Tees, Esk and Wear Valleys
NHS Foundation Trust

EXTRAORDINARY MEETING
BOARD OF DIRECTORS
25 June 2026
at 1.00pm

via MS Teams

AGENDA

No.	Report Title	BAF Risk	Lead	Timing
Standing Items				
1.	Chair's welcome and introduction (verbal)	-	Chair	1.00pm
2.	Apologies for absence (verbal)	-	Chair	
3.	Declarations of interest (verbal)	-	All	
Strategic Items				
4.	Report of the Chair of Audit and Risk Committee (verbal), which includes the following reports to Board for approval:	-	Cmt Chair	1.03pm
	a. The Annual Report and Accounts 2025/26*	10	CEO EDFE&F	1.15pm
	b. The Quality Account 2025/26	10	CN	1.30pm
	c. Data Security and Protection Toolkit*	7	CIO	1.45pm
	d. Register of Interests of the Board of Directors	10	Co Sec	2.00pm

*papers will be circulated following consideration by Audit and Risk Committee on 22 June 2026.

M Burnham
Trust Chair
19 June 2025

Contact: Karen Christon, Deputy Company Secretary - karen.christon@nhs.net

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Meeting of:	**Board of Directors**
Date:	**25 June 2026**
Title:	**Annual Report and Accounts 2025/26**
Executive Sponsor(s):	**Alison Smith, Chief Executive** **Liz Romaniak, Director of Finance, Estates and Facilities** **Phil Bellas, Company Secretary**
Report 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: We will co-create high quality care	✓
2: We will be a great employer	✓
3: We will be a trusted partner	✓

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
10	Regulatory Compliance	Under its Provider Licence, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the Licence, 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.

REPORT:

Purpose:

The purpose of this report is to seek the Board's approval of the Annual Report and Accounts 2025/26 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 2025/26.
(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 2025/26 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 2026, the form of the documents is set out in the "NHS Foundation Trust Annual Reporting Manual 2025/26" (published by NHS England) and the "Department of Health and Social Care Group Accounting Manual 2025/26" (DHSC GAM 2025/26).

The Board is asked to note that:

(1) The draft Annual Report and Accounts 2025/26.

(a) The draft Annual Report and Accounts has been prepared on a group basis as the income and expenditure of the Trust's main subsidiary, Positive Individual Proactive Support Ltd, remains material.

(b) At its meeting held on 22 June 2026, 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, should there be any changes post the meeting of the Audit and Risk Committee. This 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 (text attached) 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 22 June 2026, the Committee:

(1) Received the Audit Completion Report from the Trust's External Auditors for the year ended 31st March 2026.

(2) Provided assurance to the Board that:

(a) The Annual Report and Accounts 2025/26, 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 2025/26.

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 2025/26 (attached)
(2) To approve the Letter of Representation (text 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.

Annual Report and Accounts

1 April 2025 – 31 March 2026

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Tees, Esk and Wear Valleys NHS Foundation Trust Annual report and accounts 2025/26

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

Contents

Foreword by the chair and lead governor

As we reflect on the past year, we do so with honesty, humility, and a genuine commitment to the people we serve. 2025/26 has been a year of real progress, but also one that has required us to look honestly at ourselves – and to acknowledge that we have not always got it right.

The announcement on 11 December 2025 of a Public Inquiry into our services was a significant and sobering moment for our organisation. We welcome it. We know that for some patients, their families, and carers, their experiences of our care have fallen short of what they deserved. That is something we carry with the seriousness it demands. The Public Inquiry gives us an opportunity – and an obligation – to listen, to learn, and to make the lasting improvements that will ensure better, safer care. Quality of care is not a measure on a page - it is felt by every person who encounters our services, and we are committed to ensuring that experience is consistently safe, compassionate, and effective, and to make lasting improvements. We are committed to engaging with that process fully and openly.

This context shapes everything we do as we look to the year ahead. Improvement is not simply an ambition – it is a responsibility.

And yet, alongside that honesty, we also want to recognise the tremendous work that continues across our trust every single day – work that is making a real, tangible difference to the lives of people in our communities.

We are proud to report that TEWV achieved zero inappropriate out-of-area placements throughout 2025/26, meaning every patient requiring inpatient care was treated close to home, near their families and support networks. Delivered ahead of this becoming a national NHS target in April 2026, this achievement was recognised at the NHS Providers Improvement Network Conference as an example of best practice – and reflects the sustained effort of our staff, partners, and the people we serve across County Durham, Darlington, Teesside, North Yorkshire, York and Selby.

This year also saw the continued transformation of our community mental health services, with the development of new hubs bringing care closer to people's homes and communities. This is not simply a structural change – it represents a fundamental shift in how we support people, offering more joined-up, accessible, and compassionate care where it is needed most. Underpinning all of this is our unwavering focus on quality – ensuring that as we transform how we deliver care, the experience and outcomes for patients remain at the heart of every decision we make.

Our 24/7 Crisis Assessment Unit received national recognition this year, a testament to the teams who are there for people around the clock, at their most vulnerable. And through our Staff Star Awards, we were reminded once again of the extraordinary individuals across TEWV – in clinical services, in support roles, and everywhere in between, who give so much, often quietly and without fanfare. To every nominee and winner: your contribution to the quality of care we provide matters deeply.

As Chair and Lead Governor, we want to be clear about where we stand. We are proud of our people and the progress we have made. We are honest about our shortcomings and the weight of the journey ahead. And we are determined that the year to come will be one of genuine, meaningful improvement – for our staff, and above all, for the patients and communities who place their trust in us. Quality of care will remain our guiding principle as we move forward – not just as a commitment written here, but as something lived and felt by every patient, carer, and family member who depends on us.

The right care, in the right place, at the right time – for everyone in our region. That remains our commitment.

Marie Burnham
Chair
25 June 2026

Gary Emerson
Lead Governor
25 June 2026

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

Alison Smith
Chief Executive
Date 25 June 2026

Performance report

Overview of performance

Purpose of the overview section

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.

It covers all aspects of performance, not only financial. It reviews the extent the organisation has supported relevant plans of the integrated care boards (ICBs) and delivery against its own standards; national quality priorities; and relevant indicators of the NHS Oversight Framework.

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' also includes Positive Individual Proactive Support Ltd (PIPS), a wholly owned subsidiary company which provides support for people with learning disabilities and autism who have complex needs.

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 Individual Proactive Support Ltd will be referred to as "the Subsidiary" or "the Company".

Statement on performance

The trust's 2025/26 Annual Report and Accounts sets out a year of both meaningful progress and significant challenge. We continued to advance our strategic direction through Our Journey to Change: The Next Chapter, with a strong focus on improving quality, strengthening partnerships, transforming services and supporting people to receive care closer to home. At the same time, the announcement in December 2025 of a Public Inquiry into aspects of the trust's services marked a pivotal moment, reinforcing the need for openness, learning and sustained improvement in the quality and safety of care.

During the year, our teams supported several notable achievements. We reported the elimination of inappropriate out-of-area placements for adult and older adults who needed an inpatient admission, ensuring patients received care closer to home ahead of the introduction of this as a national NHS target. Community mental health transformation continued across our footprint, including the development of new hubs and neighbourhood-based models of care, and our teams received national recognition for the 24/7 crisis assessment offer in Middlesbrough and community transformation in Hartlepool. The report notes progress we have made in co-creation, workforce metrics, service quality and partnership working, supported by an increasingly mature integrated performance approach. These are all important indicators of how we are responding to community need and to improving patient experience. The report also highlights key strategic risks, including pressures linked to access and waiting times, workforce and the potential impact of the Public Inquiry on organisational capacity.

Our annual accounts demonstrate strong performance. We met our financial performance targets for revenue, capital, cash and prompt supplier payments, and delivered challenging cash releasing efficiency targets in full. As always, this reflects the significant and sustained contributions of more than 8000 colleagues and support from, and our collaboration with, numerous partners.

Looking ahead, our key priorities are to strengthen the quality and consistency of care, respond openly to scrutiny, reduce inequalities, support a positive and accountable culture, and deliver sustainable transformation. Taken together, these issues provide governors and stakeholders with an overview of the

trust's performance, the challenges requiring continued scrutiny, and the areas where governor engagement and assurance remain especially important.

Alison Smith
Chief Executive
25 June 2026

About Tees Esk and Wear Valleys NHS Foundation Trust

We are a specialist mental health, learning disabilities and autism trust serving over two million people across County Durham and Darlington, Teesside, North Yorkshire and York.

We provide inpatient, community, and crisis services, including child and adolescent mental health services (CAMHS), adult mental health, older people's services, forensic services, and neurodevelopmental assessment 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, we became the first mental health Foundation Trust in the North and since then, we have 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.

In addition to our mental health, learning disability and autism services, we operate a wholly owned subsidiary company, Positive Individual Proactive Support Ltd (PIPS)

We also have our trust charity and we are 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.

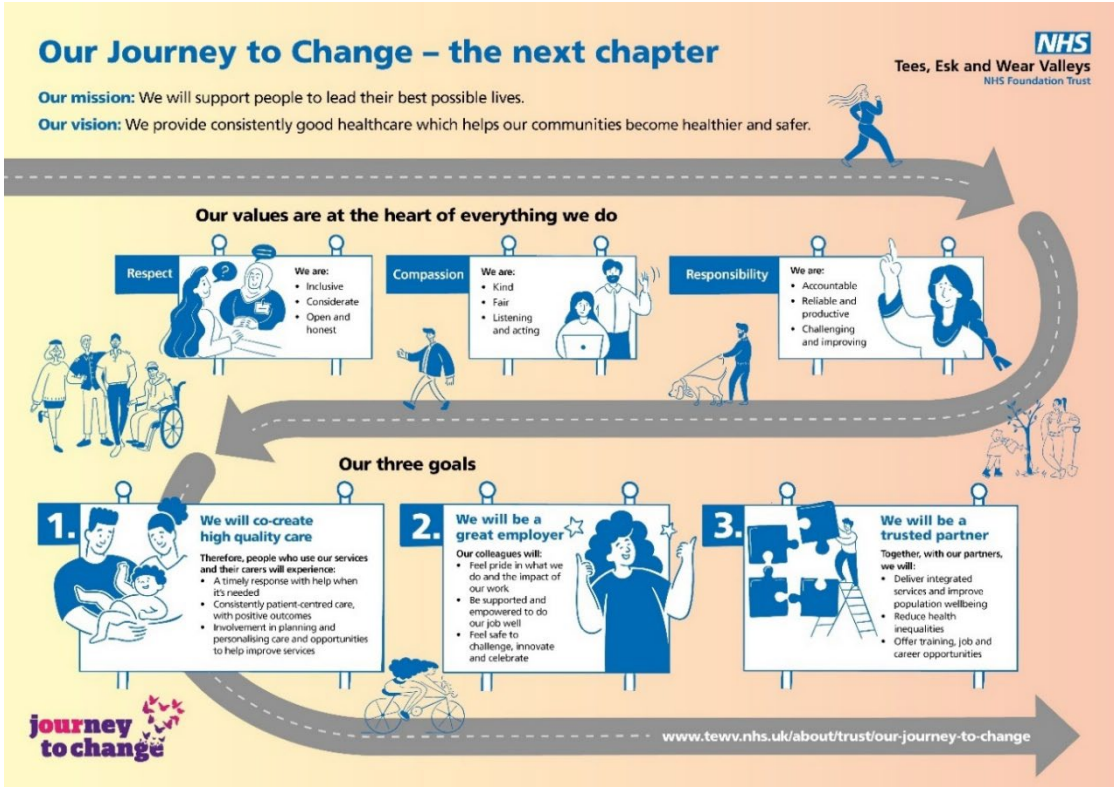
The Group also includes TEWV Estates and Facilities Management Ltd, a dormant wholly owned subsidiary.

Neither of the trust charity nor the dormant subsidiary are consolidated into the accounts as they are not material to the performance of the Group. In total, our Group has around 8,500 staff and an annual income of over £550 million.

Our purpose

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.

We have a high-level strategic framework, Our Journey to Change. This was originally co-created with patients, carers, colleagues and partners during 2020. A refreshed version was agreed by our Board of Directors in April 2025 and is show below.



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 Objective
    - 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

Supporting the delivery of the NHS 10 year health plan

During this financial year, the government published the NHS 10 Year Plan (July 2025), followed by guidance on medium term planning for all NHS trusts. This focused on three key shifts - hospital to community, sickness to prevention and analogue to digital

Whilst these were areas we were already focused on, it has enabled us to ensure they are fundamental within our medium-term plan.

This will enable more care, closer to home, aligned to population need and neighbourhoods. It will be underpinned by partnership working, more effective use of estate and community assets and harnessing of digital technology. It will be enabled by further transformation within our organisation on culture and values, quality improvement and productive working.

We already have examples of ongoing work that supports the 10 year health plan including:

- Significantly reducing the use of independent sector beds across our trust including by ceasing “our of area” adult and older people’s assessment and treatment inpatient care
- Continued transformation of community services in collaboration with our primary care and voluntary sector partners. This includes the development and opening of a 24/7 mental health centre in Acomb in the City of York which is one of 6 pilot sites across England and the One Life Centre in Hartlepool.
- Implementation of a Tees Valley children and young people’s service based on i-Thrive principles
- Reduction in the admission of people with learning disabilities to mental health inpatient beds

Our five year plan focusses on transformations to ensure the population we serve receives care and treatment as early as possible to reduce the progression and levels of their condition. This will also support financial sustainability, ensuring that we provide value for money.

We also continue to focus on providing secondary community and inpatient mental health care to meet the needs of the populations we serve, including learning disabled and neurodivergent people. We also continue to support prevention and early intervention activity, as this is important to maximise wellbeing and reduce the demand for our services. We influence NHS and local authority commissioners to ensure that they see the importance of investing in primary prevention, early intervention, supported housing and social care services.

We continue to work in partnership with both North East and North Cumbria ICB and Humber and North Yorkshire ICB at a strategic and operational level to support their overall strategies. This includes the development of inpatient quality transformation plans, the review of assertive outreach functions and other relevant services and policies. We have also worked with both ICBs to jointly develop proposals and implement plans to achieve national policy priorities such as extending coverage of mental health support teams for schools, and individual placement and support services.

We are 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 also work with NHS England and Cumbria, Northumberland, Tyne and Wear Foundation Trust as partners to develop a North East North Cumbria secure service model and an eating disorder bed / service model for the future.

We maintain a monthly “partnership issues” report which is discussed at our Care Group Boards and our Executive Directors’ Group meeting. We also produce a quarterly environmental intelligence and partnership issues report for our Resources and Planning Committee where assurance is provided on executive actions, and other issues escalated as required.

Our Board of Directors assess our trust’s effectiveness, efficiency, economy and quality of healthcare delivery in a number of ways.

Our strategy and medium-term plan (2026-2031), set out our long-term objectives and deliverables, aligned to ICP and ICB priorities and local place-based partnerships. Via the Chair and Chief Executive reports to the Board, the trust receives regular updates on engagement with partners, and proactive partnering at system and place level. During 2025/26 we have worked collaboratively to develop new, innovative services. This includes the Tees Getting Help service for children and young people, and responding to shared system challenges such as work with multi-agency partners to ensure service users who are

clinically ready to return to their place of home from an inpatient stay do so in a timely way. We continue as an active member of Provider Collaboratives across both the NENC and HNY footprint, developing and improving services for specialist mental health care pathways. Our Resources and Planning Committee receives regular reports on the delivery of our strategic plans and partnering activities, with oversight at Board.

PIPS' Alignment to Our Journey to Change

The priorities and delivery model for Positive Individual Proactive Support (PIPS) Ltd are strongly aligned with the ambitions of TEWV's Our Journey to Change strategy, in particular the commitment to co-create high quality, person-centred care. PIPS Ltd's core approach - supporting individuals with complex needs to transition from inpatient treatment settings into personalised community provision - directly reflects the Trust's strategic shift from hospital-based care to more flexible, recovery-focused community models. This is evidenced through the demonstrated ability to facilitate discharge for individuals with long lengths of stay, reduce reliance on restrictive inpatient environments, and invest in intensive community support that better meets individual need. This provides direct alignment and support for identified Trust strategic challenges, such as those patients who are clinically ready for discharge, but unable to be discharged in a timely manner from inpatient settings due to lack of available community support.

In addition, PIPS Ltd's role in enabling system flow, reducing bed occupancy pressures, and working in partnership with housing providers, local authorities and commissioners reflects the wider strategic intent to operate as a trusted partner across the system and to deliver sustainable, value-based care. PIPS Ltd's delivery model facilitates a range of financial and operational benefits such as reductions in inappropriate or high-cost inpatient stays with reinvestment into more meaningful community alternatives. These benefits support the Trust's broader shift toward prevention, productivity and financial sustainability.

Given the above, the PIPS Ltd's portfolio can be seen to represent an innovative and practical delivery mechanism for translating the Trust, and wider ICB's strategic ambition into measurable impact for both patients and the wider health and care system.

Strategic Risks

The principal risks to the delivery of Our Journey to Change, and to the future success and stability of our trust, are described in the Board Assurance Framework (BAF) together with the key controls for managing the risks and mitigations to reduce exposure.

New risks and changes to existing risks are identified annually. This is based on an assessment of changes to the environments in which we operate. Emerging risks are also identified, in year, through our governance processes.

Our Board overseas the strategic risks taking assurance from a range of sources including our committees, reports from management (including the integrated performance reports), internal audit and regulators.

During the year:

- The strategic risks relating to quality of care, quality governance, partnerships and system working and regulatory compliance were successfully mitigated to the extent it was reasonably practicable to achieve.
- Controls were also strengthened for the strategic risks relating to safe staffing, digital – supporting change and estates/physical infrastructure.
- Exposure to risks relating to estates/physical infrastructure increased due to the reduction in capital allocated following revisions to the national formula.

Looking forward, our Board has recognised that an emerging risk is the announcement of the public inquiry and its potential impact on capacity available to maintain effective organisational and service levels at the current rate. Mitigations to reduce exposure to this risk are being put in place.

Further information on the strategic risks for 2025/26 and our governance and internal control arrangements is provided in the Annual Governance Statement.

Engaging with our communities

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. Our co-creation framework launched in 2024/25 forms the foundation of all co-creation work that we do across the organisation and is well embedded across the trust.

We now have services user and carer groups embedded across each of our clinical specialties along with a transformation co-creation group. These specialty groups work very closely with services and our strategy and transformation directorate in informing emerging transformation priorities, shaping business as usual policies, as well as redesigning specific services where necessary. We have continued to amplify lived experience voices over the last year, to underpin how we deliver care. The trust has two lived experience directors and a head of co-creation (and team) to support this work.

During 2025/26 our lived experience networks, our lived experience (peer role) staff and clinical staff across six wards in the trust have worked closely together as part of the national Culture of Care programme. This is producing cultural and operational improvements in the “pilot” wards and is creating the potential to share and spread across all of our inpatient wards. Our services also continue to ensure lived experience underpins safety plans, and we are embedding patient safety partner roles within our wards.

Engaging with place partners

During 2025/26 we continued to work in partnership with commissioners in:

- Central ICB-level commissioning teams in both North East North Cumbria and Humber North Yorkshire ICBs, including multi-agency groups linked to the national inpatient quality transformation policy.
- Place commissioning teams in York, North Yorkshire, Tees Valley and County Durham, including neighbourhood level discussions around service integration and community transformation.
- Specialist provider collaboratives (as an inpatient bed provider partner to the Cumbria, Northumberland Tyne and Wear NHS Foundation Trust (CNTW) led North East Collab, and the Humber FT led Humber North Yorkshire specialist provider collaborative as a community service only stakeholder).

We also supported Stockton Borough Council and its partners in the development of their national pilot integrated neighbourhood health model.

Our operational managers maintain close relationships with delivery partners in the places and criminal justice institutions that we serve. Where issues such as lack of social care placements / supported housing for people in inpatient beds who are clinically ready for discharge occur, our first response is to engage with partners and support mutually agree solutions. Our subsidiary, PIPS is often a key stakeholder in these discussions where their complex support provision could meet the needs of people who are ready to leave hospital but cannot.

Our executive team considers a monthly report on emerging partnership issues and individual executives engage with appropriate ICB, local authority / partnership and other meetings and initiatives.

