team (MDT).

National Institute for Clinical Excellence (NICE): NHS body that provides guidance sets quality standards and manages a national database to improve people's health and to prevent and treat ill health. NICE works with experts from the NHS, local authorities, and others in the public, private, voluntary and community sectors – as well as patients and carers – to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

National Institute for Health Research (NIHR): An NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of the patients and the public.

National Reporting and Learning System (NRLS): A central (national) database of patient safety incident reports. All information submitted is analysed to identify hazards, risks, and opportunities to continuously improve the safety of patient care.

NHS England (NHSE): leads the National Health Service in England.

NHS Staff Survey: Annual survey of staff experience of working within NHS trusts.

Non-executive directors (NEDs): Members of the Trust Board who act as a critical friend to hold the Board to account by challenging its decisions and outcomes to ensure they act in the best interests of patients and the public.

North Cumbria and North East Integrated Care System: Consists of four Integrated Care Partnerships – North, South, East, and West (see Integrated Care Partnerships).

PARIS: Our electronic care record, designed with mental health professionals to ensure that the right information is available to those who need it at all times. See Cito definition also.

Patient-led Assessments of the Care Environment (PLACE): Assessments of the hospital environment reviewing how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness, the general building maintenance and the extent to which the environment is able to support the care of those with dementia or with a disability.

Patient Safety Incident Investigation (PSII): PSII's are one method to extensively review and investigate an incident. These are acts and/or omissions occurring as part of NHS-funded healthcare (including in the community), resulting in one of the following - unexpected or avoidable death of one or more people which includes homicide by a person in receipt of mental health care within the recent past, unexpected or avoidable injury to one or more people that has resulted in serious harm.

Patient Safety Incident Response Framework (PSIRF): sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Peer worker: Someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a patient or carer) to support other patients, in line with the recovery approach.

Personalised Care Planning: describes the flexible, responsive and personalised approach following a high-quality and comprehensive assessment means that the level of planning and co-ordination of care for patients can be tailored and amended, depending on a number of factors. Factors include the complexity of a person's needs and circumstances at any given time, the assessed and identified intervention required to meet personalised needs, what matters to them and the choices they make, the views, needs and circumstances of carers and/or other important people in their life, professional judgment and evidence-based practice. It is called 'an approach' rather than a system because of the way these elements are carried out, which is as important as the tasks themselves.

Prescribing Observatory in Mental Health (POMH): A national agency led by the Royal College of Psychiatrists, which aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Programme: A coordinated group of projects and/or change management activities designed to achieve outputs and/or changes that will benefit the organisation.

Project: A one-off, time limited piece of work that produces a product (such as a new building, a change in service or a new strategy/policy) that will bring benefits to relevant stakeholders. Within our Trust, projects will go through a scoping phase, and then a business case phase before they are implemented, evaluated, and closed down. All projects will have a project plan and a project manager.

Psychiatric Intensive Care Unit (PICU): A unit (or ward) that is designed to look after people who cannot be managed on an open (unlocked) psychiatric ward due to the level of risk they pose to themselves or others.

Quality Account: A report about the quality of services provided by an NHS healthcare provider, the report is published annually by each provider.

Quality Assurance Committee (QuAC): Sub-committee of the Trust Board responsible for quality and assurance.

Quality Assurance and Improvement Groups (QAIG): Care Group forums within the Trust responsible for quality and assurance.

Quarter one/quarter two/quarter three/quarter four: Specific time points within the financial year (1 April to 31 March). Quarter one is from April to June, quarter two is from July to September, quarter three is October to December and quarter four is January to March.

Reasonable adjustments: A change or adjustment unique to a person's needs that will support them in their daily lives, e.g., at work, attending medical appointments, etc.

Research Ethics Committee: An independent committee of the Health Research Authority, whose task it is to consider the ethics of proposed research projects which will involve human participants, and which will take place, generally, within the NHS.

Royal College of Psychiatrists: The professional body responsible for education and training and setting and raising standards in psychiatry.

Safeguarding: Protecting vulnerable adults or children from abuse or neglect, including ensuring such people are supported to get good access to healthcare and stay well.

Single Oversight Framework: sets out how NHS trusts and NHS foundation trusts are overseen.

Staff Friends and Family Test: A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It helps us identify what is working well, what can be improved and how.

Statistical Process Control (SPC) charts: a graph used to show how a process changes over time and to see whether a situation is improving or deteriorating, whether the system is likely to be capable to meet the standard and whether the process is reliable or variable.