Our committees consider partnership related issues as appropriate – for example our quality assurance committee had an in-depth discussion regarding community transformation arrangements, and the resources and planning committee discussed partnership issues as part of their wider environmental change quarterly discussions. Our PIPS subsidiary reports on its financial and quality outcomes to the resources and planning committee as well as to the Quality Assurance Committee for quality oversight.

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 agreed to adopt the going concern basis in preparing the accounts and following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Performance analysis - how we performed in 2025/26

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 some of the National Oversight Framework measures (NOF), where appropriate; national and local quality requirements and 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 is maintained by the Integrated Care Group Board, which comprises corporate and clinical senior managers aligned to each service, and the reports are shared monthly with our two local Integrated Care Boards and 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 2025/26 we launched ward, team and specialty dashboards to support managers, at every level of the organisation to have oversight of performance in their respective areas. Managers are encouraged to use these dashboards to monitor performance, identify areas for improvement (as part of our assurance processes) and celebrate where they are doing well.

Following the launch of our people and culture dashboard in April 2024 and quality dashboard in January 2025, work is continuing to develop on a mental health legislation dashboard which will be completed in 2026/27.

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.

Analysis and explanation of financial and operational performance

The trust's key performance measures for 2025/26 are contained in the integrated performance dashboard reported to trust Board and Board Committees, underpinned by statistical process control (SPC) methodology. Performance by domain area as at March 2026 is set out below and in the following pages.

For all identified areas for improvement, remedial actions are in place, supported by robust scrutiny and oversight from both Board Committees and the Board. Any identified risks are appropriately managed through the Corporate Risk Register and the Board Assurance Framework.

Our quality measures

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 - patient reported
- Percentage of children and young people (CYP) showing measurable improvement following treatment - clinician reported

Information on the delivery of our quality priorities is provided in our Quality Account 2025/26 which is published on our website.

Our people measures

OUR PEOPLE MEASURES	Standard	Actual	Commentary on Achievement
16) Percentage of staff recommending the Trust as a place to work	60.00%	56.16% (Jan 2026)	Requires Improvement and Actions in place
17) Percentage of staff feeling they are able to make improvements happen in their area of work	65.00%	59.33% (Jan 2026)	Requires Improvement and Actions in place
18) Staff Leaver Rate	11.00%	9.92%	Achieving and demonstrates improvement
19) Percentage Sickness Absence Rate	5.50%	6.73%	Requires Improvement and Actions in place
20) Percentage compliance with ALL mandatory and statutory training	85.00%	92.22%	Achieving and demonstrates improvement
21) Percentage of staff in post with a current appraisal	85.00%	88.81%	Achieving 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

Our activity measures

OUR ACTIVITY MEASURES	Standard	Actual	Commentary on Achievement
22) Number of new unique patients referred	N/A	96,530	No significant change
23) Unique Caseload (snapshot)	N/A	62,979	Improvement

Our finance measures

The trust received £3,276k additional income during the year, a condition of receipt was that the originally breakeven planned position was increased by the same value. The below table reflects the updated planned position.

OUR FINANCE MEASURES	Plan £000s	Actual £000s	Commentary
24) Financial Plan: SOCI - Final Accounts Surplus	£3,276	£3,763	**Achieved**
25a) Financial Plan: Agency expenditure compared to agency target	£7,333	£7,712	**Requires Improvement and Actions in place**
25b) Agency price cap compliance	67%	55%	**Requires Improvement**
26) Use of Resources Rating - overall score	2	2	**Achieved**
27) CRES Performance – Recurrent	£16,879	£13,709	**Requires Improvement and Actions in place**
28) CRES Performance – Non-Recurrent	£10,525	£13,694	**Achieved**
29) Capital Expenditure (Capital Allocation)	£13,765	£13,694	**Achieved**
30) Cash balances (actual compared to plan)	£36,335	£54,902	**Achieved**

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

- ✓ Financial Plan: SOCI – Final Accounts – (Surplus)/Deficit
- ✓ Use of Resources Rating – overall score
- ✓ CRES Performance – Non-Recurrent
- ✓ Cash Balances

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 2026.

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

Measure Name	Trust £000s	PIPS £000s	Total £000s
24) Financial Plan: SOCI - Final Accounts – Surplus	£3,350	£413	£3,763
25a) Financial Plan: Agency expenditure compared to agency target	£6,581	£1,131	£7,712
25b) Agency price cap compliance	55%	n/a	55%
26) Use of Resources Rating - overall score	2	n/a	2

27) CRES Performance – Recurrent	£13,709	n/a	£13,709
28) CRES Performance – Non-Recurrent	£13,694	n/a	£13,694
29) Capital Expenditure (Capital Allocation)	£13,694	£0	£13,694
30) Cash balances	£53,657	£1,245	£54,902

(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 national quality requirements (Trust)

The National Quality Requirements and Mental Health Priorities set the strategic framework for delivering safe, effective and person-centered mental health services across the NHS. They reflect national policy objectives to improve access, reduce inequalities and ensure timely, evidence-based care. Within this context, providers are required to meet defined standards relating to access, outcomes and experience, while also responding to increasing demand, workforce pressures and the ongoing shift towards integrated, community-based models of care. Together, these priorities guide service improvement, performance management and accountability, ensuring that services continue to evolve in line with the needs of the population.

Our performance against these standards and priorities is reported through our Integrated Performance Report and is aligned to the NHS Standard Contract. Our commitment to robust contract performance management is demonstrated through routine contract performance and quality meetings with commissioners, which are consistently well attended by senior staff. These forums provide a structured focus on key areas including service quality, service development and financial performance, supporting transparent oversight and continuous improvement.

National Quality Requirements

Achievements: There were eight national quality requirements for delivery during 2025/26, of which we achieved the following for all areas:

- 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 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.
- Percentage of service users referred to an NHS Talking Therapies programme who wait 6 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.

Performance against mental health priorities

Achievements: There were seven mental health priorities for delivery during 2025/26, of which we achieved the following:

- Number of active inappropriate adult acute OAPs that are either ‘internal’ or ‘external’ to the sending provider (trust priority).
- Average Lenth of Stay for adult acute beds (trust priority).
- Talking Therapies: Reliable improvement rate for those completing a course of treatment for North Yorkshire and York.
- Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting

caseness for North Yorkshire and York.

- Number of women accessing specialist community perinatal mental health (PMH) services for Tees Valley, North Yorkshire and York.
- Number of children and young people (CYP) aged 0-17 supported through NHS funded mental health with at least one contact for County Durham, North Yorkshire and York.

NHS Oversight Framework

Achievements: Five performance domains were scored and published as part of the Quarter 3 release in March 2026, with the trust placed in Segment 2, ranking 24th out of 61 trusts.

Domain	Quarter Units	Q3 2025/26		Q3 2025/26		Q3 2025/26	
		Metric score	Rank	Metric score	Rank	Metric score	Rank
People & Workforce	Segment	4.00		4.00		4.00	
	Score	3.68	57 out of 61	3.59	56 out of 61	3.44	54 out of 61
Patient Safety	Segment	2.00		2.00		2.00	
	Score	2.11	20 out of 61	2.44	32 out of 61	2.41	33 out of 61
Effectiveness & Experience	Segment	1.00		1.00		1.00	
	Score	1.53	3 out of 60	1.53	3 out of 60	1.57	6 out of 59
Finance & Productivity	Segment	1.00		1.00		1.00	
	Score	1.45	12 out of 61	1.45	12 out of 61	1.11	5 out of 61
Access to Services	Segment	4.00		4.00		4.00	
	Score	2.91	41 out of 59	3.35	52 out of 58	3.37	49 out of 58

Assessing and Monitoring Culture

Culture underpins the safety and quality of the care we provide and the assurance and governance that we implement across the trust. This is built on our three co-created values and the associated behaviours which have all been reviewed this year.

Measures of culture are built into the trust People Dashboard available across the organisation and reflected in the Integrated Quality and Performance Report at People Culture and Diversity Committee and then into board. They then triangulate with clinical culture of care assessments.

Culture is significantly influenced by the quality and tone that our leaders and managers set, and we now have a well-established leadership and management academy, setting out expectations and training for all leaders and managers. This has enabled us to be an early engagement site with the new national leadership and management framework. This year we have established our new people management programme, alongside a specific programme for ward and team managers, both designed to meet the national ‘expectations of people managers’ and to address our scores on questions related to experience of my manager which remain below national average.

Executive directors and the People Committee receive regular reports on the following areas, which enables us to identify and explore any themes of concern and ensure controls and mitigations are effectively put into place.

- workforce strategy delivery and assurance
- workforce data
- inclusive cultures
- health and wellbeing

A thorough investigation has taken place on our sickness levels as a result of these analyses at EDG and a review of the cultural indicators at People committee.

Key policies on attendance/wellbeing, disciplinaries, capabilities and grievances have all been reviewed with our staffside colleagues.

Evidence of impact of these processes can be seen in our national staff survey results from 25-26:

- A significant increase in engagement with the survey - the final response rate was 52%, compared to 44% in 2024.
- We are ranked number 11 against 19 Mental Health Trusts for overall positive score.
- We were recognised as having the second-largest positive score increase for 2025.

We made significant progress on:

- Feedback on changes after incidents
- Not working additional paid hours
- Ensuring errors/incidents are not repeated

And are above the national average on:

- Fairness in career progression
- Opportunities to access clinical supervision
- Not experiencing discrimination from patients, families or the public
- Not seen any errors, near misses, or incidents that could hurt patients, staff, the public

Only a single area – career development – showed a decline of more than 3% against our previous organisational average.

And we have work to do against the national average on:

- Flexible working / work life balance
- Management skills
- Colleagues feeling involved in work-related changes and helping make improvements – beyond being able to recommend changes.
- Ensuring the trust is a great place to work, and that colleagues are confident with the services we provide

In the national quarterly pulse survey in January 2026, we were above the national average for uptake levels and for all three of the domains for staff engagement: Advocacy, Involvement and Motivation.

Rewarding and promoting the wellbeing of our workforce

The staff survey results provide us with valuable insights relating to being safe and healthy. Results show that when compared with other trusts, our overall score of 6.4 is slightly above the average of 6.3.

Element	2021	2022	2023	2024	2025
People promise "we are safe and healthy"	6.16	6.21	6.32	6.34	6.4
Sub score : Health and safety climate	5.52	5.51	5.78	5.78	5.84
Sub score: Burnout	5.04	5.12	5.24	5.22	5.24
Sub score: Negative experiences	7.91	7.99	8.08	8.01	8.1

Key progress in the past year includes

- Achieved ‘Continuing Excellence’ Better Health at Work Award and working towards maintaining excellence accreditation.
- In November 2025 the Reasonable Adjustments Team won the National Health People Management Award for Health and Wellbeing for their work to improve access to work for people with disabilities or long-term conditions.
- Completed a three year project on standardised job descriptions that has clarified the differing expectations between roles with similar job titles.
- Designed and have started to deliver a leadership and management programme based on NHS England and TEWV’s Expectations of Line Managers in relation to People Management
- Increased our thriving network of Health and Wellbeing champions to more than 355.
- Increased oversight of health and wellbeing services provided by TEWV to staff. Services provided by Employee Psychology Service, Mindfulness team, Employee support service and Long-Term sickness team all have positive impact and outcomes relevant to their remit.
- Mapped our information flows relating to violence and aggression incidents towards staff, allowing us to identify gaps. A dashboard reporting system is in development to ensure transparent, consistent trustwide reporting. We have also reviewed and revised our governance structure relating to this.
- Audited and raised awareness about the prevalence of sexual safety incidents in the workplace from patients, relatives, the public and colleagues as part of prevention of violence and aggression workstream. This continues our commitment as signatories to the NHS England Sexual Safety Charter.
- In collaboration with the three local police forces, we have developed a guidance document to ensure clear understanding between partners in all matters concerning Police and Criminal Justice responses with trust staff and services.
- Started a trustwide Staff Experience group that is deepening understanding of staff experience whilst reducing duplication across trust workstreams. Topics identified are: Staff Survey; Flexible working and reasonable adjustments; Sexual Safety and Aggression at work.
- Expanded the network of Professional Nurse Advocates (PNA) from March 2024 until now March 2026 from 15 Professional Nurse Advocates to 91 qualified PNAs and a further 25 in training. This will almost get us to the ratio set by NHS England of one PNA to 20 Nursing and Midwifery council (NMC) registered staff members.

Financial Performance (subject to Audit)

In 2025-26 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 2025-26 financial plan was agreed by the Board of Directors as part of the trust’s Integrated Business Planning cycle and underpinned the achievement of the trust’s strategic objectives.

Our financial objectives, both planned and achieved, are summarised below:

Objective	Outcome
NHS England (NHSE) Approved Opening Plan: Delivering a £0.00m adjusted financial surplus (before impairments, depreciation on peppercorn right of use (RoU) assets and technical adjustments on PFI accounting).	Opening Adjusted Group financial surplus of £0.49m achieved (excluding nationally reallocated Deficit Support Funding).
NHSE Approved Closing Target: Delivering a £3.28m surplus (Opening Plan plus £3.28m improvement following allocation of nationally redistributed Deficit Support Funding)	Closing Adjusted Group financial surplus of £3.76m achieved.
Delivery of £27.40m Cash Releasing Efficiency Savings (CRES).	Delivery of £27.40m CRES, inclusive of non-recurrent in-year recovery actions.

	Full delivery of planned recurrent savings taking into account schemes' full year effects e.g. where commenced mid-year.
Managing our capital plan priorities and leased asset obligations* within a trust capital allocation of £18.50m.	Capital expenditure of £18.39m including leased asset obligations of £0.90m generated £0.11m under spending against allocated capital resources.
Supporting wider management of the Integrated Care System (ICS) capital pressures within the system envelope.	Supported management by the wider ICS of partner provider pressures.
Achieving an end of year cash balance of £36.34m.	Cash balances were £54.90m.

**Following adoption by the NHS of International Financial Reporting Standard (IFRS) 16 in 2023/24, amendments to Right of Use leased assets are charged against capital allocation.*

Revenue Position

The Group planned to breakeven (£0.00m surplus) in the 2025-26 financial year and realised an end of year surplus (excluding impairments, depreciation on peppercorn Right of Use leased assets and technical adjustments on Private Finance Initiative (PFI) accounting) of £0.49m, which was better than planned.

Cash Releasing Efficiency Savings Delivery

Savings achieved by 31 March 2026 were £27.40m and in line with plan, with better than planned non-recurrent delivery of £3.17m mitigating recurrent slippage in-year.

In year savings of £13.71m were delivered recurrently and £13.69m were delivered non-recurrently. Taking into account full year effects where schemes commenced during, or where savings increased throughout, the year, the recurrent target was delivered in full.

The trust is making good progress with future year plans and has Executive Leads responsible for facilitating planning and delivery of identified schemes.

Capital Investment

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

Over the last 12 months capital increasingly constrained national capital allocations have meant we have needed to work closely with partners to prioritise the use of funding allocated via the North East and North Cumbria Integrated Care System. We have invested trust cash balances and nationally allocated funds with the aim of providing the safest environments and best supporting infrastructure possible.

The 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 2025-26, the trust invested £19.60m in capital assets, and £0.90m in right of use assets (property lease additions and inflationary increases).

The trust was successful in bidding for £5.71m of central cash backed capital funding to support estates backlog maintenance, IT infrastructure, energy efficiency schemes and medical equipment purchases.

Cash Balances

The Group's cash balances were planned to reduce from £51.37m to £36.24m. Plans reflected ongoing capital commitments and the breakeven revenue position.

Closing cash balances were £54.90m, which was £18.57m higher than planned. This reflected higher than planned opening cash balances, favourable financial performance and working capital movements. Working capital included higher than planned capital creditors following allocation of helpful national capital funding during quarter four.

Asset Valuation

The trust's land and buildings (including Right of Use assets) were subject to a full revaluation exercise, which resulted in impairments* as follows:

	2025-26		
	£m		
	Realised in surplus	**Realised in reserves**	**Total**
Impairments	19.45	0.07	**19.52**
Reversal of impairments	(4.52)	(0.93)	**(5.45)**
Total loss (gain) realised	**14.93**	**(0.86)**	**14.07**

**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 the trust's overall Statement of Comprehensive Income position for income and expenditure), 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 10.8 to 8.8 days, principally due to capital expenditure exceeding levels of internally generated capital that were assumed at plan.

Environmental Performance - a summary of progress on delivery of the green plan

Our commitment

The Health and Care Act 2022 placed new duties on NHS bodies to contribute towards statutory emissions and environmental targets. The trust's plans are aligned to these statutory top-level targets:

- **By 2040 the emissions we control will be Net Zero** – these emissions form our 'Carbon Footprint'. There is an interim target to reduce these emissions by at least 47% by 2028 to 2032 (compared to 2019/20 levels).
- **By 2045 the emissions we can influence will be Net Zero** – these are emissions from all sources and referred to as our 'Carbon Footprint Plus'. This includes the requirement for our suppliers to have also reached Net Zero. There is an interim target to reduce these emissions by 73% by 2036 to 2038 (compared to 2019/20 levels).

NHS guidance asked NHS bodies to develop refreshed Green Plans in 2025. The trust's Green Plan 2025-2028 was approved in early August 2025. It summarised progress so far and plans for the next three years aligned to key requirements for the NHS in the Delivering a Net Zero NHS Strategy and those set out in the Estates Net Zero Delivery Plan, Net Zero Travel and Transport Strategy and Net Zero Supplier Roadmap.

Progress is reported six monthly to the Resources and Planning Committee and the Energy and Sustainability Manager co-ordinates sub-groups to progress the 9 key areas below and support updates to our quarterly Sustainability Group. Key areas for action include:

- **System leadership and workforce**
    - Staff awareness raising using new communications resources, Microsoft Teams channels, a sustainability intranet presence and from increased service involvement.
- **Sustainable models of care**
    - Identifying high impact options for mental health pathway redesign that will reduce emissions, including through funded research project bids and integrating sustainable quality improvement into existing quality improvement work and Green Plan areas.

1. **Digital transformation**

- Monitoring data centre energy consumption, migrating data systems to the cloud, reducing paper-based outputs, considering our use of digital or remote appointments and digital care channels. We completed a baseline Digital Maturity Assessment.

2. **Travel and transport**

- Developing travel plans across our sites, liaising with regional partners to standardise our work and engage with local authorities, monitoring and reporting business mileage through a Greener NHS Fleet Data Collection and decarbonising our fleet by switching to zero emission vehicles and from a network of 80 EV charging points.

3. **Estates and facilities**

- By accessing Great British Energy Solar and NHSE Decarbonisation funding we could make solar, LED lighting and Building Management Systems improvements.
- We were unable to secure funding to develop site Heat Decarbonisation Plans but continue regional partnerships on feasibility studies for longer-term low-carbon heat network solutions for our larger sites and are developing pipeline projects for future funding opportunities.
- We met our annual water use reduction target by completing a new boosted cold-water main at Roseberry Park, eliminating leaks and reducing use by over 70%.
- We are assessing our EV charging infrastructure to support fleet transition and in anticipation of funding opportunities to progress our Travel and Transport plans.
- We are collecting food waste data per national guidance and will develop reporting and waste reduction initiatives. We rolled out food waste recycling to meet simpler recycling legislation and met the 60% offensive waste stream target.
- We have a biodiversity and green space working group, and our teams are considering how we manage our green spaces to benefit patients, staff and the environment. We are mulching trees we remove to suppress weeds and retain moisture. This is beneficial in a warming climate and has reduced herbicide use.
- Natural England have supported us to co-create a wellbeing courtyard garden at Foss Park Hospital with staff, volunteers and patients and we hope to replicate this elsewhere. We are identifying areas for hedgerow planting in Autumn 2026 and want to partner with organisations including NHS Forest to do this. Several of our hospital sites took part in 'No Mow May' 2025. We are expanding the scheme this year, and meadow management techniques will increase biodiversity and allow patients and staff to spend time in nature.

4. **Medicines**

- Our working group assessed our dispensaries against six Royal Pharmaceutical Society Green Pharmacy Guide domains. It aims to empower pharmacy staff to decarbonise pharmacy settings.

Our sites are registered and working towards accreditation. Medicines waste is being integrated with clinical waste management.

5. **Supply chain and procurement**

- Procurements above Public Contracts Regulations (PCR) 2015 thresholds include mandated social value and net zero considerations which will help us to work towards national Scope 3 emissions targets: our largest carbon footprint impact. Our external procurement partners are exploring how they can support our progress. We will increase the granularity of our data to develop our high-level methodology to calculate carbon emissions by sector type as a priority for the coming year.

6. **Food and nutrition**

- Our nutrition and hydration steering group is developing with support from hotel services and catering teams, NHS England guidance and networking opportunities.

7. **Adaptation**

- Our working group is helping integrate adaptation into our Emergency Preparedness, Resilience and Response (EPRR) processes, with climate risks captured in the related Risk Register. Our three-year EPRR Strategy outlines our comprehensive approach to Business Continuity and Emergency Planning and addresses management of climate-related risks such as Adverse Weather and Power and Utilities Failure. Work this year has focussed on risk management processes and a baseline maturity assessment against the NHS Climate Adaptation Framework.

Taskforce on climate related financial disclosures (TCFD)

NHS England has adopted a phased approach to incorporating TCFD recommended disclosures in sustainability reporting for NHS bodies. Requirements are being implemented on a phased basis up to 2025/26, and local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions which NHS England compile nationally.

The phased approach incorporates disclosures for governance, strategy, risk management and metrics and targets pillars for 2025/26, which are provided below and cross referenced to relevant information elsewhere in the annual report and accounts and other publications.

Governance

The board's oversight of climate-related issues is through:

- six-monthly updates on Green Plan, sustainability and net zero progress through the trust net zero lead and Resources and Planning Committee on behalf of the board.
- bi-monthly reporting on Green Plan progress to Executive Directors.
- a discrete entity EPRR Risk Register, using the National Risk Register and Community Risk Registers from four Local Resilience Forums our geography. This incorporates climate-related risks relevant to us, with risks recorded on our electronic Risk Management system.
- quarterly risk review and reporting by the EPRR Manager, with findings shared annually with Audit and Risk Committee and the Board.

To date, there has been no material impact on the organisation.

Management's role in assessing and managing climate-related issues is:

- the Chief Executive has assigned net zero leadership to the Executive Director of Finance, Estates and Facilities. Operational responsibility is delegated to the Director of Estates, Facilities and Capital who, with a qualified Energy and Sustainability Manager, develops and implements the Green Plan and reports against targets.
- The Deputy Director of Estates and Facilities is responsible for mitigations across scope 1 and 2 emissions, including for developing heat decarbonisation strategies.
- The quarterly Sustainability Group provides a forum for directorate and corporate team leads to report on Green Plan progress and share learning on the nine key areas for action outlined above.

- Climate-related impacts are covered in local business continuity plans. A developing incident response plan will include modules covering extreme weather events.
- Executives review the bi-annual sustainability report and its recommendations, and an update is provided to Resources and Planning Committee on behalf of the Board.

Managers are informed about climate-related and monitor climate-related issues using:

- Data around climate-related issues from various sources, including incident reporting system. Additional risk classifications and staff training are needed to embed this.
- Operational matters are directed to Estates and Facilities leads and, if necessary, escalated via regular their Directorate Management Team meeting.
    - Any climate-related issues would be reported to the quarterly sustainability group and included in six-monthly Green Plan reporting. Metrics and targets are to be developed. In future, the number of heat and flood events will be reported via the Estates Return Information Collection (ERIC) annual submission.

Strategy

Climate-related risks and opportunities identified over the short, medium and long term:

- Our Adaptation working group reports to the Sustainability Group. Its baseline maturity assessment using the NHS Climate Adaptation Framework assessed climate risks and organisational resilience. The framework and Climate Change Risk Assessment tool will be used to identify risks and Adaptation responses.
- Climate-related risks and opportunities have not yet been confirmed. Our Green Plan includes production of a Climate Change Risk Assessment by Quarter 3 2026/27, with its findings informing a Climate Adaptation Plan by March 2027.
    - (We have consequently not yet assessed impacts from climate-related risks and opportunities on our operations, strategy or financial plans over the short to long term, when considered against a global warming pathway of 2°C or lower).
- Our three-year EPRR Strategy (2026–2029) outlines a comprehensive approach to Business Continuity and Emergency Planning and addresses management of climate-related risks and incidents, as specified by the NHS EPRR Framework.

Risk management

Our processes to identify and assess climate-related risk include:

- Our Board Assurance Framework (BAF) incorporates risks from failing to deliver our Green Plan., including failure to comply with legislation, adverse impacts of climate-change, and failure to meet carbon reduction targets. Our BAF Regulatory risk is being updated in 2026/27 to include NHS EPPR Core Standards Assurance risks.
- Extreme weather risks will be incorporated in our EPRR risk register; however, we recognise that a key first step is completing the Climate Change Risk Assessment, using national and local tools, e.g. National Adaptation Programme tool.
- It is expected that climate risks will be shared across and monitored by Integrated Care Boards. These are monitored by our EPRR Manager and ICB Sustainability Programmes and Director of Estates meetings and sub-groups. Our EPRR Manager attends monthly ICB EPRR meetings and sub-groups.

We have identified no material climate-related risk to the trust to date. Our processes for recording climate incidents will be embedded and included in our six-monthly update reports.

- Climate-related extreme weather risks are manged and mitigated though business continuity plans, owned by services and trust wide thematic EPRR plans.

- The EPRR Manager obtains Weather Health Alerts covering heat and cold from UKHSA, and flood guidance statements from the Environment Agency and Flood Guidance Service and escalates relevant risks as needed.
- We plan to include site relevant flood mapping metrics into the Adverse Weather plan, to better inform management and mitigation of climate-related risks.

Metrics and targets

Metrics and targets we use to assess climate-related risks and opportunities include:

- Our metrics and measurements are guided by NHS England in our refreshed Green Plan (2025 – 2028). as well as through annual ERIC returns. Green plan indicators include percentage reduction against our 2019/20 baseline carbon footprint.
- 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, meeting NHS and Health and Care Act 2022 requirements.

We report on metrics and targets through a bi-annual Green Plan and Sustainability Report, and in the trust's Annual Report.

Tackling Health inequalities

Our full response to NHS England's refreshed expectations on reporting information about health inequalities for 2025/26 can be found on our website. It brings together key information on who we serve, the main inequalities affecting our communities, what the trust has done during the year, and the areas we will focus on next.

- **Deprivation and poverty:** parts of our footprint include some of the most deprived neighbourhoods in England. Poverty and financial hardship contribute to poorer mental and physical health and can make it harder for people to access care.
- **Ethnically minoritised and racialised communities:** our overall population is mainly White British, but some local areas have much higher proportions of ethnically minoritised and racialised communities. Local and national evidence shows different experiences and outcomes by ethnicity, so we need to respond at neighbourhood level in partnership with our communities.
- **Co-occurring needs:** many people face overlapping challenges (mental health, learning disability, neurodiversity, housing, employment, and social isolation). Co-occurring substance use and mental ill health is also a key concern, linked to avoidable harm and early death.
- **Physical health inequality:** people with serious mental illness and/or learning disability experience higher rates of long-term conditions and early death.

What TEWV has done in 2025/26

- **Improved how we use data:** we strengthened our population health analysis (including use of Fingertips and other sources) to inform planning, including work linked to our 5-year plan and community transformation.
- **Built capacity:** we secured 3 years of NHS England salary support for a Level 7 Health & Care Intelligence Specialist Apprenticeship to increase analytical capability.
- **Developed better dashboards:** we published our first Patient, Carer and Race Equality dataset and developed a new Equality, Diversity and Inclusion (EDI) dashboard to help teams look at access, experience and outcomes by ethnicity and deprivation (and at trust, care group and team level).
- **Implemented stronger governance:** we developed measures aligned to our health inequalities plan (for example, reducing unknown ethnicity recording, understanding DNA/cancellations, and

monitoring restrictive interventions, admissions and Mental Health Act use by ethnicity and deprivation).

- **Took action in services:** we progressed work on inclusive inpatient care through the Culture of Care programme; strengthened targeted approaches in Talking Therapies; continued community transformation work focused on groups and places at greatest need; progressed physical health improvement work (for example Making every contact count, screening pathways for longer-stay inpatients, and healthy weight approach in secure settings) and progressed our approach and partnership working for those experiencing drug and alcohol related harm.

Key challenges highlighted by the data

Persistent inequalities affect ethnically minoritised and racialised communities (including lower access in some services and higher levels of detention and inpatient care for some groups), alongside the continuing impact of deprivation, poverty, and substance-related harm. A specific operational challenge is that ethnicity recording has declined and is below the national mental health trust average, which limits how confidently we can understand and address inequalities. This is being addressed through the patient and carer race equality framework (PCREF) action plan.

Headline priorities for 2026/27

- **Build strong foundations (data and governance):** improve the quality of our data (especially ethnicity), publish simple dashboards for services, and set up regular reporting so teams can make better decisions and track progress.
- **Work in partnership on prevention:** agree TEWV's role with partners and focus on three prevention priorities in 2026/27: neighbourhood health and community transformation, suicide prevention, and dementia prevention.
- **Test and learn through three 'pathfinder' programmes:**
    - **Personalising care:** develop and test an approach to reduce Did Not Attend/Was Not Brought (DNA/WNB), focusing on our most deprived communities and people facing multiple disadvantage.
    - **Patient and Carer Race Equality Framework (PCREF):** build stronger relationships with community partners to learn from racialised communities, then use what we hear to adapt services, improve access and improve people's experience.
    - **Culture of Care:** roll out Standard 5 "Equality" through innovation and learning hubs at inpatient sites, shaped by local drivers of inequality (including poor physical health, poverty, and drug and alcohol-related harm).

Inequalities in our population are real, local and overlapping; our focus is to use better data and lived experience insight to deliver practical improvements in access, experience and outcomes for the people most affected.

Information about the following issues: social and community

- Last year there were a number of incidents of unrest within our communities near Middlesbrough. This impacted people living in and around those communities as well as colleagues living and working in the area, and those who have family, friends or loved ones there.
- Over the last year there has continued to be instances of increasing tensions related to immigration. This has an impact on our communities, including our colleagues.

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

The trust has established robust control measures to ensure full compliance with all obligations arising from equality, diversity, and human rights legislation. We have implemented a comprehensive Human Rights, Equality, Diversity and Inclusion Policy, which supports staff in understanding human rights principles and our statutory duties under the Human Rights Act. Human rights matters are formally reported to the Equality, Diversity and Human Rights Steering Group, providing assurance that issues are monitored, addressed, and escalated where appropriate. As part of our governance processes, we review human rights considerations within all Equality Impact Assessments conducted for policies, procedures, and major projects. In addition, human rights principles are integrated into our equality, diversity and inclusion training to ensure all staff are equipped with the knowledge required to uphold and promote these rights in their daily practice.

Equality of service delivery

A revised set of Equality Objectives for 2023–2027 was approved by the trust Board of Directors in January 2023. The trust sets equality objectives to meet its Public Sector Equality Duty under the Equality Act 2010 and to drive focused, measurable action to improve fairness and outcomes for both staff and patients.

The development of the equality objectives was informed by consultation with service users, carers and staff during 2022. Clear themes emerged from this engagement, which directly shaped the objectives and ensured they reflected lived experience and local priorities.

Objectives 1 and 3 relate specifically to service delivery and align with the trust's strategic objective to co-create a great experience for 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.

Key actions during the year include:

- Additional training on gender identity has been delivered to staff to raise awareness of trans and non-binary identities and to strengthen confidence in providing inclusive and supportive care.
- The trans awareness page on the staff intranet has been further developed to provide accessible information, guidance and signposting for staff supporting trans patients.
- The Trans Reference Group, which provides specialist advice to support complex decision-making relating to admissions, has been expanded to offer guidance on all trans patient pathways, including those accessing community services.

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.

Key actions during the year include:

- Ongoing delivery of specialist GRT awareness training for trust staff by the GRT specialist nurse and wellbeing practitioner based in Durham. Since 2023, over 500 staff have attended this training, improving understanding of cultural differences and how services can be made more accessible and responsive to GRT communities.
- In partnership with the trust, York University completed an engagement project exploring mental health needs and barriers to accessing services within GRT communities. A best-practice report has been produced and shared across the trust. A further project has been commissioned to build on this learning and is due for completion in 2026.
- Development of "Top Tips for Teams Working with GRT Communities", which was promoted Trust-wide during Gypsy, Roma and Traveller History Month.

The publication of patient information

The trust publishes annual information demonstrating compliance with the three aims of the Public Sector Equality Duty. This information supports understanding of whether, and why, particular groups may be under- or over-represented in the Trust's patient population and informs appropriate action.

The published data highlights differences in access, experience and clinical outcomes across protected groups to support the delivery of high-quality, equitable care for all. This includes access to services, patient experience and outcomes. The trust also publishes information relating to key areas of focus under the Patient and Carer Race Equality Framework (PCREF) 2025.

The full report can be found on our website.

Equality Delivery System (EDS) 2022 We completed the EDS 2022 and published the report in February 2026. 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 on our website.

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.

Alison Smith
Chief Executive
Date 25 June 2026

Group Board members as at 31 March 2026

Marie Burnham

Chair of the trust and chair of the nomination and remuneration committee

Marie brings over 35 years of leadership experience from across the NHS, charitable, educational and business sectors, in executive and non-executive roles. Before joining our trust, she served for a number of years as Chair of South West Yorkshire Partnership Teaching NHS Foundation Trust which is now one of the country's best performing NHS organisations. Marie previously led one of the country's largest joint clinical commissioning groups. Since starting her early career as a registered nurse, she has also held several NHS chief executive roles and has extensive expertise in integrated health and social care systems having been Chair of the Lancashire Place Based Partnership Committee.

In addition, Marie has also chaired for NICE on a number of their national guideline committees. As well as Marie's NHS career she has also been involved in the retail and pet Industry in the UK and USA.

Marie currently serves as a volunteer as Chair of the Pennine Multi Academy Trust, a position she has held since 2017.

Qualifications: RNMH,CHSM, MBA-Durham University.

Term of office: 16 March 2026 to 15 March 2029 (first term)

Date of Initial appointment: 16 March 2026

Dr Nini Adetuberu

Non-executive director

Nini qualified as a medical doctor 20 years ago from Imperial College and carried out core training in psychiatry in Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW). Nini brings experience from her career working within health and social care clinically and in commissioning mental health services across a local authority and primary care trust. She has worked at a national level on the regulation of mental health providers, as deputy director of policy at the Care Quality Commission and on developing policy reforms around the Mental Health Bill at the Department of Health and Social Care. She was previously an associate non-executive director on the board of Newcastle Hospitals NHS Foundation Trust and she is currently a non-executive director on the board of the North East Ambulance Service. Nini has a passion for ensuring all people get fair access to health services and experience safe care with high-quality outcomes.

Qualifications: MBBS, BSc

Term of office: 1 November 2025 to 30 October 2028 (first term)

Date of Initial appointment: 1 November 2025

Roberta Barker

Non-executive director, chair of the people culture and diversity committee and interim chair of the mental health legislation committee

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 and 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

Term of office: 1 September 2025 to 31 August 2028 (second term)

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

John Maddison

Non-executive director, chair of the audit and risk committee and interim chair of the resources and planning committee

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 foundation trust (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.

Term of office: 1 July 2023 to 30 June 2027 (extended 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 and chair of the charitable funds committee

Jules has extensive experience in the NHS, having served as the inaugural Chairman of the Northumberland, Tyne and 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 and 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.

Term of Office: 1 September 2025 to 31 August 2028 (second 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 and chair of the quality assurance committee

Bev has been a Nurse for 39 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)

Term of office: 1 September 2025 to 31 August 2026 (third term).

Date of initial appointment: 1 September 2019

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.

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

Date of initial appointment: 1 December 2024

David Butcher

Associate non-executive director (non voting)

David is a chartered accountant and has held various financial management positions across both private and public sectors. He also brings strategic oversight and governance experience from multi-stakeholder public sector environments across multiple sectors.

He has recently retired from his role as Director of Finance and University Secretary at Leeds Trinity University, with responsibilities including strategic and operational financial management, strategic business planning and leading the risk management processes.

Qualifications: BA (Hons) and Qualified Associate Chartered Accountant

Term of office: 1 December 2025 to 30 November 2028 (first term)

Date of Initial appointment: 1 December 2025

Edward Gorringe

Associate non-executive director (non voting)

Edward has many years of experience in the voluntary sector; he is currently a trustee of a national mental health charity and was previously the chief executive of a mental health charity delivering services across Northern Ireland. His interest in mental health in part derives from his personal and family experience and he is committed to ensuring that the voice of the service user and carer is heard. Edward is a qualified accountant and has held a number of senior finance and management positions across the public and voluntary sectors; he is currently the Chief Executive of a hospice in the North East.

Qualifications: Fellow of the Chartered Institute of Management Accountants (FCMA), IOD Chartered Director (CDir), Advanced Diploma in Sustainable Investment, Advanced Diploma in Social Enterprise, Master of Business Administration (MBA), BA.

Term of office: 1 December 2025 to 30 November 2028 (first term)

Date of Initial appointment: 1 December 2025

Executive directors

Alison Smith

Chief executive

Alison Smith brings to Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) a wealth of experience built across more than three decades of healthcare leadership. Since taking up the role of Chief Executive Officer in September 2025, Alison has brought her signature blend of compassionate, visible leadership and sharp operational expertise to one of the region's most important mental health and learning disability trusts.

Alison's career is a testament to her deep commitment to people - both the communities she serves and the teams she leads. Beginning her professional journey as a Royal Veterinary Nurse, she developed an early appreciation for care, precision and partnership that has remained a thread throughout everything she has done since. She later earned a Master of Business Administration, grounding her clinical instincts in rigorous strategic and financial thinking.

Before joining TEWV, Alison served as Deputy Chief Executive Officer at Avon and Wiltshire Mental Health Partnership NHS Trust, where she stepped up as Interim CEO during periods of planned and unplanned absence - ensuring continuity of leadership, board accountability and executive momentum without interruption. Prior to that, she was Managing Director at Isle of Wight CCG and the Hampshire and Isle of Wight ICS Partnership, where she guided a financially challenged organisation back onto stable footing while developing integrated care capabilities across the system. Earlier roles as Chief Operating Officer at Mid Essex NHS Trust and Director of Integrated Pathways at East Suffolk and North Essex NHS Trust further sharpened her ability to lead complex transformation programmes and build strong, trust-based relationships across health and social care partners.

Throughout her career, Alison has championed staff engagement, clinical leadership and patient-centred improvement. Whether redesigning urgent care pathways, reducing health inequalities, or embedding robust governance frameworks, she has consistently delivered sustainable change in some of the NHS's most challenging environments.

At TEWV, Alison is focused on building a trust where every patient receives outstanding, compassionate care, every member of staff feels genuinely valued, and the organisation plays its full role as an anchor institution within its community

Qualifications: MBA (University of East Anglia), graduate of the NHS Leadership Academy's Nye Bevan programme and has completed the Cabinet Office's Leading Collaborative Organisations programme

Appointed: September 2025

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 Chartered Institute of Public Relations (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

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 and Language Therapy, Acting Lead for Allied Health professionals and most recently Executive Director of Therapies.

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

Appointed: April 2022

Dr Sarah Dexter-Smith

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 having worked clinically with older people and people with dementia. 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 and the impact on patient care and opportunities for our communities.

Qualifications: Fellow Chartered Institute of Personnel and Development (CIPD), Doctorate Clinical Psychology, PhD Psychology, ILM5, PGDips Supervision/ Neuropsychology

Appointed: February 2021

Kathryn Ellis

Interim executive director of strategy and transformation

Kathryn started in the NHS as a graduate management trainee. She has extensive senior leadership experience in health, social care and the voluntary sector, having worked across acute, general practice, community and mental health services.

Kathryn's held several executive director positions in both commissioning and provider organisations, working in operational and strategic roles leading transformation and improvement. Her previous roles have included leadership of organisational and system improvement, transformational change across service pathways, and design and delivery of new models of care. She is a qualified organisational consultant and coach, passionate about patient, staff and community involvement, and integrated partnership working.