Steering group: Made up of experts who oversee key pieces of work to ensure that protocol is followed and provide advice/troubleshoot where necessary.

Strategic framework: primarily intended as a framework for thinking about the future and a guide to inform the investment and disinvestment decisions by those tasked with future planning.

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust.

TEWVision: The in-house built application for recording staff clinical supervision, managerial supervision, and appraisals.

Thematic review: A piece of work to identify and evaluate Trustwide practice in relation to a particular theme. This may be to identify where there are problems/concerns or to identify areas of best practice that could be shared Trustwide.

The Trust: Tees, Esk and Wear Valleys NHS Foundation Trust.

Trust Board: See Board/Board of Directors above

Trustwide: The whole geographical area served by our Trust.

Unexpected Death: A death that is not expected due to a terminal medical condition or physical illness.

Urgent Care Services: Crisis, Acute Liaison and Street Triage services across our Trust.

Whistleblowing: this is a term used when a worker highlights a concern about their organisation and/or services to the Freedom to Speak Up Guardian or NHS Regulators. This will normally be regarding something they have witnessed at work.

Year (e.g., 2024/25): These are financial years, which start on the 1 April in the first year and end on the 31 March in the second year.

Appendix 3: Stakeholders' views

Tees Valley Joint Health Scrutiny Committee (Received 19/05/2025)

The Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Account presentation was considered by the Tees Valley Joint Health Scrutiny Committee at its meeting on the 13th March 2025.

The Committee welcomed the content of the presentation in relation to the quality account improvement priorities for 2024/25, in particular –

- Patient experience: Promoting education using lived experience
- Patient Safety: Relapse prevention
- Clinical effectiveness: Improving personalisation in urgent care.

Attention was drawn to Priority 3 (clinical effectiveness), Members noted the improvements being made towards personalisation in urgent care, in particular the training module that had been made available to staff. Members are interested to observe the impact this will have and look forward to the findings of the evaluation. Members also supported the continuing work with services users to identify the priorities for the year ahead.

Members received an overview of the Niche assurance review commissioned by NHS England and its findings and the recent Care Quality Commission (CQC) inspection of the Mental Health Crisis Service and health-based places of safety. Members were pleased that the service had received a rating of 'good'.

Referring to the most recent CQC well-led inspection of October 2023 Committee Members again expressed concern due to the number of service areas, under the 'safe' domain, listed as 'requires improvement'. Members noted the improvement plan and the subsequent audit that was taking place to ensure the effective completion and embeddedness of internal response to CQC recommendations. Attention was drawn to the recording of clinical supervision and assurance was given by the Trust that improvements to staff training and the recording of clinical supervision were being embedded.

In relation to future priorities the Committee continues to be concerned about capacity issues identified in relation to the demand on the Child Adolescent Mental Health Services (CAMHS) and those waiting for assessments by neurodevelopmental services. The Committee emphasised the importance of addressing these issues and whilst being assured that ways to manage this were being explored, the Committee would like to receive further information about how this was being achieved.

TEWV continue to co-operate with requests for attendance at Committee meetings to provide information on a range of topics, and Members are grateful for the time and input of Trust Representatives. The 2024-2025 municipal year saw senior officers address the Committee regarding several service areas including changes to the respite care provision and the development of the 111 service for those in need of mental health support.

The Committee was keen to note the improvements and developments to service provision. However, Members also highlighted there was still significant improvements needed and the Committee looks forward to receiving further progress updates.

Councillor Moss Boddy
Chair of Tees Valley Joint Health Scrutiny Committee 2024/25

Darlington Borough Council (Received 21/05/2025)

Members of the Health and Housing Scrutiny Committee welcomed the opportunity to consider the draft Quality Account 2024/2025 for Tees, Esk and Wear Valleys NHS Foundation Trust and had the following comments to make:

The Committee considered that the Quality Account was clearly set out and noted the progress made against the three priorities, 'Patient Experience: Promoting education using lived experience', 'Patient Safety: Relapse Prevention' and 'Clinical Effectiveness: Improving Personalisation in Urgent Care'.

Members were pleased to note the work undertaken to progress the outlined priorities and their clear descriptions provided by the trust's representatives on the day.

Questions were raised including as to whether there is a timeframe for improving CQC ratings for which a detailed response was provided and members were pleased to learn that all points of improvement from the last major inspection (2023) have now been met.

Questions were also asked regarding the governance and recruitment structure of the Trust and members were pleased to learn that those with lived experience were involved in the recent recruitment process for the Trust's new Chief Executive. Members were also pleased to learn that training for staff is occurring in face-to-face settings and that sections of training are provided by those with lived experience.

Members asked who was given opportunity to take part in the Big Conversation and were informed that staff, service users and their friends and families were welcome to take part, members expressed that they would have ideally liked to have seen a greater response with Trust representatives agreeing. However, members accepted that requests for feedback were well-promoted by the Trust.

Discussions were held with regards to recruitment and staffing, particular attention was paid to the presence of agency workers with members expressing that they would like to see permanent Trust employees hired where possible over the use of agency staff, a sentiment which was shared by the Trust's representatives.

A further discussion was held regarding the quality of the Trust's buildings and members were pleased to hear that buildings are generally of a high standard in the vast majority of cases with high quality in-patient facilities and a good standard of food and cleanliness. Members had no specific requests for additions to next year's quality account.

Overall, the Health and Housing Scrutiny Committee welcomed the opportunity to comment on the Trust's Quality Accounts and fully endorsed the proposed priorities. Appreciation was expressed for the clear layout of the Quality Account particularly in respect of the included glossary of terms.

Members universally expressed their thanks to the Trust for the positive work being carried

out.

Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee (received 27/05/2025)

The Adults Wellbeing and Health Overview and Scrutiny Committee welcomes Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust's draft Quality Account 2024/25 and the opportunity to provide comment on it. The Committee are mindful of their statutory health scrutiny role and the need to demonstrate a robust mechanism for providing assurance to the residents of County Durham that health service provision is efficient and effective. The Quality Account process provides the Committee with one such mechanism.

The Adults Wellbeing and Health OSC has engaged with the Trust in respect of the Trust's CQC Inspection results and associated Improvement Action Plans as well as performance issues identified when considering the 2023/24 Quality Account. Additional engagement with the Trust has been undertaken by the Council's Children and Young Peoples' OSC in respect of the Trust's involvement and work following the Joint CQC/Ofsted CYO Special Educational Needs and Disabilities (SEND) inspection; Children and Adolescents Mental Health Services (CAMHS) demand for service access, assessments and waiting times together with an evaluation into a pilot for Mental Health support in schools in the Consett area.

It is evident that the Quality Account is clearly set out and that progress made against 2024/25 priorities is clearly identified.

Within Priority One: Patient Experience, the development of training sessions for all employees which include input of people with lived experience of services is welcomed particularly the work in engaging with clinical staff in Accident and Emergency and Primary Care services to raise awareness of challenges when people present with mental health challenges.

Priority Two: Patient Safety references the work done to review safety and care plans within community services alongside the new Personalising Care Planning Policy which aims to prevent relapse and the associated communications plan to embed this policy. Again this work is supported as a major step to reduce relapse and the incidence of mental health crisis episodes. The introduction of an audit tool to performance manage delivery of this work is also supported.

Priority Three: Clinical Effectiveness and the use of the "my story once" approach was supported by the Committee for 2025/26 and it is noted that this approach was incorporated into the Personalising Care Planning Policy launched in January 2025 and the subsequent staff training which will continue into 2025/26 for all appropriate staff.

The Committee notes the extensive demands placed upon the Trust in rolling out the initiatives for the 2024/25 Quality Account priorities and the proposal to carry forward these into 2025/26. There are a number of key areas identified within the report which will support the delivery of the Quality Account priorities. Plans to assess the embeddedness and quality of patient's Safety and Care Plans, including reviewing the findings from the established Peer Quality Reviews which are undertaken throughout the year are welcomed. A commitment to ongoing roll out of an extensive training programme for staff is noted and assessment of how this training delivers improvements in personalisation in urgent care and improved patient feedback should provide some assurance to patients, families and carers and the Committee. This is vital to restore patient, public and system

trust in the services provided by TEWV following a number of high profile critical media reports of system failures and inadequacies.

In respect of Trust performance and key achievements there are a number of positive developments to note including the CQC Rating of good for Mental Health Crisis Services and Health Based places of safety and liaison services; the implementation of mental health services into the NHS 111 system; the Durham Community Reorganisation Plan for Mental Health Services for Older People delivering reduced waiting times and enhanced quality of care and the work by the Trust in supporting patients with paid employment aspirations and outcomes.

Finally, in order to ensure that it continues to provide a robust health scrutiny function and to provide assurances in this respect to the residents of County Durham, the Committee would request a progress report on delivery of 2025/26 priorities and performance targets.