Qualifications: MSc Healthcare Policy and Management, MA Leading and Consulting to Organisations, Professional Postgraduate Diploma Chartered Institute of Marketing, PGCert Coaching, BSc Industrial Relations and Human Resource Management

Appointed: April 2025

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 over 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 with a high quality training experience and welcomes them as a place to work.

Qualifications: MBBS, DPM, MD, FRCPsych, MPhil

Appointed: June 2022

Naomi Lonergan

Interim managing director

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

Appointed: September 2024 (interim managing director for the Durham, Tees Valley and Forensic Services Care Group) and November 2025 (interim managing director for both care groups).

Beverley Murphy

Chief nurse and deputy chief executive

Beverley has worked as a chief operating officer, chief nurse and deputy chief executive in mental health services and has had executive roles on five NHS Trust Boards. Beverley is proud to be back 'home' where she first trained as a nurse in 1985. Having worked as a mental health nurse for 42 years, Beverley has held a range of clinical leadership roles and has actively sought roles in mental health trusts where improvement was required.

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 successfully completed Executive Coach training at Tavistock Consulting.

Qualifications: RMN, MA

Appointed: May 2023

Liz Romaniak

Executive director of finance, estates and facilities

Liz joined the NHS over 35 years ago and has extensive deputy and executive director board-level experience from roles within commissioning and community/mental health provider organisations. Liz led work in her previous organisation between 2014-15 to develop the aspirant Foundation Trust's long term financial model and successfully navigate all financial aspects of the trust's Monitor foundation trust (FT) application and due diligence processes. At different points Liz has also had executive responsibility for planning and performance and served as deputy chief executive (and interim Chief Executive), both substantive 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 PFI legal case between 2020 and 2024, is an active member of two national finance Committees of the Healthcare Financial Management Association (HFMA), and recent member of the Advisory Committee for Resource Allocation (ACRA).

Qualifications: qualified accountant, ACMA

Appointed: October 2020

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 Board of Directors 2025/26

David Jennings, Chair of the trust, left the trust on 2 May 2025.

Bev Reilly was appointed as the Interim Chair of the trust from 12 May 2025 to 15 March 2026.

Marie Burnham became the Chair of the trust on 16 March 2026.

Brent Kilmurray, Chief Executive, left the trust on 22 April 2025.

Patrick Scott was appointed as the Interim Chief Executive on 23 April 2025 and left the trust on 30 September 2025

Beverly Murphy was appointed as the Interim Deputy Chief Executive on 3 April 2025 and was the Acting Interim Chief Executive between 26 June 2025 to 8 Sept 2025. Beverley became the substantive Deputy Chief Executive on 9 September 2025

Alison Smith became the Chief Executive on 9 September 2025.

Zoe Campbell, Managing Director for the North Yorkshire, York and Selby care group retired on 1 November 2025

Naomi Lonergan, Interim Managing Director for the Durham, Tees Valley and Forensic Services Care Group, became the interim managing director for both care groups on 1 November 2025.

Kate North, Joint Executive Director for People and Culture, was seconded to Cumbria Partnership NHS Foundation Trust on 1 October 2025

Kathryn Ellis joined the trust as the Interim Executive Director of Strategy and Transformation on 22 April 2025

Charlotte Carpenter, non-executive director and Chair of the Resources and Planning Committee, left the trust on 1 October 2025.

Jane Robinson, non-executive director, left the trust on 28 February 2025.

Nini Adetuberu joined the trust as a non-executive director on 1 November 2025.

Edward Gorringe and David Butcher joined the trust as associate non-executive directors on 1 December 2025.

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 2025-26 as directed by NHS England and fully complied 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, consolidating its subsidiary company Positive Individual Proactive Support (PIPS) Ltd. Prior year comparators in financial statements and notes reflect Group totals, with trust totals shown separately in line with IFRS disclosure requirements (or annotated where relate to trust only).

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 2025-26.

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.

Better Payment Practice Code

The Better Payment Practice Code, which monitors the prompt payment of suppliers by the Public Sector, requires that the Group 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 is a key priority, including through the use of No Purchase Order No Payment procedures ('No PO, no Pay') within the trust.

Performance across 2025-26 improved for 5 of the 6 metrics below compared to prior year, (whilst performance on numbers of NHS invoices paid remained above target there was a marginal 0.1% deterioration from 97.2%) and was as follows:

	2025-26	
	Number of Invoices	**Value of invoices (£000s)**
NHS Creditors		
Total bills paid	2,139	23,101
Total bills paid within target	2,076	22,610
Percentage of bills paid within target	**97.1% (↓)**	**97.9% (↑)**
Non-NHS Creditors		
Total bills paid	62,457	108,088
Total bills paid within target	59,735	104,493
Percentage of bills paid within target	**95.6% (↑)**	**96.7% (↑)**
Total Creditors		
Total bills paid	64,596	131,189
Total bills paid within target	61,811	127,103
Percentage of bills paid within target	**95.7% (↑)**	**96.9% (↑)**

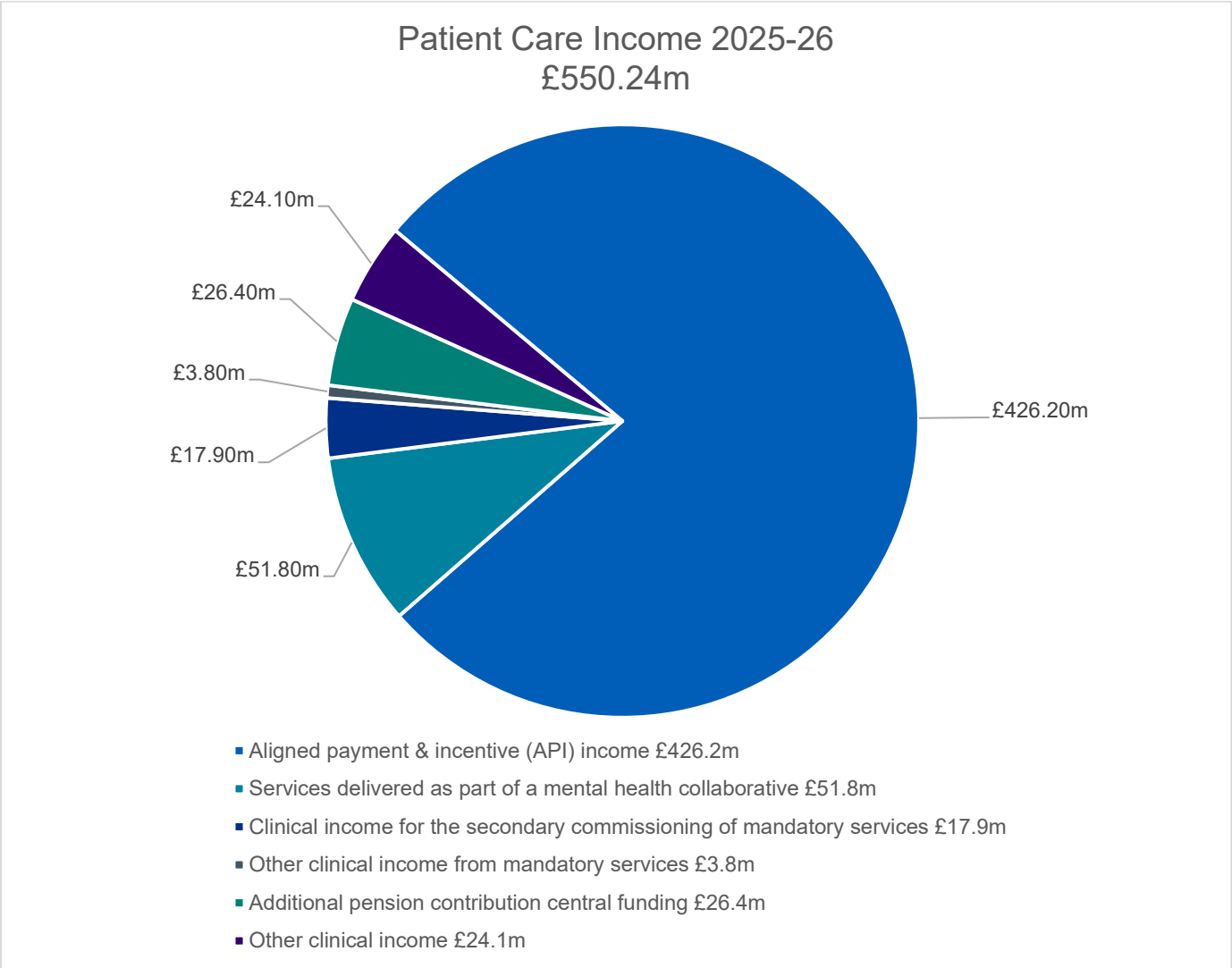
The total potential liability to pay interest on invoices paid after their due date during 2025-26 would be £1,878,371, a decrease on the estimated potential prior year liability (2024-25: £2,279,006). There have

been no claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

Income Generation (subject to audit)

During 2025-26, the trust received £585.52m income from a range of activities.

£550.24m Patient care income (94.0% all income) was from the following areas:



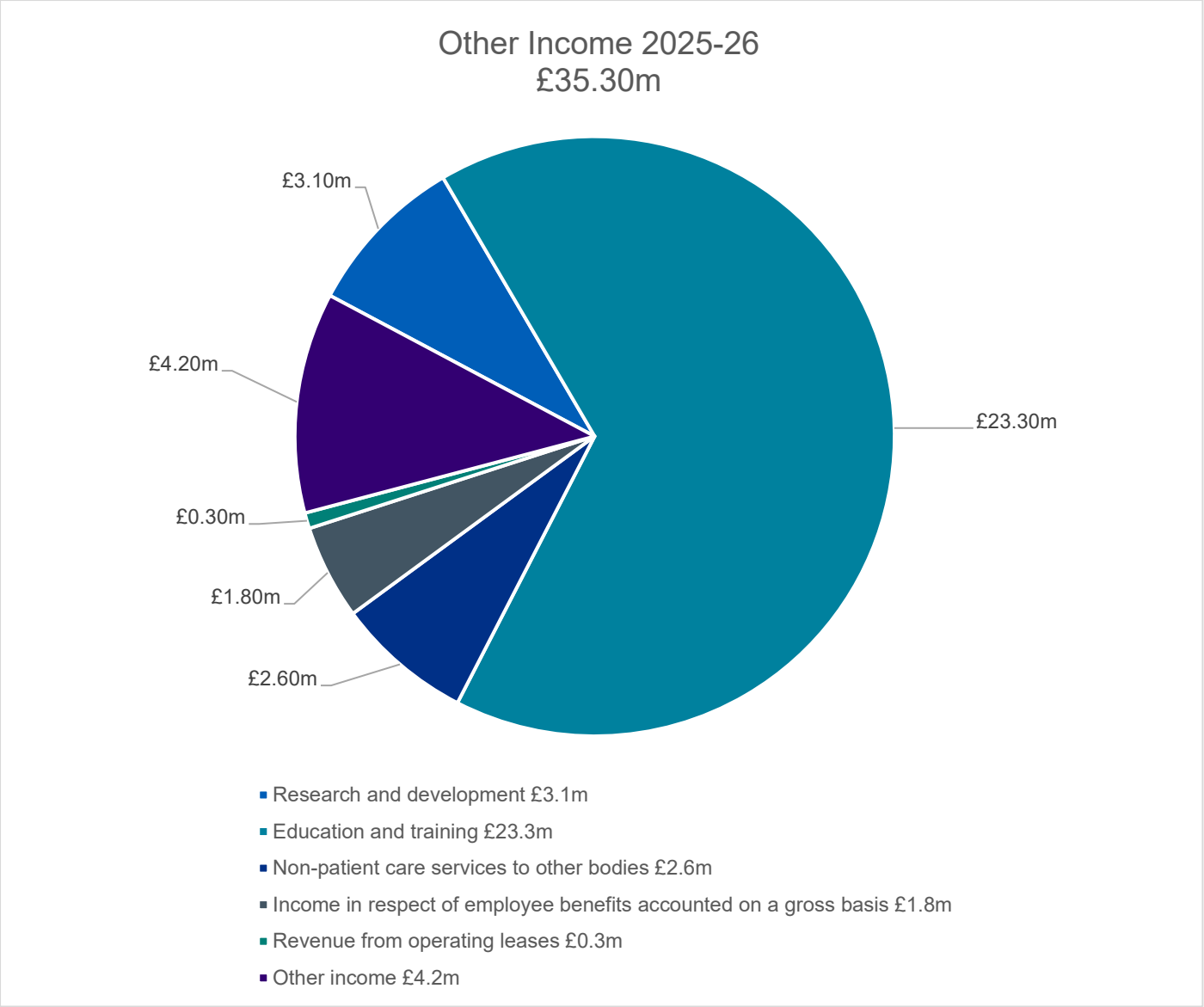
API income is received mainly from North East and North Cumbria ICB, Humber and North Yorkshire ICB, and NHS England.

Mental Health Collaborative income is mainly received from Cumbria, Northumberland Tyne and Wear NHS FT.

The additional pension contributions were received from NHS England.

Other clinical income is mainly from Offender Health services, Local Authorities Primary Care Networks.

A further £35.30m income (6% all income) 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 (£550.24m) was greater than its income from the provision of goods and services for any other purposes (£35.30m). The provision of goods and services for any other purposes had no negative impact on the provision of health services.

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 the eight domains of NHS Improvement's well-led framework in arriving at our overall conclusions about the position of the organisation:

- 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

During 2025/26 we have navigated a period of transition and opportunity

- In April 2025 the Board approved the refresh of our strategy: “Our Journey to Change – the Next Chapter”.
- We have experienced considerable leadership change, including the appointment of a new Chair and a new Chief Executive and the commencement of a review of the executive directors’ portfolios.
- The Board also signed off the improvement plan, arising from the development review of leadership and governance conducted by Deloitte LLP in 2023/24, as completed.
- Our new Chief Executive has commissioned a review to provide assurance on the embeddedness of the revised arrangements taking into account changes arising in year.
- We have reviewed our governance arrangements in the context of NHS England’s provider capability assessment.

This review demonstrated:

- Strategic alignment with both ICBs and active participation in system transformation, particularly evidenced via our service initiatives for the Crisis Assessment Service and Community Mental Health Team models.
- Maturing governance and assurance processes, with regular Board oversight of quality, performance, and risk.
- A culture of openness, engagement, and service user involvement, with strong evidence of cocreation.

The areas for development, including making substantive key Board roles, people and culture development and strengthening Freedom to Speak Up processes have been addressed.

- We have considered and responded to recommendations of the Aubery Report into the breast service at County Durham and Darlington NHS Foundation Trust.

In conclusion the Board was assured that, whilst further developments were required, the trust was well positioned to deliver on its strategic objectives, respond to regulatory expectations, and continue to improve outcomes for the communities it serves.

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/

Care Quality Commission

The most recent Care Quality Commission (CQC) trustwide inspection was published in October 2023. At that time, our overall rating remained as ‘**requires improvement**’ and the CQC recognised that we are 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 previous 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 published in March 2025, provided substantial assurance that actions were delivered in line with internal reports to the trust Board of Directors.

The most recent CQC inspection was of mental health Crisis Services, Health-based Places of Safety and Liaison Services trustwide undertaken June 2024. The report was published in February 2025 and the speciality rated as ‘**good**’ overall with ratings of good for safe, effective, caring, and responsive domains and ‘requires improvement’ for the well-led domain.

We know that there is still more to do and we are continuing to focus on Our Journey to Change the Next Chapter, to set the direction for continuous improvement across all services.

The following diagram shows the current CQC rating overall and per trust service:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust Rating	Requires Improvement →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Requires Improvement →← Oct 2023	Requires Improvement →← Oct 2023	Requires Improvement →← Oct 2023
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 services for older people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
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	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020

	Safe	Effective	Caring	Responsive	Well-led	Overall
	Mar 2020					
Mental health crisis services and health-based places of safety	Requires Improvement ↓ June 2024	Good →← June 2024	Good →← June 2024	Good →← June 2024	Good →← June 2024	Good →← June 2024

As well as trustwide inspections, the CQC also visits inpatient wards to check compliance with the Mental Health Act.

Further details are available: https://www.cqc.org.uk/provider/RX3

During this period, there were also joint HMIP (His Majesty's Inspectorate of Prisons) / CQC inspections of the following prisons where the trust delivers mental health services (either as a direct contract or under a sub-contract for another provider):

- HMP Hull – report published 27/05/25.
- HMP Haverigg – report published 15/07/25.
- HMP & YOI Deerbolt – report published 17/11/25
- HMP Northumberland – report published 02/12/25
- HMP & YOI Low Newton – report published 24/02/26

The inspection reports are available on the HMIP's website: hmiprisons.justiceinspectorates.gov.uk

During 2025/26, the trust completed delivery of those elements of the CQC Improvement Plan which related to the trustwide Inspection in 2023. Some of the extensive improvement work which has been undertaken includes:

- Implemented and monitored an Immediate Life Support training programme, achieving compliance above trust standards.
- Significantly improved Mandatory and Statutory training compliance.
- Revised and embedded the Section 17 Leave Policy with routine monitoring and quality assurance checks.
- Established an Urgent and Emergency Care Board to oversee assertive community care.
- Developed supervision guidance for Peer Support Workers.
- Improved patient food provision, including securing a new supplier and ensuring food safety compliance.
- Implemented updated guidance and the revised Environmental Ligature Risk assessment tool in line with national standards.
- Ensured Board-level Committees have clear Terms of Reference and workplans.
- Updated the Duty of Candour Policy to meet national standards and introduced routine reporting.
- Completed a Complaints process review, introducing a revised policy and Local Issue Resolution approach.
- Updated the Physical Health and Wellbeing Policy to strengthen oversight of staff physical health training.
- Promoted the Think Family approach to reinforce safeguarding standards.
- Launched DIALOG/DIALOG+ alongside Cito to enhance co-produced goal setting and strengthen patient and carer involvement in care plans.
- Appointed a trustwide Professional Nurse Advocate, supporting further embedding of PNA roles.
- Updated the Harm Minimisation Policy, now the Safety and Risk Management Policy.

In addition to clearly evidencing delivery of the required actions, we continue to implement a wider programme of change and improvement. During 2025/26 this has included:

- Significant enhancements to organisational learning from a range of internal and external sources.
- Implementation of an alternative trust supervision recording system.

- Improvements in incident reporting/ management, risk registers, complaints and audit activity via the InPhase system.

TEWV continues to implement learning from the Quality Assurance and Improvement Programme to improve practice and gain assurance of the impact of our actions to improve care for patients, families and carers. This work continues to nurture a positive culture of patient safety and continuous quality improvement.

PIPS has a separate registration with the CQC. The report on the regulator's last inspection 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

New or significantly revised services

The trust introduced several new and significantly revised services during the year.

The York 24/7 Hub became fully operational, strengthening crisis responsiveness and improving system flow, and community transformation programmes progressed across all localities with new models of care now embedded in several neighbourhood teams.

We successfully transferred adult learning disabilities services from Bankfields to the purpose designed Levick Court, providing safer and higher quality accommodation.

In Tees, delivery of the Getting Help model has improved access and coordination of early support for children and young people, and the child and adolescent mental health services (CAMHS) tender demonstrated strong partnership working and a clear commitment to stable, sustainable provision.

Adult mental health urgent care services achieved sustained reductions in out of area placements, lower bed occupancy and shorter lengths of stay, all supported by strengthened community pathways. Crisis Tees received the Seni Lewis Award in recognition of leadership in reducing restrictive practice, and our Eating Disorders Service achieved accreditation, confirming high standards of care and governance.

The Ridgeway education Centre celebrated two years of operating and achieved a rating of 'Outstanding' in its first City and Guilds inspection. This has led to the development of the Ridgeway college and its vision of "*any patient, any subject, any day, any time"* model has now enabled the team to encourage and support patients enrolling for multiple education courses, within their ability the team have developed a full prospectus for 2026 and beyond and have exceeded all current improvement trajectories for enrolments.

From 1 April 2025, we successfully secured and began mobilisation of the contract to provide mental health services at HMP Millsike.