County Durham Health and Wellbeing Board (received 28/05/2025)

Thank you for the opportunity to comment on the Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust Quality Account 2024-25. The County Durham Health and Wellbeing Board (HWB) appreciate this transparency and as such would like to provide the following comments on the document.

The HWB note that there continues to be unprecedented demand for mental health services, and acknowledge the challenges this brings for TEWV, supporting people across County Durham, Darlington, Teesside, North Yorkshire, York and Selby.

We note the overall CQC rating for TEWV is 'required improvement', however the CQC inspection in February 2025, rated TEWVs mental health crisis services and health-based places of safety as 'good', which is a maintenance rating from the previous year. It is reassuring to see that the report highlights that staff shared a vision and culture, worked with capable and compassionate leaders and that there are sound structures in place for staff to speak up. The HWB note the actions the Trust intends to take to address the points made by the CQC and acknowledge that some progress has already been made on these.

We also note the examples of positive change documented throughout the quality account, and commend colleagues, partners, patients and carers for their commitment to improve the quality and safety of the care provided by the Trust. It is pleasing that the two lived experience directors are now established across the care boards and are offering their knowledge and insight as well as providing challenge to strategic decisions. It is great to see that in addition to this, you also have four strategic lived experience roles working across the Trust. We are reassured that patient and carer experiences are being considered and used to co-create, where possible across the Trust, using the newly launched co-creation framework.

The patient stories are noted as a great way to share real life experiences, and we are pleased to see the impact the Trust has made on their lives, and their commitment to supporting others and shaping mental health care across the North East.

It's good to see continued progress against your 'Journey to Change', and that changes have been made following feedback from the Big Conversation, including an updated vision statement, changes to the goals and recognising the need for staff to do their duties well and to be

productive, and supportive of innovation and change. We note that the Journey to Change approach is at the forefront of everything you do across the Trust.

We note that the Trust will continue to focus on three key areas around improving hospital to community care, moving from analogue systems to digital systems, and changing the approach from treating sickness to preventing it. Particular points to note in regard to achievements during the previous year include:

- Hospitality Assured rated the Trust as 'world class' hospitality – the highest standard of customer service quality standard accreditation that can be achieved.
- The crisis service moving to NHS 111 (mental health option), and the considerable work with partners to ensure the right care, right person approach provides the most appropriate support to those in crisis.
- Implementation of the Durham Community Reorganisation Plan for mental health services for older people, with significant benefits such as reduced waiting times and enhanced quality of care
- Work on the Chris's Voice Campaign, to help improve involvement of patients and families in care delivery
- Support to patients with paid employment aspirations, resulting in 600 patients being supported and 300 paid employment outcomes being achieved.
- Launching the dedicated CAMHS web section on the Trust's website, which was co-created by staff, children and young people, along with their parents and carers
- Launching a 360-degree virtual tour of the Dalesway Unit, Roseberry Park Hospital, to relieve anxiety for first time visitors to the service.
- The vast range of work to co-create a great experience for colleagues
- The improvements around working with partners, including the implementation of systemwide peer support networks.

It would be useful to know a bit more about how the Right Care Right Person implementation has impacted upon TEWV NHS Foundation Trust and the quality of service. We acknowledge that all police forces the Trust works with will have different ways of implementing the initiative. It would be useful for partners if further information in respect of this was included within the Quality Account report.

We acknowledge performance against the following priority areas of improvement for 2024-25:

Priority 1: Patient experience: promoting education using lived experience We are pleased that successful recruitment has taken place to appoint a training lead for the involvement and engagement team, to coordinate training packages and support roll out of these across the Trust. It is important that the voice of children and young people is being sought in relation to feeling safe and that this is used in relevant training.

Priority 2: Patient safety: relapse prevention It is noted that a review of safety and care plans has taken place and that the new personalised care planning policy was revised and published in January 2025 to support and reduce patient relapse. It is reassuring to see that there have been improvements in most of the metrics for inpatient services and community services, as demonstrated in the quality assurance and improvement programme.

Priority 3: Clinical effectiveness: improving personalisation in urgent care It is good to see that work continues on improving 'my story once' approach, and that this is modelled in the training packages and included in the personalised care planning policy.

We note these priorities will be carried forward over a three year period to allow time for sustained continuous improvement, and look forward to receiving progress updates against these over the coming years.

It is important that the TEWV quality account aligns, where appropriate to the County Durham Joint Local Health and Wellbeing Strategy (JLHWS) 2023-28 which has been agreed through the HWB and recognises the importance of good mental health. Improving Mental Health, Resilience and Wellbeing is one of the key priorities of the JLHWS, with a local ambition to reduce the number of people in County Durham who self-reported feeling anxious to 10% or less by 2034.

In line with the HWB work programme we hold focused JLHWS priority meetings quarterly. The HWB meeting in March 2025 focused on Mental Health, Wellbeing and Resilience and Jo Murray, Associate Director, TEWV and Jamie Todd, Director of Operations were in attendance at the meeting and contributed to discussions. Continued active contribution to the HWB at a senior level is valued.

Positive partnership working in County Durham is also evidenced through the Mental Health Strategic Partnership Board and mental health is a key priority across the integrated health and care system. A Mental Health Governance Working Group has been established to review the form and function of current arrangements and map areas of duplication across the system, which includes work through our Suicide Prevention Alliance. This work will bring together all plans and commissioning intentions across the system.

As part of this work, proxy indicators which help us achieve the ambition and span the life course will be developed and key programmes of work will be identified that will be part of achieving the ambition.

Learning from deaths
During 2024-25 there were 1744 deaths reported to the Trust, with the majority of these from natural causes however 379 had further reviews, with 186 having case record reviews. Of the 1,744 deaths 1.31% were judged to be more likely than not to have been due to problems in the care provided to the patient. It is disappointing that this seems to be an increase on the previous year (1322 deaths / 0.007%). We understand that actionable learning will continue to be monitored and that 38 patient safety briefings have been circulated during the period as a result of this learning.

The County Durham HWB look forward to continuing work with TEWV as an important partner to achieve our vision for County Durham to be ‘a healthy place, where people live well for longer’, and to support the place-based integrated health and social care systems.

Amanda Healy, FFPH Director of Public Health

Healthwatch Middlesbrough and Healthwatch Redcar and Cleveland (Received 30/05/2025)

Healthwatch South Tees is pleased to have the opportunity to comment on the Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account. We’d like to acknowledge that you have produced a highly informative document.
Some specific comments:

- We are pleased to see that patient, carer, and staff feedback is being actively utilised to drive forward the Journey to Change. The inclusion of patient stories that describe the effectiveness of the support received is a positive step in demonstrating impact.
- **Pages 19-21:** The list of national awards is impressive. Could any of these recognitions be highlighted further to demonstrate impact?
- **Physical health** – it is good to see the work being undertaken here.
- **Page 36:** The survey results print is difficult to read. Can you comment on the bottom five survey results illustrated?
- **Page 40:** Could participation in clinical audits and national confidential inquiries be combined?
- Good to see the clinical audit taking place similarly with regard to participation in clinical research.
- **Page 45:** There should be a reference here to the statement made on page 14 "Further information is provided within section 2.13: What the Care Quality Commission (CQC) says about us."
- **Page 46:** "The Trust CQC improvement plan was formally submitted to the CQC on 01 May 2025 after approval by our Executive Chief Nurse." Did this result in the closure mentioned further down the page?
- **Pages 60-61:** Comments on the drop in patient experience scores compared to previous years would be helpful.
- **Pages 63-64:** Performance against quality metrics - any comments on those items where the Trust have not met their target? (The comments on medication errors are noted).

I hope you find these comments helpful. We have also included on a separate page queries and suggestions for amendment (e.g. clarification and minor typographical corrections) which I am sure would have been addressed in final proof reading.
Linda Sergeant, HWST Project Lead

Healthwatch Hartlepool (Received 31/05/2025)

Healthwatch Hartlepool would like to make the following points –

- Overall, we were pleased to note areas of significant progress in the previous 12 months, particularly in the manner in which co-production and lived experience continue to be embedded both in strategic and operational aspects of service design and delivery within the trust.
- We were pleased to note that Hartlepool was recognised for the part that it played in the successful early development work in the community transformation process and the significant part this has played in shaping ongoing work in this area across the organisation
- We were pleased to note the progress outlined against the 24/25 quality improvement priorities and noted that developments made will be built upon and enhanced through ongoing areas of work around patient safety and care planning identified in the 25/26 quality priority areas.
- We were pleased to note the emphasis given to staff training and development in the 25/26 quality priority areas, and in particular, a greater emphasis given to face-face training around care planning.
- We were concerned to note ongoing issues with electronic patient records and data quality following the introduction of the CITO system in February 24, and the impact this has had on data quality and planning processes. We hope these issues are resolved in the coming year.
- We were pleased to note the inclusion of patient stories and the insight descriptive insight they give to the Quality Account. However, we felt that overall, language used in the document was not inclusive, and that all too often, there was little or no context to many much of the data and

statistical content. This must be addressed if TEWV are to encourage greater co-production and a more inclusive approach to all aspects of organisation and its ongoing development.
- Some context is needed regarding the activity and purpose of the Governing Body and the role individual Governors play. In future, a short statement from the Lead Governor covering key activity in the previous year may be a useful addition.