Respite mental health provision previously delivered at Aysgarth and Unit 2 at Bankfields Court was relocated to Levick Court, a Middlesbrough Borough Council–managed facility, where the trust now provides clinical input into the service. In addition, the trust concluded the planned closure of inpatient rehabilitation services at Primrose Lodge, enabling a shift in focus toward community-based models of care. This included the development of an enhanced community rehabilitation service aimed at supporting service users' recovery and independence within their local communities.

Improvement work aligned to national initiatives

We have embedded an infrastructure and a range of approaches that support the delivery of high quality, safe and effective care with robust governance arrangements. Some examples include the following:

- We have been using Quality Improvement (QI) since 2007 and, as a core element of Our Journey to Change, we will continue to use it in the future. Our QI approach gives people who access our services, who deliver our services and who partner with us, to have a voice and to participate in QI activity to help make our trust a great place to work, a great partner to work with and to enable people to live their best possible lives. Our dedicated Quality Improvement Team provides expertise and support across the trust. To continue to build our capacity and capability, QI training is provided at four different levels: foundation, intermediate, leader and expert.
- A wide range of staff training and development opportunities are accessible to staff.
- The new InPhase system has successfully assisted with the trust's transition to the Learning from Patient Safety Events (LFPSE) service from the National and Reporting Learning System (NRLS) and implementing the Patient Safety Incident Response Framework (PSIRF) process. We have implemented effective training provisions in relation to risk management, including incident reporting, risk registers, complaints and clinical audit.
- We have systems and structures that support organisational learning including rapid patient safety after action reviews, safety alerts, learning from patient safety incident bulletins and share and learn webinars. This is supported by our established Organisational Learning Group (OLG).

We have a well-established Quality Assurance and Improvement Programme which has continued since its inception from April 2021. This is focused partly on patient care documentation, recognising that high quality documentation is an enabler of high-quality patient care. The Programme also includes Peer Quality Reviews which observe practice and involve on site collaboration with teams and patients in clinical areas.

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 are subject to review to ensure they are informed by current areas of risks where further assurance is required.

- Inpatient Quality Review Tool
- Community Quality Review Tool
- HMP 3 Part Plan tool
- Peer Quality Review Tool

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 practice improvements and provides the organisation with both quantitative and qualitative assurance evidence.

Key learning from incidents, patient surveys, complaints and other forms of intelligence helps to shape our trust's quality improvement priorities and continues to be monitored using the Quality Assurance and Improvement Programme. In addition, the trust ensures oversight and assurance of key quality and risk issues via a Quality Dashboard Report. This report incorporates triangulated information with wider governance intelligence from the Quality and Learning Dashboard, the Positive and Safe Dashboard, Quality Assurance risks, and feedback from Clinical and Corporate Leaders and Subject Matter Experts. The report is presented to the Quality Assurance Committee as a Board Level Committee, and also to the Care Group governance forums.

Co-creation is central to our overall approach. We work closely with patients, families and carers to identify and deliver our priorities. We were one of the first trusts nationally to create lived experience director roles for people with lived experience of mental illness and currently have two lived experience directors in across the care groups. These roles ensure that services continue to be developed and improved by working closely with our network of patients and carers, local communities, and colleagues in other lived experience roles.

We gain important feedback from national and local patient and carer surveys, which enable us to focus improvements on specific wards and services.

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, website, posters and leaflets outline how concerns can be raised 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 NHS Complaints Regulations (2009) and the Parliamentary and Health Service Ombudsman (PHSO) for NHS Complaint Standards (2022).

We encourage individuals 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.

Learning and good practice identified from complaints is shared and discussed within the trust's Organisational Learning Group. Learning is then disseminated via Clinical Networks, Fundamental standards, briefings where appropriate, to ensure that learning feeds into existing improvement work.

Public and patient involvement activities

Throughout 2025–26, we continued to strengthen how we listen to and work alongside our service users, carers and community partners. We have further embedded co-creation as a core part of how we design, deliver and improve our services.

We now have dedicated service user and carer groups across each of our clinical specialties. These groups work closely with services to shape everyday practice, influence trust policies and support service redesign where needed. Over the last year, this approach has helped us continue to amplify lived experience voices and ensure they meaningfully inform how we deliver safe, compassionate and person-centred care.

Building on the launch of our co-creation framework in 2024–25, we refreshed our trustwide co-creation strategy to reflect the needs and aspirations of staff, service users and carers at different stages of their co-creation journey. This work also focused on removing barriers to involvement, including access to digital tools and support for people contributing through their lived experience. The updated strategy is now being operationalised in partnership with staff, service users, carers and system partners, supported by the co-development of new enabling structures.

Our Co-Creation Boards, established in both Care Groups in 2023, have continued to grow and mature. We are seeing increased lived experience leadership, including service users and carers taking up roles on the Durham Tees Valley and Forensic Care Boards. Their insight is helping shape how these boards conduct their business and strengthen their partnership approach across our geography.

Service users, carers and community partners have played a central role in major transformation programmes across the trust, including the Urgent Care Programme, the Culture of Care work, and the implementation of Oxevision. Co-produced approaches continue to underpin safety planning, and during the next year we will implement a new Patient Safety Partner model, co-produced over the past 12 months.

Our Patient Experience Service introduced the "I Want Great Care" platform this year, with all questions and structures co-produced with service users, carers, staff and voluntary and community sector partners.

We have continued to make significant progress across several priority areas:

- We continued to expand lived experience roles, including peer support workers, supported by system leadership and collaborative training with Teesside University. Peer networks are now established across Teesside, Durham and York, working closely with voluntary, community and social enterprise organisations.

- We developed new induction, support and reflective practice training for involvement members. Work is underway to establish enhanced structures and resources to sustain and grow this community.
- We co-developed a national Community of Practice for strategic co-production, the first of its kind, bringing together leaders from NHS trusts and charities. Chaired by our head of co-creation, this group shares learning and resources on areas such as evaluation, diversity in co-production and strategic infrastructure.
- Our internal Co-Creation Community of Practice continues to thrive, supporting staff to act as co-creation champions within their services. A co-developed train-the-trainer programme has been rolled out, enabling champions to build confidence, identify barriers and embed co-creation methodologies in their teams.
- Launched in October 2025, the Lived Experience Education Collective brings together mental health education services across the TEWV footprint, including voluntary sector partners. The group is now well established and has ambitious plans to extend lived experience education models to more communities.
- Throughout 2025, we co-developed the business case and service specification for a new Crisis House service using Design Thinking methodology, rooted in personal stories and experience. This was the first time the trust used this methodology at scale, enabling staff at all levels to work alongside service users, carers and community organisations from the earliest stage of development.
- Major transformation projects and policy development now routinely include lived experience leadership and input. This includes the Oxehealth policy and procedure, the Positive and Safe Strategy, and the Personalised Care Planning Policy, all of which have been co-produced.

Progress on embedding and growing co-creation across the organisation includes:

- **515 people** remain active on the Involvement Register. Recruitment continues, with a focus on engaging young people, autistic service users, and people with learning disabilities, alongside carers.
- The involvement and engagement team has strengthened relationships with voluntary and community sector partners to reach more diverse communities.
- **196 involvement opportunities** were shared during this reporting period, covering a wide range of activities including interviews, service redesign, quality improvement projects and training delivery.

Remuneration report

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 Board's 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 2025/26, the Committee:

- Put in place interim executive arrangements, with commensurate remuneration levels, in response to the departure of the Chief Executive.
- Approved an acting up allowance for the Interim Deputy Chief Executive to cover the duties of the Chief Executive.
- Approved the remuneration package for the new Chief Executive.
- Approved a 3.25% 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.
- Commenced a restructure of the executive directors including a review of salaries aligned to their revised portfolios.

Marie Burnham

Chair of the Board's Nomination and Remuneration Committee

(Notes:

- *the report of the Council of Governors' Nomination and Remuneration Committee, which is responsible for advising on the remuneration and terms and conditions of the Chair and non-executive directors, is provided in the governance report*
- *The remuneration of Directors of PIPS is determined by its Board of Directors)*

Senior Managers' Remuneration Policy

Basic pay	A new very senior managers (VSM) pay framework was launched in 2025, jointly produced by NHS England and the Department of Health and Social Care (DHSC). The VSM pay framework applies to all integrated care boards (ICBs) and NHS provider trusts and seeks to strengthen the link between reward and performance outcomes, increase transparency and offer flexibility to attract talented candidates to the most challenging roles. The trust complies with the VSM framework, with pay for Executive/Director roles being aligned with turnover as per the framework requirements and these roles all falling within the minimum and maximum pay ranges.
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 2025/26.
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.

Statement of consideration of employment conditions elsewhere in the Foundation trust

A new VSM pay framework was launched in 2025, jointly produced by NHS England and the Department of Health and Social Care (DHSC).

The VSM pay framework applies to all integrated care boards (ICBs) and NHS provider trusts and seeks to strengthen the link between reward and performance outcomes, increase transparency and offer flexibility to attract talented candidates to the most challenging roles.

The framework covers new pay bands which account for organisational size and aligns with complexity and responsibility of roles. With five pay bands for provider trusts where each band has a minimum and maximum range.

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. 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 objectives these are 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.

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.

Alison Smith
Chief Executive

25 June 2026

Senior managers' remuneration (subject to audit)

Name and Title	2025-26						2024-25					
	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 (to 13 April 2025) ***	5 - 10	-	-	-	5 - 10	300	215 - 220	-	1,700	87.5 - 90.0	305 - 310	2,000
Ms Alison Smith, Chief Executive (from 08 September 2025)	115 - 120	-	-	105.0 - 107.5	225 - 230	10,300	-	-	-	-	-	-
Mrs Zoe Campbell, Managing Director North Yorkshire York and Selby (to 31 October 2025)	80 - 85	40 - 45	-	-	125 - 130	100	140 - 145	-	-	32.5 - 35.0	175 - 180	400
Mr Patrick Scott, Deputy Chief Executive & Managing Director Durham Tees Valley and Forensic Services (to 29 September 2025) and acting Chief Executive from 14 April to 19 June 2025 ***	90 - 95	120 - 125	1,000	-	215 - 220	-	135 - 140	-	8,700	-	145 - 150	-
Mrs Naomi Lonergan, Interim Managing Director (from 01 November 2025), Managing Director Durham Tees Valley and Forensic Services (to 31 October 2025) ***	145 - 150	-	9,100	-	150 - 155	-	75 - 80	-	8,900	-	85 - 90	-

Mrs Liz Romaniak, Director of Finance, Estates and Facilities	160 - 165	-	-	62.5 - 65.0	220 - 225	1,400	155 - 160	-	-	15.0 - 17.5	170 - 175	-
Mrs Beverley Murphy, Deputy Chief Executive & Chief Nurse (deputy from 14 April 2025, acting Chief Executive from 20 June 2025 to 07 September 2025))***	160 - 165	-	1,600	97.5 - 100.0	260 - 265	2,700	140 - 145	-	1,100	-	140 - 145	4,100
Dr Kedar Kale, Medical Director ***	190 - 195	-	7,700	145.0 - 147.5	345 - 350	1,200	165 - 170	-	20,400	-	185 - 190	1,300
Dr Sarah Dexter-Smith, Director of People and Culture	125 - 130	-	-	42.5 - 45.0	170 - 175	1,600	120 - 125	-	-	17.5 - 20.0	140 - 145	2,200
Mrs Kate North, Joint Director of People and Culture (to 01 October 2025)	55 - 60	-	-	-	55 - 60	1,500	60 - 65	-	-	77.5 - 80.0	140 - 145	300
Mrs Ann Bridges, Director of Corporate Affairs and Involvement ***	125 - 130	-	1,900	32.5 - 35.0	160 - 165	100	115 - 120	-	4,400	27.5 - 30.0	150 - 155	1,000
Dr Hannah Crawford, Director of Therapies ***	125 - 130	-	1,600	67.5 - 70.0	195 - 200	700	125 - 130	-	900	7.5 - 10.0	135 - 140	1,000
Mrs Kathryn Ellis, Interim Director of Transformation and Strategy (from 22 April 2025)	125 - 130	-	-	20.0 - 22.5	145 - 150	-	-	-	-	-	-	-
Mr David Jennings, Chair (to 02 May 2025)	0 - 5	-	-	-	0 - 5	400	50 - 55	-	-	-	50 - 55	2,600
Mrs Beverley Reilly, Deputy Chair (Interim Chair from 12 May 2025 to 15 March 2026) and Chair of the Quality Assurance Committee to 12 May 2025	45 - 50	-	-	-	45 - 50	1,000	20 - 25	-	-	-	20 - 25	1,000

Mrs Marie Burnham, Chair (from 16 March 2026)	0 - 5	-	-	-	0 - 5	-	-	-	-	-	-	-
Mr John Maddison, Non-Executive Director & Chair of the Audit and Risk Committee, Interim Chair of Resources and Planning Committee from 1 October 2025 and Digital / Cyber Non-Executive Director Champion	15 - 20	-	-	-	15 - 20	-	15 - 20	-	-	-	15 - 20	-
Dr Charlotte Carpenter, Non-Executive Director and Chair of the Resources and Planning Committee (to 1 October 2025)	5 - 10	-	-	-	5 - 10	-	10 - 15	-	-	-	10 - 15	-
Mr Jules Preston, Non-Executive Director, Senior Independent Director, Chair of the Charitable Funds Committee, Interim Chair of the Mental Health Legislation Committee (to 31 August 2025) and Interim Chair of the Quality Assurance Committee (from 12 May 2025)	15 - 20	-	-	-	15 - 20	2,200	15 - 20	-	-	-	15 - 20	2,400
Mrs Roberta Barker, Non-Executive Director and Chair of the People, Culture and Diversity Committee and Interim Chair of the Mental Health Legislation Committee (from 01 September 2025)	10 - 15	-	-	-	10 - 15	-	10 - 15	-	-	-	10 - 15	-
Mrs Jane Robinson, Non-Executive Director (to 28 February 2026)	10 - 15	-	-	-	10 - 15	500	0 - 5	-	-	-	0 - 5	100
Ms Catherine Wood, Non-Executive Director	10 - 15	-	-	-	10 - 15	2,000	0 - 5	-	-	-	0 - 5	400

Mrs Niniola Adetuberu, Non-Executive Director (from 01 November 2025)	5 - 10	-	-	-	5 - 10	-	-	-	-	-	-	-
Mr Edward Gorringe, Associate Non-Executive Director (from 01 December 2025)	0 - 5	-	-	-	0 - 5	-	-	-	-	-	-	-
Mr David Butcher, Associate Non-Executive Director (from 01 December 2025)	0 - 5	-	-	-	0 - 5	-	-	-	-	-	-	-
	Remuneration ranged from				5 - 10		**Remuneration ranged from ******				85 - 90	
	Remuneration ranged to				345 - 350		**Remuneration ranged to**				305 - 310	
	Band of highest paid directors' total remuneration (£000)				210-215		**Band of highest paid directors' total remuneration (£000)**				215 - 220	
	Percentage increase from prior year of highest paid director salary				-2.3%		**Percentage increase from prior year of highest paid director salary**				10.1%	
	Percentage increase from prior year of median salary				3.6%		**Percentage increase from prior year of median salary**				5.5%	

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 is payment for mutually agreed resignation scheme (including lieu of notice).

*** 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

**** Restated to exclude Non-Executive Directors

In 2025-26, 4 (2024-25, 23) employees received remuneration in excess of the highest-paid director / member

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

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

2024-25	25th Percentile	Median	75th percentile
Salary component of pay	25,674	36,483	46,148
Total pay and benefits excluding pension benefits *	27,752	36,483	48,093
Pay and benefits excluding pension: pay ratio for highest paid director	7.8:1	6:1	4.5:1
*restated to reflect updated values			

2025-26	25th Percentile	Median	75th percentile

Salary component of pay	26,598	37,796	47,810
Total pay and benefits excluding pension benefits	28,847	37,796	47,810
Pay and benefits excluding pension: pay ratio for highest paid director	7.4:1	5.6:1	4.4:1

Pension related benefits (subject to audit)

Senior managers' pension benefits

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 2026	Lump sum at retirement age related to accrued pension at 31 March 2026	Cash Equivalent Transfer Value at 31 March 2026	Cash Equivalent Transfer Value at 31 March 2025	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
Ms Alison Smith, Chief Executive (from 08 September 2025)	5.0 - 7.5	-	50 - 55	-	962	757	107
Mrs Liz Romaniak, Director of Finance, Information and Estates	2.5 - 5.0	2.5 - 5.0	70 - 75	180 - 185	1,641	1,549	73
Dr Kedar Kale, Medical Director	7.5 - 10.0	17.5 - 20.0	60 - 65	150 - 155	1,387	1,196	167
Dr Sarah Dexter-Smith, Director of People and Culture	2.5 - 5.0	0.0 - 2.5	45 - 50	110 - 115	1,041	979	47
Mrs Beverley Murphy, Deputy Chief Executive & Chief Nurse (deputy from	5.0 - 7.5	-	5 - 10	-	97	0	76

14 April 2025, acting Chief Executive from 20 June 2025 to 07 September 2025))							
Mrs Kathryn Ellis, Interim Executive Director of Transformation and Strategy (from 22 April 2025)	0.0 - 2.5	-	35 - 40	80 - 85	667	637	14
Dr Hannah Crawford, Director of Therapies	2.5 - 5.0	2.5 - 5.0	45 - 50	120 - 125	1,119	1,028	75
Mrs Ann Bridges, Director of Corporate Affairs and Involvement	0.0 - 2.5	-	10 - 15	-	170	129	25

*NHS Business Services Authority provided a correction to the 2024/25 pension information for Dr Kedar Kale. The movements reported above are calculated using the updated amounts.

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members. Any executive members not showing in the above table are not in the NHS Pension Scheme.

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.

Expenses of Governors

At 31 March 2026 the trust had 37 Governors (31 March 2025, 30), with 15 receiving reimbursement of expenses (2024-25, 6). The total amount reimbursed as expenses was £1,789, (£1,592 in 2024-25).

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 three months.

Alison Smith

Chief Executive

25 June 2026

The Staff Report

Staff costs (Group - subject to audit)

Staff costs

	Group			
			2025/26	2024/25
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	339,957	29,833	**369,790**	346,036
Social security costs	39,693	3,395	**43,088**	32,770
Apprenticeship levy	1,539	136	**1,675**	1,611
Employer's contributions to NHS pension scheme	61,376	5,428	**66,804**	62,838
Pension cost - other	283	(2)	**281**	370
Temporary staff	-	7,712	**7,712**	11,555
Total staff costs	**442,848**	**46,502**	**489,350**	**455,180**
Of which				
Costs capitalised as part of assets	446	164	**610**	1,290

Average number of employees (WTE basis)

	Group			
			2025/26	2024/25
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	333	128	**461**	459
Administration and estates	1,689	69	**1,758**	1,747
Healthcare assistants and other support staff	2,006	313	**2,319**	2,085
Nursing, midwifery and health visiting staff	2,354	170	**2,525**	2,789
Scientific, therapeutic and technical staff	627	242	**868**	834
Social care staff	107	-	**107**	138
Other	12	-	**12**	12
Total average numbers	**7,127**	**922**	**8,050**	**8,064**
Of which:				
Number of employees (WTE) engaged on capital projects	11	-	**11**	22

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.

	Male	Female
Directors	**6**	**10**

Directors & associate directors	**13**	**31**
Senior Managers		
• Band 8c	32	96
• Band 8d	12	17
• Band 9	3	7
• Personal Salary	17	17
All employees	1798	6548

Sickness and absence data (Trust)

Information on sickness absence up to and including December 2025 for the trust is available online at the address below:

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

Staff Policies and Actions Applied During the Year

Policies for giving full and fair consideration to applications for employment made by disabled persons having regard to their particular aptitudes and abilities

The trust remains committed to being an inclusive employer and to ensuring that disabled applicants are treated fairly and equitably throughout the recruitment process. Our Recruitment and Selection Procedure - fully equality-impact assessed - continues to underpin all recruitment activity and ensures that no applicant is disadvantaged due to disability. As a Disability Confident employer, we guarantee an interview to all applicants with a disability who meet the essential criteria for the role.