Humber and North Yorkshire Integrated Care Board (ICB) (Received 02/06/2025)

NHS Humber and North Yorkshire Integrated Care Board (HNY ICB) commission healthcare services for the local population and welcome the opportunity to review the Annual Quality Account for Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) for 2024/2025. As with previously, this year's report is reflective of the Trust's values, vision, and ambitions for the future. We congratulate the Trust and its staff on the many successes detailed in the report and during this reporting period.

The ICB recognise the ongoing commitment and ambitions of the Trust, in strengthening co-production and the voice of lived experience and colleagues; examples of which include the co-creation boards. We acknowledge the significant work in this area, supported by the Trusts overarching strategy as detailed in the 'Our Journey to Change'. We are pleased to see that once again the Trust further demonstrates the importance of the voice of people with lived experience, in informing the improvement priorities for the Trust.

The ICB have recognised the significant work undertaken throughout the year, and the progress made towards achieving the quality priorities set out for 2024/25. We note the programme of both training and development and work to further strengthen the partnerships with local Trusts. We recognise the role of Clinical Advisory Group, their priorities and associated workplan. Also, the connectivity to the work of Physical Health Group and ambition to further improve outcomes and the experience of patients using health services.

We note the development and implementation of the Personalised Care Planning Policy which will strengthen timely and proactive access, supporting the prevention of the relapse of patients and improve the effective use of the ‘my story once’ approach.

We note the launch of a dedicated CAMHS resource on the Trust website and the roll out of the Leadership and Management Academy which has seen many positive outcomes including the reduction in vacancies and use of restrictive interventions. Furthermore, we recognise the work of the trust in ensuring the voice of young people is present and informs safeguarding training development.

We congratulate the Trust in achieving full implementation and embedding of the Patient Safety Incident Response Framework (PSIRF), the introduction of the Organisational Learning Group (OLG) and the integration of Suicide Prevention Leads. All of which will support the Trust in providing greater focus on and sharing of the learning from adverse events, both internal and system wide.

We note that the Trust has achieved the implementation of the Opel Framework, improved sustainability and seeing a reduced out of area placements. The commitment of the Trust to work in partnership on large scale change including community mental health transformation is welcomed. This is demonstrated through the continued development of primary mental health

workers and hybrid roles to strengthen integration and the interface between primary and secondary care.

The ICB congratulate the Trust in achieving a `good` rating, following the recent CQC targeted inspection of Mental Health Crisis Service, Health Based Places of Safety and Liaison Services.

The ICB is supportive of the Trusts quality priorities for 2025/2026 and the work of all, in ensuring continuous improvement. As outlined in the account, the Trust remains committed to delivering high quality care; the assessment, evaluation and understanding the impact on the quality of patient experience.

The Humber and North Yorkshire Integrated Care Board remain committed to working with the Trust and its regulators to improve the quality and safety of services available for the population of the patients served by the Trust in order to improve patient experience and patient outcomes. Finally, we confirm that to the best of our knowledge, the report is a true and accurate reflection of the quality of care delivered by the Trust and that the data and information contained in the report is accurate.
Deborah Lowe, Director of Nursing, Safety, Quality and Experience

NHS North East and North Cumbria Integrated Care Board (NENC ICB) (Received 02/06/2025)

NHS North East and North Cumbria Integrated Care Board (NENC ICB) is committed to commissioning high quality services from Tees, Esk & Wear Valley NHS Foundation Trust. NENC ICB is responsible for ensuring that the healthcare needs of patients that they represent are safe, effective and that the experiences of patients are reflected and acted upon. The ICB welcomes the opportunity to review and provide comment on this 2024/25 Quality Account.