Reasonable adjustments are routinely asked about and supported during all stages of the recruitment process, supported by our dedicated, permanent Reasonable Adjustments Team and, where appropriate, through signposting to Access to Work. Recruiting managers are required to proactively consider any adjustment needs for new starters, ensuring a smooth and supported transition into employment.

Policies for the continuing employment of, and arranging appropriate training for, employees who become disabled during the period

The trust is committed to retaining colleagues who acquire a disability or long-term health condition during their employment. Our Workplace Adjustments Procedure, supported by the Reasonable Adjustments Team and Occupational Health, ensures that colleagues receive timely guidance and the adjustments necessary to continue in meaningful employment.

Where an individual is unable to continue in their current role, we work collaboratively with them to explore redeployment to alternative suitable employment within the trust. Individual workplace adjustment plans are used to document and review agreed adjustments, ensuring colleagues are able to access training, perform their duties effectively, and continue to progress in their careers.

The Long term health conditions staff network is sponsored by one of our executives and supports revisions to policies, including the Staff health, wellbeing and attendance procedure which has been reviewed this year.

Policies for the training, career development and promotion of disabled employees

The trust is fully committed to providing equitable access to learning, development and progression opportunities for all colleagues, including those with disabilities and long-term health conditions. Our Reasonable Adjustments Team works closely with staff and managers to ensure colleagues can participate fully in mandatory and developmental training through tailored support and accessible learning environments.

Career development forms part of our People Journey and is strengthened through the TEWV Leadership and Management Academy, which promotes inclusive leadership and supports the creation of accessible pathways for career progression. These arrangements help ensure that disabled colleagues are not disadvantaged in opportunities for development or promotion. Personal and professional growth programmes were also facilitated, ensuring colleagues have the support to align career and wider life choices. And our new people management programme integrates meeting the needs of all colleagues across their career lifespan.

Actions taken to provide employees systematically with information on matters of concern to them as employees

The trust continues to prioritise clear, timely and accessible communication with colleagues. Throughout the year, staff received regular updates on matters of significance through the weekly staff briefing, the staff intranet, and executive led webinars, supported by other senior leaders and frontline staff to ensure a breadth of voices are heard.

“Working Together in Our trust” sessions were held monthly, providing colleagues with opportunities to discuss employment-related matters directly with the director of people and culture and other senior leaders. These sessions also enabled the sharing of progress against workforce plans and organisational priorities, ensuring staff remained informed and engaged, including work undertaken in response to the National Staff and Pulse surveys.

Quarterly sessions are also held for all senior leaders and managers, providing opportunity for updates and discussions about emerging matters of importance across the trust.

Actions taken to consult employees (or their representatives) on a regular basis

The trust maintains well-established consultation arrangements to ensure that colleagues and staffside representatives are engaged meaningfully in decisions that affect them. Local Consultative Committees (LCCs) were held regularly within each care group and corporate service area, supported by the Joint Consultative Committee (JCC), which met bi-monthly and included full staffside representation.

The Pay and Workforce Group - reporting into the JCC - continued to provide a structured forum for negotiating workforce-related local agreements. Staff networks, each sponsored by an executive director, met bi-monthly with the Director of people and culture to ensure that the views and experiences of diverse colleague groups informed trust policy and practice.

For formal organisational change processes, the trust followed its Organisational Change Procedure, which included group and one-to-one consultation meetings, and invited contributions from affected staff and staffside partners prior to the implementation of any changes. These arrangements ensured colleagues’ views were considered in all matters likely to affect their employment.

Encouraging the involvement of employees in the trust’s performance

All staff are supported with regular managerial supervision (and clinical when relevant to their role) and an annual appraisal. During this appraisal, the staff member's objectives are reviewed in relation to the wider team's purpose and impact and any areas of support that are needed are identified. Senior Leaders and Managers meet together with executives quarterly to discuss national, regional and organisational priorities and the implications for local services. Those operational, clinical and corporate leaders are then able to work with their services on alignment across the trust. Alongside this, the regular quality and performance reviews which take place locally and then up to executive and board, ensure that objectives mitigate areas of risk or reduced effectiveness.

Health and Safety

During the reporting period, 53 RIDDOR-reportable incidents were submitted to the Health and Safety Executive (HSE). Each incident was reviewed in accordance with the Health and Safety Team's incident management procedures, with recurrence prevention measures documented and corresponding actions identified as part of the review process.

One of the main factors driving our upcoming programme is the formal implementation of the NHS Health and Safety Standards. These national standards give us the ability to assure ourselves about the quality of the trust's health and safety culture, guaranteeing consistent scrutiny and risk assessments across all services. The decision to adopt these standards was approved by the Executive Directors Group, Resource and Planning Committee, and the Board of Directors.

In 2026/27, a board strategy and action plan will be created. This strategy will tackle any identified gaps with targeted action plans, informed by Health and Safety audits and gap analyses, and will encourage active involvement at Board level.

Compliance with Health and Safety Mandatory Training remains consistent and stands at 92%, against a target of 85%.

A heightened focus will be maintained throughout 2026/27 on Management of Violence and Aggression, as well as Lone Working risk assessments. An audit programme is currently in progress to inform a comprehensive trust-wide improvement plan. This plan will incorporate proportionate control measures to ensure full compliance with legal requirements and effective management of operational risks.

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 the 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 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 2025/26 the trust continued to run the internal transfer scheme whilst opening this further to more roles. The introduction of a mutually agreed resignation scheme (MARS) has had the largest effect on driving up our leavers numbers, with our overall turnover rate remaining stable over the last year.

Further information on staff turnover can be found at the link below:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/january-2026

NHS Staff survey results

Staff Experience and Engagement

The following principles describe how we 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 in TEWV has a voice, meaning colleagues feel heard when they raise concerns or ideas and can see that their feedback is acknowledged and acted upon
  - Working with service users and carers to better understand how we can support our colleagues to deliver an excellent experience of care.
  - Collaborating with partners across the region, including education and training providers, social care and the voluntary sector to ensure our workforce is skilled, innovative and emotionally astute.
  - Building strong connections with our local communities to create supportive and appealing pathways into employment across the wide range of roles we offer now and in the future.
- **Value-based**
  - Grounded in our core values of Respect, Compassion and Responsibility, shaping how we work, how we behave and how the organisation is led.
- **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 carried out annually. Since 2021/22, the questions have been aligned to the seven elements of the NHS People Promise, while retaining the two previous themes of engagement and morale. These replaced the ten indicator themes used in 2020/21 and earlier years. All indicators are scored out of 10, with each indicator score calculated as the average of its related question.

Within the 2025 benchmarking group of 48 organisations, the median response rate was 52%. Response rates ranged from a low of 38.85% to a high of 73.12%, with an overall average of 51.72%. TEWV achieved a response rate of 52% (an improvement from 44% in 2024). For the 2025 survey, TEWV used a mixed-mode approach, including paper surveys targeted specifically at Estates and Facilities staff. While this method increased responses for this group by 78 (from 200 in 2024 to 278 in 2025), the additional cost associated with paper surveys means the approach will need to be carefully considered for 2026.

Scores for each indicator together with that of the survey benchmarking group

Indicators ('People Promise' elements and themes)	2025		2024	
People Promise:	**Trust Score**	**Benchmarking Group**	**trust Score**	**Benchmarking Group**
We are compassionate and inclusive	7.55	7.61	7.49	7.93
We are recognised and rewarded	6.37	6.37	6.37	6.90

We each have a voice that counts	6.85	6.89	6.92	7.34
We are safe and healthy	6.38	6.34	6.37	6.70
We are always learning	5.84	5.83	5.77	6.45
We work flexibly	6.61	6.84	6.58	7.25
We are a team	7.02	7.17	7.00	7.47
Staff engagement	6.87	7.02	6.94	7.45
Morale	6.11	6.12	6.07	6.61

	2025	
	Trust score	**Benchmarking group score**
Workforce Race Equality Standard (WRES) - White Staff Responses. All other ethnic groups Responses		
Percentage of white staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months (3797*) **All other ethnic groups** (391*)	20.6% 33.5%	21.38% 33.83%
Percentage of white staff experiencing discrimination at work from manager/team leader or other colleagues in the last 12 months: Responses (3772*) **All other ethnic groups:** Responses (383*)	5.51% 13.05%	5.8% 12.69%
Workforce Disability Equality Standards (WDES) - Staff with a long-term condition (LTC) or illness. Staff without a long-term condition or illness		
Percentage of staff with a LTC or illness experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months: Responses (1459*)	24.61%	27.24%

Percentage of staff without a LTC or illness: Responses (2674*)	20.34%	22.13%
Percentage of staff will a LTC or illness experiencing harassment, bullying or abuse from managers in the last 12 months: Responses (1448*)	8.70%	11.55%
Percentage of staff without a LTC or illness: Responses (2647*)	5.18%	5.74%
Advocacy		
Care of patients/service users is my organisations top priority	77.56%	75.94%
I would recommend my organisation as a place to work	58.13 %	64.00%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	57.79%	64.45%
Inclusion		
I have a strong personal attachment to my team	65.11%	66.08%
Autonomy		
I have a choice in deciding how to do my work	61.01%	62.31%
Raising Concerns		
I feel safe to speak up about anything that concerns me in this organisation	66.89%	64.89%
Appraisals		
My appraisal helped me agree clear objectives for my work	34.52%	36.37%
Work-Life Balance		
My organisation is committed to help me balance my work and home life	53.69%	58.41%

- We are ranked #11 against 19 Mental Health (MH) Trusts for final response rate, who commission Picker for the survey. This is compared to #12 in 2024 (against 21 MH Trusts).
- We are ranked #2 in overall positive score change, building on the #1 improvement in 2022.

Compared to 2024, our most improved scores (+3% or more) for 2025:-

- Don’t work any additional paid hours per week for this organisation, over and above contracted hours (+6%)
- Feedback given on changes made following errors/near misses/incidents (+4%)

- I can eat nutritious and affordable food at work (+3%)
- Organisation ensure errors/near misses/incidents do not repeat (+3%)

A dedicated Managers Resource Pack, which includes a helpful toolkit, has been developed to support managers in working with their teams on the staff survey results. The pack provides practical guidance, tools and prompts to help teams explore their results together, hold constructive discussions, and co-develop focused actions for improvement.

How we responded to the 2024 Results

- Developed and rolled out the People Management Programme.
- Secured permanent funding for the Reasonable Adjustments Team.
- Reviewed and streamlined mandatory and statutory training across all staff groups – with further work ongoing.
- Reviewed key HR policies, including Conduct/ Disciplinary, Capability and Health, Wellbeing and Attendance.
- Introduced new Occupational Health and Freedom to Speak Up providers.
- Made the internal transfer scheme a permanent, year-round process rather than two 'windows' per year.
- Updated and improved the Star Awards criteria.
- Continued work to strengthen responses to violence and aggression, sexual misconduct, and racism.
- Expanded out offer of Aspiring Leaders and Personal/Professional Growth Programmes.

Focus areas for 2026

- Strengthening our flexible working approach to ensure it is fair and transparent for everyone
- Continuing to embed the people management programme. Currently four cohorts underway and will be rolled out to all Band 5 and above staff
- Strengthening support to services when colleagues are off work, ensuring all appropriate options are fully considered

Consultancy Costs

Expenditure on consultancy costs was zero during 2025-26. There was consequently no requirement to seek national NHSE approval for management consultancy work costing £50k or above.

Off-payroll arrangements (trust)

Highly-paid off-payroll worker engagements as at 31 March 2026 earning £245 per day or greater:

	Number
Number of existing engagements as of 31 March 2026	19
Of which:	
The number that have existed for less than 1 year at the time of reporting	1
The number that have existed for between 1 and 2 years at the time of reporting	7
The number that have existed for between 2 and 3 years at the time of reporting	5
The number that have existed for between 3 and 4 years at the time of reporting	2
The number that have existed for 4 or more years at the time of reporting	4

All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater

	Number
Number of off-payroll workers engaged during the year ended 31 March 2026	44
Of which:	
Number not subject to off-payroll legislation	0
Subject to off-payroll legislation and determined as in-scope of IR35	44
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 2025 and 31 March 2026

	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.	13

Exit packages (Group-subject to audit)

During 2025-26 three trust employees retired early on the grounds of ill health; the value of these early retirements (provided by NHS Pensions) was £0.05m.

Reporting of compensation schemes - exit packages 2025/26

During 2025-26 the trust offered access to Mutually Agreed Resignation Schemes (MARS) in two separate phases. 87 applications were accepted, at a cost of £2,658k (2024-25, nil). These are classified as "other departures" in the tables below.

A MARS is a form of voluntary severance designed to enable employees, in agreement with their employer, to choose to leave their employment voluntarily in return for a severance payment. The scheme operates within boundaries approved by HM Treasury and is intended to give greater flexibility to organisations in managing cost reductions and change given the challenging financial context.

	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	-	18	**18**
£10,000 - £25,000	1	25	**26**
£25,001 - 50,000	-	24	**24**
£50,001 - £100,000	1	19	**20**
£100,001 - £150,000	1	1	**2**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**4**	**87**	**91**
Total cost (£)	£379,000	£2,722,000	**£3,101,000**

Reporting of compensation schemes - exit packages 2024/25

	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 resource cost (£)	£0	£0	**£0**

Exit packages: other (non-compulsory) departure payments

	2025/26		2024/25	
	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	87	2,658	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	2	64	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT / DHSC approval	-	-	-	-
Total	**89**	**2,722**	**-**	**-**
Of which:				
Non-contractual payments requiring HMT / DHSC 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 website (https://gender-pay-gap.service.gov.uk/employers/12077).

A copy of the 2025 gender pay gap report is are available on our trust website (https://www.tewv.nhs.uk/about/publications/tees-esk-and-wear-valleys-nhs-foundation-trust-gender-pay-gap-report-2025/), in addition the Ethnicity and Disability pay gap reports are included as part of this report.

Governance and the Code of Governance

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.

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 31 March 2026, including details of their qualifications, skills and expertise, is provided in the Accountability Report.

The Board considers that, as at 31 March 2026:

- 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 criteria for independence set out in the Code.

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.

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 31 March 2026, 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.

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 2025/26.

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.
- Where the extension is beyond six years, approval is given by NHS England.

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.

Under the Code of Governance any extensions to the terms of office of Board Members should be agreed by NHS England

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

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

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

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 (CQC) 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.

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 2025/26 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	Section
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 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.*	Overview of Performance
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.*	Performance Analysis (Assessing and Monitoring Culture)
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.*	Overview of Performance
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 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 Accountability Report (Statement on the Independence of each non-executive director)

	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.*	Governance & the Code of Governance (The Board of Directors/The Board Committees)
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.*	Governance & the Code of Governance (The Council of Governors/Resolution of Disputes with the Council of Governors)
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.*	Governance & the Code of Governance (The Nomination & Remuneration Committee of the Board/The Council of Governors Nomination and Remuneration Committee)
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.*	Governance & the Code of Governance (Appointments to the Board and how they can be terminated)
C 4.2	*The board of directors should include in the annual report a description of each director's skills, expertise and experience.*	The Accountability Report (Group Board Members as at 31 Marh 2026)
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.*	The Accountability Report (NHS England's 'well-led' Framework)
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*	Governance & the Code of Governance (The Nomination & Remuneration Committee of the Board/The Council of Governors Nomination and Remuneration Committee)f

	workforce and communities served • the gender balance of senior management and their direct reports.	
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.*	Governance & the Code of Governance (Governor involvement in the development of the forward plan)
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.	Governance & the Code of Governance (Statement on the Directors' responsibility for preparing the Annual Report and Accounts)
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.	Annual Governance Statement
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.	Annual Governance Statement
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.	Overview of Performance (Going Concern)
E 2.3	Where a trust releases an executive director, e.g. 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.	Governance & the Code of Governance (The Council of Governors – 1 April 2025 to 31 March 2026)
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.	Governance & the Code of Governance (Contacts)

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, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.~~94~~	Governance & the Code of Governance (Keeping informed of the views of governors and members)
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 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)	Not applicable

The Board of Directors

The following table provides details of the attendance at the 14 meetings of the Board of Directors held during 2025/26:

Board Member	Position	Number of meetings attended
Nini Adethuberu	Non-Executive Director (from November 2025)	5 (7)
Roberta Barker	Non-Executive Director Chair of Mental Health Legislation Committee Chair of People, Culture and Diversity Committee	12
Ann Bridges	Executive Director for Corporate Affairs and Involvement (non-voting)	9
Marie Burnham	Chair of the trust (from March 2026) Chair of the Board of Directors Nomination and remuneration Committee (from March 2026) Chair of the Roseberry Park Hospital Sub-Group (from March 2026)	1 (1)
David Butcher	Associate Non-Executive Director (non-voting) (from December 2025)	5 (5)
Zoe Campbell	Managing Director, NYYS Care Group (until November 2025)	7 (7)
Charlotte Carpenter	Non-Executive Director (to October 2025) Chair of Resources and Planning Committee	4 (7)
Hannah Crawford	Executive Director of Therapies (non-voting)	13

Sarah Dexter-Smith	Joint Executive Director for People and Culture (non-voting) (until October 2025) Executive Director for People and Culture (non-voting) (from October 2025)	8
Kathryn Ellis	Interim Executive Director of Strategy and Transformation (non-voting) (from May 2025)	12 (13)
Edward Gorringe	Associate Non-Executive Director (non-voting) (from December 2025)	4 (5)
David Jennings	Chair of the trust (until May 2025) Chair of the Board of Directors Nomination and remuneration Committee (until May 2025) Chair of the Roseberry Park Hospital Sub-Group (until May 2025)	1 (1)
Kedar Kale	Executive Medical Director	12
Brent Kilmurray	Chief Executive (until April 2025)	1 (1)
Naomi Lonergan	Interim Managing Director, DTVF Care Group and (from November 2025) Interim Care Group Managing Director	11
John Maddison	Non-Executive Director Chair of Audit and Risk Committee Chair of Resources and Planning Committee (from November 2025)	14
Beverley Murphy	Chief Nurse Interim Deputy Chief Executive (from April 2025 to 2025) Interim Chief Executive (from June 2025 to September 2025) Deputy Chief Executive (from September 2025)	14
Kate North	Joint Executive Director for People and Culture (non-voting) (until October 2025)	3 (5)
Jules Preston	Non-Executive Director Senior Independent Director Chair of Charitable Funds Committee Chair of Quality Assurance Committee	14
Bev Reilly	Non-Executive Director Chair of Quality Assurance Committee (until May 2025) trust Chair (from May 2025 to March 2026) Chair of the Board of Directors Nomination and Remuneration Committee (from May 2025 to March 2026)	12

	Chair of the Roseberry Park Hospital Sub-Group (from May 2025 to March 2026)	
Jane Robinson	Non-Executive Director	8 (10)
Liz Romaniak	Executive Director for Finance, Estates and Facilities	11
Patrick Scott	Assistant Chief Executive (until May 2025) Interim Chief Executive (May 2025 to June 2025)	3 (5)
Alison Smith	Chief Executive (from October 2025)	7 (9)
Catherine Wood	Non-Executive Director	14

NOTE: The maximum number of meetings to be attended by those Board members who held officer during part of the year is shown in brackets.

Keeping informed of the views of governors and members

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

- Attendance by Board Members at meetings of the Council of Governors.
- 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 at the Annual General and Members' meeting.
- Governors encouraged to observe public Board meetings.
- Regular liaison between the Chair and the Lead Governor.
- Sub-committees to involve governors on subjects such as membership.
- 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.

Board member attendance at meetings of the Council of Governors during the year was as follows:

Name	Attendance incl. AGM (No. of eligible meetings)
Nini Adetuberu	1 (1)
Roberta Barker	3*
Ann Bridges	4
David Butcher	1 (1)
Zoe Campbell	2 (5)
Charlotte Carpenter	1 (5)

Hannah Crawford	3*
Sarah Dexter-Smith	4
Kathryn Ellis	3*
Edward Gorringe	1 (1)
Kedar Kale	3*
Naomi Lonergan	3*
John Maddison	4*
Beverley Murphy	5 *
Kate North	0 (3)
Jules Preston	6
Bev Reilly	5
Jane Robinson	2
Liz Romaniak	4*
Patrick Scott	0 (1)
Alison Smith	3 (3)
Catherine Wood	5*

(Notes:*The maximum number of meetings to be attended by those Board members who held officer during part of the year is shown in brackets.*

Only Bev Reilly, as the Interim Chair and Jules Preston, Senior Independent Director were required to attend one of the six meetings due to the nature of the business to be transacted)

Evaluating Board performance and the performance of individual directors

The performance of the Board, and its committees, is evaluated by:

- regular independent reviews
- annual surveys of Board members

The last external review was commissioned from Deloitte LLP in 2023/24. The firm has no other connection with the trust or individual Directors.