Overview
North East and North Cumbria ICB would like to thank Tees, Esk & Wear Valley NHS Foundation Trust for the openness and transparency reflected in this year's Quality Account. Equally we would like to commend your workforce for their commitment and dedication demonstrated throughout these challenging times and for striving to ensure that patient care continues to be delivered to a high standard. The ICB would also like to thank the Non-Executive Director for Quality and the Chief Nurse for welcoming the ICB to be a full member of the Trust's quality committee.

Achievements
We would like to congratulate the Trust on the achievements made during this period and recognise the attainments detailed within the quality account, in particular:
- Recognition of the community mental health transformation work in Hartlepool by the Parliamentary Health Select Committee.
- Implementation of the national OPEL (Operational Pressures Escalation Levels) Framework, which has positively impacted on bed occupancy and patient flow.
- Implementation of the NHS 111 service mental health option.
- The work to improve culture both risk-based and the culture of care programme to improve experience of care and improve therapeutic benefits and outcomes.
- The launch of a dedicated CAMHS section on your website, co-created with the community that you serve.

- The 17% increase in volunteers recruited by the Trust and establishment of peer worker roles across the Durham Tees Valley forensics area.
- The ongoing commitment to co creation as part of your framework and the benefits that this approach has already realised.
- The multiple awards that the Trust have received as reflected within the quality account narrative.
- The considerable work undertaken to date to deliver the 2024/2025 quality priorities to enhance safe, effective services and deliver good patient experience.

Areas for Further Development
The ICB recognises the additional work that the Trust is undertaking to further support the ongoing delivery of the 2024/25 quality priorities. In particular, the approach being taken to ensure the voice of service users, relatives and carers is at the heart of any quality improvements and maintain a focus on co-creation.
We also acknowledge the continued focus taking place on the 5 'quality journeys' to support the Trusts 'Our Journey to Change' strategy and recognise the achievements teams have made to improve personalised care planning, physical health and patient safety.

Future Priorities
The ICB is fully supportive of the 2025/2026 quality priorities and the 3 key areas outlined in section 2.5, to support their delivery. We acknowledge that the quality priorities are being carried forward for a 3-year period within the Trusts operational framework to enable sustainability and fully embed the necessary improvements.

The Quality Account is reflective of the Trusts overall CQC rating of ‘Requires Improvement’ and the ICB has been monitoring the robust improvement initiatives that have been put in place following inspection through attendance at the Trust Quality Assurance Committee and NHSE led quality forums.

The ICB can confirm that to the best of our ability that the information provided within the annual Quality Account is an accurate and fair reflection of Trust performance for 2024/25. It is clearly presented in the required format, contains information that accurately represents the Trust's quality profile and aspirations for the forthcoming year.

NENC ICB remain committed to working in partnership with the Trust to assure the quality of commissioned services in 2025/26.

Kate O'Brien
Director of Nursing, Mental Health, Learning Disabilities, Autism and Complex Care
NHS North East and North Cumbria Integrated Care Board

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Meeting of:	**Board of Directors**
Date:	**25 June 2025**
Title:	**The Register of Interests of the Board of Directors**
Executive Sponsor(s):	**-**
Author(s):	**Phil Bellas, Company Secretary**

Report for:				
	Assurance	✓	***Decision***	
	Consultation		***Information***	✓

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
10	Regulatory Compliance	Under its Provider License, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the License, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Executive Summary:

Purpose: To provide the Register of Interests of the Board of Directors as at June 2025.

Proposal: To note the Register of Interests of the Board of Directors as at June 2025.

Overview: The Trust is required to maintain a register of interests of directors in accordance with para. 20(1)(d) of Sch.7 of the NHS Act 2006.

The format of the register and the definitions of types of interest reflect the requirements of policy HR-0020-v4.2. This policy is based on NHSE guidance.

The Register of Interests of the Board of Directors of Tees, Esk and Wear Valleys NHS Foundation Trust, as at June 2025, is attached to this report.

It has been updated based on returns provided by individual Board Members.

The Register is published on the Trust website to ensure compliance with the relevant provision in the Annual Governance Statement.

Prior Consideration and Feedback	The Register of Interests of Directors was reviewed by the Audit and Risk Committee at its meeting held on 20 June 2025. *(Please note that the version of the register provided to that meeting has been subsequently updated)*
Implications:	The Trust is required to establish and implement processes and systems to identify risks and guard against their occurrence. Failure to do so would be a breach of the provider licence.
Recommendations:	The Board is asked to note the Register of Interests of the Board of Directors as at June 2025.