Individual performance appraisals and the setting of objectives, in accordance with guidance published by NHS England, are conducted by:

- The Senior Independent Director for the Chair
- The Chair for the Chief Executive

- The Chair for the non-executive directors
    - (Note: the appraisal of Bev Reilly for 2025/26 will be conducted by the Senior Independent Director in view of her being the Interim Chair for the majority of the year)
- The Chief Executive for the executive directors

The outcomes of the appraisals are reported to the Board and Council of Governors' Nomination and Remuneration Committees.

The Board Committees

As of 31 March 2026 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 2025/26, can be found at our website.

The Audit and Risk Committee

The membership of the Audit and Risk Committee consists of four independent Non-Executive Directors (from December 2025). 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 1 September 2020 and is a former Executive Director of Finance with significant NHS experience.

There were five formal meetings during 2025/26. Attendance was as follows:

Committee Member	No. of meetings attended
John Maddison (Chair)	5
Charlotte Carpenter	0 (3)
Jules Preston	5
Catherine Wood*	2 (2)

Nini Adetuberu	2 (2)
Davie Butcher	1 (1)

Notes: The maximum number of meetings to be attended provided in brackets.

C Wood attended as a pro temp member on behalf of Charlotte Carpenter for three meetings.

Bev Reilly, Acting Chair of trust/Non-Executive Director attended as an observer in June 2025 and March 2026.

Liz Romaniak, the Executive Lead, attended all five meetings held during the year.

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 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, including as reported through an annual self-assessment against their standards.

The Committee met its responsibilities during 2025/26 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 and with reference to assurances reported from the Executive Risk Group.
- Monitoring progress with the embeddedness of the risk management framework.
- Reviewing risk and internal control-related disclosures, such as the Annual Governance Statement (for the 2024/25 annual accounts).
- Receiving the Local Counter Fraud Annual Report for 2024/25.
- Reviewing the work and findings of the Local Counter Fraud Specialist for 2025/26 and progress to deliver their agreed annual plan for proactive and reactive work.
- Receiving the Head of Internal Audit Opinion for 2024/25 and considering learning from related planning arrangements to agree improvements for 2025/26.
- Reviewing the work and findings of Internal Audit, including consideration and approval of the 2025/26 Internal Audit 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 2025/26 Internal Audit plan to target a timely and well-informed Head of Internal Audit Opinion.
- Reviewing the work and findings of External Auditors, Forvis Mazars LLP, on their audit of the 2024/25 annual accounts audit and their plan for the 2025/26 annual accounts audit.
- Reviewing the process by which clinical audit is undertaken, which is also reported into the Quality Assurance Committee.
- Reviewing compliance with the NHS England, Emergency Preparedness Resilience and Response (EPRR) core standards, and considering the further actions necessary to bolster business continuity arrangements and improve overall compliance.

- Reviewing the 2024/25 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.
- Having oversight of the findings and conclusions of the External Auditor following their Independent Review of the Charitable Funds 2024/25 Annual Report and Accounts.
- Receiving assurance from presentation of detailed planning processes for production of the 2025/26 Annual Accounts and Annual Report, that robust arrangements are in place to ensure timely and accurate content that meets regulatory and other requirements.
- Seeking assurance from the Executives that the 2025/26 financial statements should be appropriately compiled on a going concern basis and making such a recommendation to the Board.
- 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.
- Receiving a report on the outcome from 2025 Performance Evaluation assessments completed by all Committees on their overall effectiveness as against their terms of reference and to note the suggested areas for improvement to be addressed by each.
- Providing alerts, assurance and escalations to the Board following each of its meetings.

The External Auditors

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

Following a competitive tendering process exercise in 2022/23, overseen by the Audit and Risk Committee Chair 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) and subsequently extended by Governors.

The cost of providing external audit services during 2025/26 was £104k 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.

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

The Internal Auditors

Internal audit services are provided by AuditOne; a not-for-profit provider of internal audit, technology risk assurance and counter 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.

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 determining their terms and conditions of service (where they are not determined nationally).

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.

Membership of the committee comprises the Chair of the trust, who Chairs the committee, and all Non-Executive Directors. The Chief Executive is an ex-officio member of the committee in relation to all matters concerning the appointment to those director positions (excluding the role of the Chief Executive) which fall within its remit.

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

Committee Member	Meetings attended
David Jennings (trust Chair)	0 (2)
Bev Reilly (Interim trust Chair from May 2025)	6
Nini Adethuberu	1 (2)
Roberta Barker	7
David Butcher	2 (2)
Charlotte Carpenter	0 (4)
Edward Gorringe	0 (2)
John Maddison	6
Jules Preston	6
Jane Robinson	4 (5)
Catherine Wood	7

Note: The maximum number of meetings to be attended provided in brackets.

During 2025/26 the committee:

- Oversaw the recruitment, and agreed the remuneration, of the new Chief Executive, with a recommendation made to Council of Governors for approval.
- Agreed interim executive arrangements, pending the appointment of the new Chief Executive.
- Received assurance on the performance of executive directors following 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 and the new executive pay framework.
- Considered proposals by the Chief Executive in relation to the executive structure, to go out for consultation.
- Agreed the appointment of a Director of Programmes.

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

- Brent Kilmurray, Chief Executive (to April 25)
- Patrick Scott, Interim Chief Executive (from May 25 to July 25)
- Alison Smith, Chief Executive (from September 25)
- Phil Bellas, Company Secretary
- Karen Christon, Deputy Company Secretary
- Sarah Dexter-Smith, Executive Director for People and Culture
- Robin Staveley, Senior Partner, Gatenby Sanderson (The firm 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 '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 Standards and any statutory Codes of Practice.

The Committee held three meetings and two development days held during 2025/26. Attendance at the formal meetings was as follows:

Committee Member	No. of meetings attended
Roberta Barker (Chair)	3
Catherine Wood	3
Jules Preston	1 (1)
Nini Adetuberu	0 (1)
Zoe Campbell	2 (2)
Kedar Kale	3
Naomi Lonergan	2
Beverley Murphy	Eve Newbury, Associate Director of Nursing attended meetings on her behalf

Notes: The maximum number of meetings to be attended provided in brackets.

The lived experience directors are invited to the meetings to facilitate patient/service user and carer input to the matters discussed.

During 2025/26 the Committee:

- Received good assurance that the legislative requirements for patients held in the trust on section 136 are being met.
- 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 nurse or doctor may prevent a patient from leaving hospital if they consider it is necessary for their health or safety). The Internal Mental Health Operational Groups or have been looking at variation across services as there is a much higher use of Section 5 with female patients.

The People, Culture and Diversity Committee

The People, Culture and Diversity Committee is responsible for providing oversight and assurance that the trust understands its strategic workforce needs (including wellbeing, culture, recruitment, retention, development of people, and organisational capacity) and the development and monitoring of delivery plans. The strategic direction for workforce needs builds on the trust's previous 'People Journey') and is aligned to the National strategic plans.

Membership of the committee comprises a Non-Executive Director (Chair), one other Non-Executive Director, the Executive Director of People and Culture, the Executive Director of Corporate Affairs and Involvement, the Executive Director of Therapies, the Interim Managing Director of Durham Tees Valley and Forensics and North Yorkshire and York Care Groups.

The Committee invites a colleague to present their story at the start of each meeting for 20 minutes.

As part of the strong partnership agreement with the Trades Unions, Staff side Chair and Deputy Chair are standing attendees.

The Committee held three formal meetings during the year and two informal meetings. Attendance at the formal meetings was as follows:

Committee Member	No of meetings attended
Roberta Barker (Chair)	3
Sarah Dexter-Smith	3
Jules Preston	2 (2)
Jane Robinson	1 (2)
Ann Bridges	1
Edward Gorringe	1 (1)
Kate North	1 (1)
Naomi Lonergan	1
Hannah Crawford	1
Zoe Campbell	0 (2)

Note: The maximum number of meetings to be attended provided in brackets.

During 2025/2026 the Committee:

- Considered regular reports on the risks aligned to the Committee to monitor risk review compliance and trajectories. Overall, there is good assurance in respect of the risk management processes in place.
- Discussed regular reports on the assurance rating for the 'Safe Staffing' risk (BAF ref 1) which remained, overall, as good. Whilst the risk score has not tracked its planned trajectory to reduce across the year, the implementation of mechanisms for tracking deployment of staff against workforce plans and the development of speciality and corporate workforce plans will reduce this risk score. In addition, further work will be progressed in relation to culture and in response to the Staff Survey to mitigate risks. Controls for this BAF risk have increased through the year.
- Discussed regular reports on Workforce Delivery Strategy. Examples of progress include: the small Reasonable Adjustments team receiving funding on a permanent basis to support colleagues and improve the trust's ability to meet statutory requirements; the final Appraisal audit having a good assurance rating; the increase in the completion rate from 44% to 52% for the national staff survey and the trust identified as the second most improved Mental Health/Learning Disability trust of those organisations using Picker; Agency use continuing to reduce in line with regional targets, including reductions in medical use due to stricter controls being put in place; the trust's first Mutually Agreed Resignation scheme (MARS) completing with 56 colleagues leaving by the end of December 2025; Estates and Facilities Management continuing to ensure the trust is able to meet both the requirements of the Supreme Court gender ruling and ensure all staff have dignified access to toilet/changing facilities where possible.
- Considered regular reports on the culture of the organisation. Examples of progress include the good level of assurance on the link between the indicators for a strong and healthy culture aligned with trust values and the interventions, such as the new people management programme through the trust's 'Leadership and Management Academy', the work on 'Belonging' and initiatives such as the introduction of a professional body for operational staff with the introduction of 'Proud2BeOps' and training of Practice Development Practitioners (PDPs) in resilience based clinical supervision, and the introduction of a new Freedom to Speak Up Service. However, there is only reasonable assurance that the interventions, based on the data provided, are achieving the impact expected.
- Agreed that there is good assurance that the trust has followed a robust process in recruiting, training, and inducting volunteers, with a total of 282 volunteers in the trust (2024/2025). Of these, 69% are from DTVF and 31% from NYY which compares to 63% and 37% respectively the previous year. Overall, there has been a 19% increase in volunteers from 2023/2024.
- Considered a number of detailed reports concerned with inclusion. There was good assurance that the trust had followed a robust process in analysing its staff data by protected group for Workforce Race Equality (WRES), Workforce Disability Equality (WDES), Sexual Orientation Workforce Equality (SOWES) Standards and Publication of Staff Equality Information. In doing so, the trust is meeting its NHS Standard Contract requirements and Equality Act duties. The following are areas of progress: the percentage of the workforce who identify as BAME is 9.7% compared with 7.9% the previous year, percentage of the workforce declaring a disability is 11.64% compared with 9.23% last year. In addition, there has been an increase in declaration rates for sexual orientation (92% declaration) and disability (89% declaration). The percentage of staff requiring reasonable adjustments who have them in place has increased from 74% to 77%. In addition, the trust can demonstrate, with substantial assurance, adherence to the statutory requirements of gender pay gap reporting, along with demonstrating commitment to equality through voluntarily undertaking ethnicity and disability pay gap reporting for 2025. Committee approved the ratification of the score of 2 (Developing) for the Equality Delivery System (EDS) 22 for 2025 and agreed to the publication of EDS 22 on the trust website as required by the NHS contract.
- Considered regular reports on Health and Wellbeing. Examples of activity include: a range of actions following the violence and aggression governance review - mapping violence and aggression information flows across the trust, identification of gaps in reporting on sexual safety/verbal aggression and some forms of physical violence; the development of an initial version of the violence and aggression dashboard via Inphase; review and agreement on a new criminal incident reporting procedure across the three police forces; a refreshed sexual safety assurance framework; completion of a sexual misconduct audit by February 2026. In addition, a new occupational health provider is in place and receiving largely positive feedback.
- Considered detailed updates on Workforce Planning. An initial Workforce Plan was submitted in December 2025 to the Integrated Care Board (ICB) based on the finance plan with reference to the clinical models work. The final submission of the Workforce Plan was in March 2026, which took into

account: the workforce implications of the three strategic shifts; technological advances and opportunities and potential impact on the workforce; and data from paired outcomes in high completion teams in each specialty, comparing workforce profiles with clinical impact.

- Received regular reports on the new external Freedom to Speak Up (F2SU) service provision (The Guardian Service) which is now successfully embedded in the organisation, following commencement of the new F2SU Guardian (Adam Howe) from November 2025. Contract management arrangements are in place within People and Culture.

The Quality Assurance Committee

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.

There were eleven meetings held during 2025/26. Attendance at these meetings was as follows.

Members	No. of meetings attended
Bev Reilly (Chair of Committee until May 2025 when she stepped into the role of Interim Chair of the trust)	2 (2)
Jules Preston	10 (11) Acting Chair on 5 occasions
John Maddison	5 (8) Acting Chair on 2 occasions
Catherine Wood	8 (11)
Jane Robinson	1 (11)
Nini Adetuberu	2 (2)
Edward Gorringe	0 (2)
Beverley Murphy	8 (11)
Kedar Kale	7 (11)
Hannah Crawford	8 (11)
Zoe Campbell	5 (6)
Naomi Lonergan	10 (11)

Notes:

The maximum number of meetings to be attended provided in brackets

During the period 20 June 2025 to 5 September 2025 Beverley Murphy was the Interim Chief Executive and the committee was attended by a senior nurse representative

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
- Use of Force

The Committee met its responsibilities during 2025/26 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 Directors 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
- The quality dashboard
- 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:

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, performance with making contact with people within 72 hours of discharge from inpatient care, compliance with mixed sex accommodation guidance, the prevalence of people using ligatures and the management of environmental risks to safety, accuracy of supervision recording, working effectively with local Police where there has been violence and aggression and the implementation of CiTO.

Over the period the committee has noted significant improvement in many of the areas discussed.

The Resources and Planning Committee

The purpose of Resources and Planning 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.
- 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.

The Committee held seven meetings during 2025/26. Attendance at these meetings was as follows:

Committee Member	No. of meetings attended
Charlotte Carpenter (Chair) To 1 October 2025	2 (2)
John Maddison (including as Interim Chair from October 2025)	7
Roberta Barker To December 2025	1 (3)
Jules Preston From January 2026	3 (4)
David Butcher From January 2026	4 (4)
Liz Romaniak	7
Ann Bridges	4

Note: The maximum number of meetings to be attended provided in brackets.

The Committee agreed:

- To recommend a Business Case for Phase 2 capital works at Roseberry Park Hospital for approval by the Board of Directors.
- To support trust involvement in an NHS led consortium contract to deliver services to the Ministry of Defence.
- To support submission of a tender for Children and Young People's Getting Help Services in the Tees Valley and recommend this for approval by the Board of Directors.
- To support the work of the Health and Justice service within the wider Yorkshire and North East North Cumbria region within previously agreed parameters.
- To proposed asset disposals to ensure continued progress on the trust's Estate Masterplan.
- To recommend to the Board of Directors the adoption of the NHS Health and Safety Standards and next steps to agree a related Board.
- To recommend procurement of a new Electronic Patient Record (EPR) system for approval by the Board of Directors, within resources identified in the trust's Medium Term Financial Plan.
- To approve a recommendation to the Board of Directors to replace the current Integrated Performance Dashboard measures on caseload with a new caseload measure.
- To award an alternative food supplier for the provision of Delivered Ready Prepared Meals, via the NHS Supply Chain Procurement Framework.
- To approve a recommendation to the Board of Directors that the profile for the Partnerships/System Working risk (BAF 9) and the profile for the new risk on Transformation (BAF 15) be formally included in the BAF.

The Committee considered:

- Links to national phased processes to develop Medium Term Plans, updates on the trust's underlying financial position and Deconstructing the Blocks workstreams and progress to develop the 2026/27 to 2028/29 Medium Term Plan (including Medium Term Financial Plan). It considered those plans, underpinning assumptions, productivity packs, and draft Board Assurance statements before plans were submitted for approval by the Board.
- Several Environmental Analysis reports and considered ways in which to influence system partners to enable the trust to become more effective, efficient and improve patient experience.
- Internal Audit reports on areas related to its work and progress to implement related follow up recommendations.
- Strategic and Corporate risks assigned to it by the Board at each meeting, including in relation to the Estate and Capital constraints, Digital Improvements and Cyber Security, Financial Sustainability, the EPR and Transformation.
- Analysis to provide assurance on Committee Metrics within the Board Integrated Performance Dashboard.
- EPR programme updates including on the critical path to develop and submit for their review, a business case for a new EPR, including the arrangements to ensure detailed oversight of the project and for the Project Board, with external procurement support and benefiting from oversight via the NHSE Digital team as part of their Frontline Digitisation work.
- An update on the Estates Master Plan and related workstreams.

The Committee received assurance:

- That the approach to cash management demonstrated strong financial governance.
- From Finance Reports at each meeting, about the effectiveness of actions to deliver better than planned performance and to develop and progress mitigation of projected risks to delivery of the break-even plan.
- From Medium-Term Plan/Financial Plan reports, that the trust had a robust integrated planning process in place to produce the related plan submissions in line with the NHS England Planning Framework.
- That a process was in place, aligned to the National Oversight Framework, to ensure the trust could complete a Provider Capability self-assessment on an annual basis.
- That work was on track to deliver the NHSE 2025/26 target to reduce 50% of corporate service cost increases since 2019/20 and to consider implications for 2026/27 plans.
- That the trust's Director of Finance, Estates and Facilities, as a member of a national a task and finish group considering Productivity and Efficiency, would seek to highlight issues impacting the

Mental Health sector and that NHSE representatives would visit the trust in March to discuss the same.

- That a robust procurement process for Secure Inpatient Transport had concluded and was expected to stabilise recurrent costs for the trust.
- On processes to complete and submit National Estates Return Information Collection (ERIC), Patient Led Assessments of the Care Environment (PLACE) and Premises Assurance Model (PAM) submissions, consider related outputs and develop, deliver and oversee annual improvement plans for each.
- That substantial savings had been made through efficiency plans within the Estates and Facilities Directorate, exceeding planned recurrent levels.
- From progress highlighted in Green Plan update reports, the assurance level had increased from limited to good.
- That, whilst nationally mandated bank cost reductions were lower than planned, this was more than offset by savings achieved from reducing premia rate agency and overtime shifts.
- That processes for the oversight and management of clinical sub-contracts were robust (with Quality Assurance Committee to consider clinical and quality issues).
- On detailed processes to ensure submission of a timely and accurate 2025/26 national cost collection submission, having approved the 2024/25 submission earlier in the year.
- On case studies that suggested PIPS Ltd (the trust's subsidiary company) had delivered meaningful support to individuals, the trust and system.

The Charitable Funds Committee

The Charitable Funds Committee was established by the Board of Directors in June 2024, and terms of reference were finalised and approved by the Board in December 2024.

The committee was established in response to a recommendation of Resources and Planning Committee that a separate committee was needed to provide 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. It does not remove from the Board overall responsibility but provides a forum for more detailed discussion and allows for direct contact with the Charity Commissioner via the Trustees of the Charity when necessary.

Committee is responsible for monitoring all aspects of charitable activity within the trust and maintaining oversight of the appropriate use of funds.

Membership of the committee comprises a Non-Executive Director (Chair), one other Non-Executive Director, the Executive Director of Finance, Estates and Facilities and the Executive Director of Corporate Affairs and Involvement.

Committee held two formal meetings during the year. Attendance at these meetings was as follows:

Committee Member	Meetings attended
Jules Preston (Chair)	2
Jane Robinson	2
Ann Bridges	2
Liz Romaniak	1

Note: The maximum number of meetings to be attended provided in brackets.