Tees, Esk and Wear Valleys NHS Foundation Trust

Register of Interests of Members of the Board of Directors

Date: June 2025

Note: 1 - This Register has been established in accordance with the National Health Service Act 2006 (as amended) and the Constitution
Note: 2 - Descriptions of the types of interests are provided in NHS England Guidance "Managing Conflicts of Interests in the NHS" (Publications Gateway Number 06419) and the Trust's Conflicts of Interest Policy
Note: 3 - Changes of interest should be recorded as notified
Note: 4 - The Register should be refreshed annually
Note: 5 - At the request of the Council of Governors, the Board agreed that material interests held in the two years before appointment should also be registered

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Bev Reilly	Interim Chair	**None**	**Yes** Member of The Royal College of Nursing since 1987	**None**	**Yes** Close family member is in receipt of TEWV care
Roberta Barker	Non-Executive Director	**None**	**None**	**None**	**None**
Charlotte Carpenter	Non-Executive Director	**None**	**None** Although I have no financial or non-financial professional interests from which I or an organisation I a member of might benefit, I do have a potential conflict of interests with respect to my full-time employment as a Director at the North East Combined Authority. As part of that role I am ultimately responsible for some funding streams which TEWV is liable to bid into a part of a competitive tender process.	**None**	**None**
John Maddison	Non-Executive Director	**None**	**None**	**None**	**None**
Jules Preston	Non-Executive Director and Senior Independent Director	**None**	**None**	**None**	**Yes** Chair of Boroughbridge Community Charity which has a contract with Harrogate NHS Chair of Boroughbridge Primary School which receives services from CAMHS
Jane Robinson	Non-Executive Director	**None**	**None**	**None**	**None**
Catherine Wood	Non-Executive Director	**None**	**None**	**None**	**None**

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Patrick Scott	Interim Chief Executive	**None**	**None**	**None**	**Yes** Due to move to current interim role that is actively involved in decision making governed by HNY ICB. My wife is a nurse consultant and VOY medical accountable clinician at Humber Teaching NHS Foundation Trust.
Ann Bridges	Executive Director for Corporate Affairs and Involvement	**None**	**None**	**None**	**None**
Zoe Campbell	Managing Director - North Yorkshire, York and Selby Care Group	**None**	**None**	**None**	**None**
Hannah Crawford	Executive Director for Therapies	**None**	**None**	**None**	**None**
Sarah Dexter-Smith	Joint Executive Director for People and Culture	**Yes** I co-authored a book a few years ago (Steps to Recovery) and at that point had an agreement in place with the then CEO about how that was recompensed. However, the materials from the book are being increasingly used in MSHOP services in TEWV, as a result of which I am uncomfortable with even the small level of royalties. From this point on, I will donate any profit I do make from the book to the Trust charity, while I am in the employment of the Trust	**None**	**None**	**Yes** A friend has some shares in Oxevision from a previous job (they do not work for them). I do not take part in any discussion relating to the use of this or any similar system
Kathryn Ellis	Interim Executive Director for Transformation and Strategy	**Yes** Director of my own limited company which provides organisational consultancy services (ad-hoc management consultancy/advisory support). No active links/work in the NHS/Tees, Esk and Wear Valleys region which may otherwise present a potential conflict.	**None**	**Yes** At the time of writing I have been offered, and am awaiting appointment to a Trustee position at 'Via' – a national drug and alcohol charity (I expect formal appointment pending Via Board ratification, final paperwork etc.). As soon as this is finalised I will confirm to you and this can be included on formal/public declarations as required.	**None**
Dr Kedar Kale	Executive Medical Director	**None**	**None**	**None**	**Yes** My wife has a private medical practice in Newcastle. I am a co-director in the company with my spouse, I do not undertaken any private practice.
Naomi Lonergan	Interim Managing Director - Durham, Tees Valley and Forensics Care Group	**None**	**Yes** Trustee role for a local charity	**None**	**None**
Beverley Murphy	Executive Chief Nurse and Interim Deputy Chief Executive	**Yes** Coaching and Consulting as a sole trader in own time. Managing the conflict by choosing organisations not linked to TEWV	**Yes** Governor of Middlesbourgh College from September 2024 - 31 May 25	**None**	**None**

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Kate North	Interim Joint Executive Director of People and Culture	**None**	**None**	**None**	**None**
Liz Romaniak	Executive Director for Finance, Estates and Facilities	**None**	**Yes** HFMA Governance and Audit Committee Member HFMA Financial Recovery Group Member	**None**	**None**

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