During 2025/26 the committee:

- Considered the Charitable trust Annual Report and Accounts and recommended to Audit and Risk Committee that the Charitable Fund could be considered a going concern.
- Considered the reclassification of funds as 'restricted' in the annual report and accounts, to reflect where donations had been made to a particular geography or service area. This took into consideration Charities Commission guidance and was subsequently verified by the external auditor.
- Reviewed quarterly transactions to provide assurance to Board on appropriate use of the funds.
- Agreed to delegate authority to the Executive Director of Corporate Affairs and Involvement or the Executive Director of Finance, Estates and Facilities to approve applications to funds administered by Trustees over £10,000, to ensure they are considered in a timely manner.
- Agreed the creation of a Fundraising Officer post, who will cocreate a charity brand identity and web presence and establish internal procedures and a digital platform for donations.
- Agreed to recommend to Executives and Audit and Risk Committee that it would be appropriate to schedule an Internal Audit of Charitable Funds in the 2025/26 Audit Plan (ending June 2026).
- Discussed opportunities to repurpose agreed laptops, where they could not be used to trust standards, including to the benefit of external community or charitable bodies.
- Received feedback from the North East and North Cumbria Integrated Care Board (ICB) Charity Chairs and Senior Officers meeting, which provided an opportunity for learning and to consider collaborative activity.

Advice was provided to the committee by:

- John Chapman, Associate Director of Finance

- Steven Forster, Head of Technology Services

The Council of Governors – 1 April 2025 to 31 March 2026

Governors in post from 1 April 2025 to 31 March 2026

Type	Constituency / Class / Organisation	Name	Term of Office (From – To)	CoG meeting attendance incl. AGM (No. of eligible meetings)
Public	Darlington	Andrea Goldie	01/07/2025 - 30/06/2028	2 (5)
Public	Darlington	Joan Kirkbride	01/07/2023 - 30/06/2026	6 (6)
Public	Middlesbrough	Mary Booth	01/07/2023 - 30/06/2026	6 (6)
Public	Middlesbrough	Tony Morris	01/07/2025 - 30/06/2028	1 (5)
Public	Middlesbrough	Alicia Painter	01/07/2022 - 30/06/2025	0 (1)
Public	North Yorkshire	Gemma Birchwood	01/09/2023 - 30/06/2026	4 (6)
Public	North Yorkshire	John Green	01/07/2025 - 30/06/2028	4 (6)
Public	North Yorkshire	Hazel Griffiths	01/07/2022 - 30/06/2025	1 (1)
Public	North Yorkshire	Cathie Hague	01/07/2025 - 30/06/2028	4 (5)
Public	North Yorkshire	John Venable	01/07/2025 - 30/06/2028	2 (5)
Public	North Yorkshire	Judith Webster	01/07/2023 - 30/06/2026	6 (6)
Public	Redcar and Cleveland	William Lambert	01/07/2025 - 02/07/2025	0 (0)
Public	Stockton-on-Tees	Gary Emerson	01/07/2023 - 30/06/2026	6 (6)
Public	Stockton-on-Tees	Gillian Restall	01/07/2023 - 30/06/2026	6 (6)
Public	Stockton-on-Tees	Judy Williams	01/07/2025 - 30/06/2028	4 (5)

Public	Durham	Joan Aynsley	01/07/2023 - 30/06/2026	4 (6)
Public	Durham	Joanne Bell	01/07/2025 - 30/06/2028	2 (5)
Public	Durham	David Coombs	01/07/2024 - 30/06/2027	2 (6)
Public	Durham	Pamela Coombs	01/07/2023 - 30/06/2025	1 (1)
Public	Durham	Kevan Gillan	01/07/2025 - 30/06/2028	2 (5)
Public	Durham	Nicola Hutchinson	01/07/2025 - 30/06/2028	3 (5)
Public	Durham	Eric Kengne Tatuene	01/07/2025 - 30/06/2028	2 (5)
Public	Durham	Jacci McNulty	01/07/2024 - 30/06/2027	4 (6)
Public	Durham	Graham Robinson	01/07/2022 - 30/06/2025	0 (1)
Public	Durham	Stephen Thomas	01/07/2025 - 30/06/2027	4 (5)
Public	Durham	Jill Wardle	01/07/2023 - 30/06/2026	3 (6)
Public	Hartlepool	Jean Rayment	01/07/2022 - 30/06/2025	0 (1)
Public	Hartlepool	Zoe Sherry	01/09/2023 - 30/06/2026	5 (6)
Public	City of York and Rest of England	Christine Hodgson	01/07/2025 - 30/06/2028	3 (5)
Public	City of York and Rest of England	Oliver Milner	01/07/2025 - 30/06/2028	0 (5)
Staff	North Yorkshire, York and Selby Care Group	Sarah Blackamore	01/07/2025 - 30/06/2028	1 (5)
Staff	Durham, Tees Valley and Forensics Care Group	Ashley Douglass	01/07/2024 - 30/06/2027	0 (3)
Staff	Durham, Tees Valley and Forensics Care Group	Karl Evenden-Prest	01/07/2024 - 30/06/2027	6 (6)
Staff	Corporate Directorates	Cheryl Ing	01/07/2024 - 30/06/2027	5 (6)

Staff	Durham, Tees Valley and Forensics Care Group	Heather Leeming	01/07/2024 - 30/06/2027	1 (6)
Appointed	Durham County Council	Lee Alexander	Appointed 03/01/2017	1 (6)
Appointed	University of York	Rob Allison	Appointed 01/04/2022	1 (6)
Appointed	Stockton-on-Tees Borough Council	Cllr Pauline Beall	Appointed 04/04/2024	4 (6)
Appointed	Hartlepool Borough Council	Cllr Moss Boddy	Appointed 07/11/2022	4 (6)
Appointed	City of York Council	Cllr Jo Coles	Appointed 28/05/25	3 (5)
Appointed	City of York Council	Cllr Claire Douglas	04/08/2023 - 28/05/2025	0 (1)
Appointed	Darlington Borough Council	Kevin Kelly	Appointed 13/08/2015	0 (6)
Appointed	University of Sunderland	Catherine Lee-Cowan	Appointed 27/10/2022	4 (6)
Appointed	Redcar and Cleveland Borough Council	Cllr Lisa Robson	Appointed 02/08/2023	0 (6)
Appointed	North Yorkshire County Council	Cllr Roberta Swiers	Appointed 20/03/2023	2 (6)

NOTE: The maximum number of meetings to be attended by those Governors who held officer during part of the year is shown in brackets.

Elections

The table below shows details for elections held in 2025/26

Constituency Name	Date of Election	Number of Seats	Number of candidates	Number of votes cast	Number of eligible voters	Turnout (%)
Staff Governors						
North Yorkshire, York and Selby Care Group	20/06/2025	1	1	-	-	-
Public Governors						
City of York and Rest of England	20/06/2025	3	2	-	-	-
Darlington	20/06/2025	1	1	-	-	-
Durham	20/06/2025	5	10	89	2,052	4.3%
Redcar and Cleveland	20/06/2025	2	1	-	-	-
North Yorkshire	20/06/2025	4	3	-	-	-
Hartlepool	20/06/2025	1	0	-	-	-
Middlesbrough	20/06/2025	1	4	32	1,033	3.1%
Stockton-on-Tees	20/06/2025	1	4	34	1,000	3.4%

The Council of Governors' Nomination and Remuneration Committee

The Nomination and Remuneration Committee supports the Council of Governors undertake its statutory role relating to the appointment and agreement of the terms and conditions of service, including remuneration, of the Chair and Non-Executive Directors.

Attendance at the six meetings of the Committee held during the year was as follows

Bev Reilly (Chair)	1
Jules Preston (SID)	6
Mary Booth (Public Governor)	5
Moss Boddy (Appointed Governor)	4 (4)

Gary Emerson (Public Governor)	6
Jill Wardle (Public Governor)	2 (4)

(Notes:

- The maximum number of meetings to be attended provided in brackets.
- Bev Reilly did not attend four meetings as they related to the appointment of the new Chair)

During 2025/26 the Committee

- Reviewed the remuneration of the Chair and non-executive directors
- Oversaw the recruitment of the new Chair, one new non-executive director and two associate non-executive directors. All the appointments were made through open competition with the recruitment supported by Gatenby Sanderson. The firm has no other connection to the trust or individual Directors.

The 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

Membership numbers for 2025/26

Public Members	
Total on 1 April 2025	**8,708**
New members (Includes 7 members who joined and left during 2025/26)	69
Members lost	58
Total on 31 March 2026	**8,719**

Staff Members	
Total on 1 April 2025	**7,882**
Total on 31 March 2026	**8,194**

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 involvement in the development of the forward plan

During 2025/26 Council of Governors has been engaged on the work of the trust to deliver its objectives and priorities, and in the trust's development of its Medium-Term Plan. Council of Governors receives updates from the Chair, Chief Executive and Non-Executive Directors on work of the trust Board and Board Committees, which includes oversight of the trust's Strategy, performance delivery and transformation.

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 (https://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 Oversight Framework

NHS England's NHS Oversight Framework 2025/2026 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

- Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity).
- Considering financial override which may limit a segment to be no better than 3.
- Contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and
- Capability assessments which consider the organisation's leadership and governance.

Segmentation

The trust has been placed in segment 2

This segmentation information is the trust's position as at 31 December 2025 (the latest segmentation published as at 31 March 2026).

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/nhs-oversight-framework/segmentation and-league-tables/. The trust is included on the non-acute hospital trust dashboard.

Modern Slavery Act statement

Human Rights, Equality Diversity and Inclusion Policy

As a leading employer and service provider, the trust is dedicated to promoting equality of opportunity and ensuring fair access and treatment throughout employment, service delivery, procurement, and partnership activities. The trust's human rights, equality, diversity, and inclusion policy outlines its obligations under the Equality Act and Human Rights Act. We uphold our commitment to equality, diversity, and inclusion by

supporting various equality network groups, each sponsored by an executive to ensure representation at Board level.

Recruitment and selection procedure

We manage recruitment internally using our own processes to make sure our policies are followed. All staff responsible for hiring must understand their legal duties under current employment laws. Agency workers go through the same careful checks as regular trust employees, such as DBS checks when needed, proof of eligibility to work in the UK, and verifying gaps in employment history. We collaborate with our counter fraud team to address any concerns or advice they offer, and we've organized events to raise staff awareness about fraud risks, especially during recruitment.

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 Tees Esk and Wear Valleys NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

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

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

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

Alison Smith
Chief Executive

Date: 25 June 2026

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

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

Capacity to handle risk

The trust's governance arrangements, including its systems of internal control and risk management, are designed to support, and provide continual assurance on, the delivery of Our Journey to Change – The Next Chapter including management of related strategic risks.

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 trust.

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 provide independent assurance to the Board on the processes underpinning risk management and internal control. As set out in the Annual Report, membership of this Committee is reserved 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 Risk Group (chaired by the Chief Executive), 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 with the support of the executive directors both individually, through their clear accountabilities for the delivery of their portfolios, and collectively, through the executive governance structure.

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 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 implementation of the "InPhase" system, which brings together incident reporting, risk management, and patient safety on one digital platform has 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.

Risk is everyone's business and the day-to-day management of risk is the responsibility of everyone in the organisation. The identification and management of risks require the active engagement and involvement of staff at all levels. Staff are best placed to understand the risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework. Key executive, management and specialist roles support this.

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

- 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.

The risk and control framework

The objectives of the Risk Management Strategy are:

- Greater devolution of decision making and accountability for the management of risk from trust Board to point of delivery (Board to Ward/Team).
- Well informed and risk-based decision-making, maximising the likelihood of achieving key strategic objectives and effective prioritisation of resources.
- Embedding a risk culture of monitoring and improvement, which ensures risks to the delivery of trust strategic goals are identified and addressed.
- Embedding a culture of open reporting to enable early learning from safety incidents and sustained improvements in safety.
- Improved processes, systems and policies throughout the trust which support effective risk management and ensure these are integral to activities in the trust.
- Increase in organisational resilience.

The key elements of the trust's risk management arrangements, as described in the Strategy and detailed in the supporting Operational Risk Management Policy, include:

- The establishment of risk appetites and tolerances for each risk domain.
- Guidance on the identification of risk, or changes in risk, both:

- **Internal** - though risk assessments; the development of the business plan; feedback on patient and staff experience; 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 based on:
    - The assignment of inherent, current and target scores.
    - The use of a 5 x 5 matrix for consequence and likelihood supported by descriptors of severity levels for each type of risk.
- The identification of key controls to manage risk with related sources of assurance, positive assurance, gaps in control and assurance and mitigation plans.
- Guidance on responding to risk 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 trust's 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 with the trust or whether actions to address with risk will give rise to other significant risks.

In accordance with the Strategy, the trust maintains a Board Assurance Framework (BAF) which provides a range of sources of assurance that the risks to the trust achieving its strategic objectives are being controlled and managed.

Operational risks, aligned to the strategic risks included in the BAF, are managed, monitored and escalated within the trust'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.

The strategy recognises the key roles played by the Board's Committees, the Executive Directors' Group and other groups in managing risk.

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 trust's ability to deliver Our Journey to Change – The Next Chapter.

Within this approach, two committees have notable roles.

The Audit and Risk Committee has specific responsibilities for:

- Providing assurance to the Board on the effectiveness and robustness of the trust's risk management arrangements and 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 processes underpinning the BAF and risk management as components of the internal control framework.

The Quality Assurance Committee is responsible for oversight of quality governance arrangements (the structured framework of controls used to lead, manage, and assure the quality and safety of services) and the provision of assurance to the Board on statutory and regulatory compliance including CQC Quality Standards and Statements.

To support the delivery of its responsibilities the Committee's reporting framework includes:

- The provision of assurances from the Executive Directors' Group and care group governance groups regarding the quality of care as well as the identification of key risks to quality and safety. This is also supported by flows of reporting from care group clinical leaders and subject matter experts on a range of quality issues.
- The triangulation of key quality and safety measures.
- Oversight of the management of relevant risks, including those presented within the Board Assurance Framework and the Corporate Risk Register.

- Cyclical reporting on the operation of key quality controls including infection prevention and control, clinical audit and research and development. patient safety, safeguarding, medicines management, restrictive interventions, infection prevention and control and clinical effectiveness (including clinical audit).
- The provision of assurances 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.
- Consideration of best practice and learning from other NHS providers and national reports, etc.
- Exception reporting where gaps in controls and assurance have been identified.

At an executive level, the Executive Directors Group gains assurance that organisational risks are being appropriately managed, with 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, including moderating scores and achieving consistency; identifying gaps and cross service risks; agreeing escalations and de-escalations; and holding care groups/corporate directorates to account for the timely and appropriate delivery of mitigations.

The joint care group board is 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.
- 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/or 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 and/or emerging 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 included in the BAF.

As at 31 March 2026, the position on the strategic risks included in the Board Assurance Framework was as follows:

Ref	*Strategic Goals*			*Risk Name & Description*	Present Risk Grade	Oversight Committee
	We will co-create high quality care	We will be a great employer	We will be a trusted partner			
1	✓	✓		**Safe Staffing** **There is a risk** that some teams are unable to safely and consistently staff their services **caused by** factors affecting both number and skill profile of the team. **This could result** in an unacceptable variance in the quality of the care we provide, a negative impact on the wellbeing and morale of staff, and potential regulatory action and a lack of confidence in the standard of care.	**High**	**People Culture and Diversity Committee**
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**	**Moderate**	**Quality Assurance Committee**

				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.		
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.	**High**	**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 engage effectively in partnerships across our	**Moderate**	**Resources & Planning Committee**

				Integrated Care Systems, Provider Collaboratives, 'places' and 'neighbourhoods' will compromise our ability to effect service improvement, transformation and population health of the communities we serve		
10			✓	**Regulatory compliance** **There is a risk** that failure to comply with our regulatory duties and obligations, at all times, could **result** in enforcement action and financial penalties and damage our reputation	**Moderate**	**Board**
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**
14	✓	✓	✓	**Health Inequalities** There is a risk that health inequalities are exacerbated/opportunities to reduce health inequalities are not realised caused by lack of service reach into underserved communities and	**High**	**Quality Assurance Committee**

				barriers within service design and delivery resulting in increased risk of late/crisis presentation, increased complexity, disengagement, suboptimal outcomes and experience.”		
15			✓	**Transformation** There is a risk that failure to ensure we have the capacity and capability to scope and deliver a trust-wide programme of transformation, realise and evidence anticipated benefits, will mean we do not deliver on the trust ambition to impact positively on the mental health and wellbeing of our local populations	**High**	**Resources and Planning Committee**

During the year:

- The strategic risks relating to quality of care (BAF 4), quality governance (BAF 8), partnerships and system working (BAF 9) and regulatory compliance (BAF 13) had been successfully mitigated to target (the level it was reasonably practicable to achieve).
- There was evidence that controls had been strengthened for the strategic risks relating to safe staffing (BAF 1), digital – supporting change (BAF 5) and estates/physical infrastructure (BAF 6)
- Exposure to risks relating to estates/physical infrastructure increased due to the reduction in capital allocated following revisions to the national operational capital formula for providers.
- There were 14 risks included in the Corporate Risk Register (CRR). This position reflected:
  - The escalation of four risks to the CRR relating to:
    - The provision of relevant information to the integrated care boards due the current performance levels of the electronic patient record
    - The critical digital infrastructure fails to deliver required service levels due to failure in maintenance and management
    - Exposure to published critical cyber vulnerabilities
    - Non-delivery of the 2025/26 financial plan
  - The removal of one prior year risk from the CRR relating to failure to optimise and make effective use of our annual financial resources

The Internal Audit review of the BAF and risk management provided substantial assurance for 2025/26.

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

The Board has demonstrated due regard to well-led principles and the well-led framework throughout the year and has gained assurance on the trust’s compliance with section 4 (governance) of the provider licence through:

- Ongoing monitoring of the delivery metrics included in the NHS Oversight Framework (NOF).
- The self-assessment undertaken for the NHS Provider Capability Assessment. Risks identified relating to the number of interim appointments on the Board and changes to the provision of the Freedom to Speak Up Guardian role have been mitigated in-year.
- Reviews of governance both into the status of delivery of the recommendations arising from the last “well-led” governance review in 2024 and in response to the recommendations arising from the Aubery review of the breast service provided by County Durham and Darlington NHS Foundation trust.

Whilst at Quarter 3 (the latest position available at the time of writing), the trust was placed in segment 2 of the NOF (“good performance across most domains”), specific risks have been identified under the

“People and Workforce Domain” in regard to sickness absence rates and the NHS staff survey engagement theme score. Actions plans to mitigate these risks are being delivered.

In addition, the Board has given specific consideration to:

- Potential internal control issues highlighted in reports from its committees in relation to:
    - The impact of those people waiting to access our services in the community (whilst acknowledging that, in some cases, there are links to national pressures and/or commissioning of services).
    - The overall quality of care and patient experience provided by perinatal services
    - The trust’s ability to meet key performance indicators for inpatient safer staffing
    - The actions in place in the Durham, Tees Valley and Forensics Care Group to address audit findings relating to Section 17 leave and time away from the ward.
    - The timely completion of after-action reviews (AAR’s) and part one mortality reviews.
    - Compliance with clinical supervision,
    - The capturing of risks relating to digital across the organisation
- The sickness absence rate which has been consistently provided limited performance assurance and negative controls assurance during the year
- Reports from the trust’s Internal Auditors which provided limited assurance, but in relations to each of which the Audit and Risk Committee received responsive briefings on actions to be taken, on controls supporting:
    - Emergency Preparedness, Resilience and Response Standards
    - Clinical supervision

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.

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

- Quality and equality impact assessments (QEIA), requiring consideration by two of the clinical executives (the Medical Director, the Director of Therapies and Chief Nurse), to assess the impact of proposals 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 (Inphase). This enables:
    - 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) which supports learning from serious incidents.
- 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.
- 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, NHS and voluntary sector partners and others to ensure the delivery of integrated care and treatment.

Clinical models are now in place across all specialties. These guide our workforce planning for each clinical pathway in the medium to long term and enable us to map the required training to build the workforce we need in the future and to ensure that our recruitment, employment and training strategies are able to meet the identified need.

On a daily basis our inpatient teams follow national guidance on aligning staffing to clinical need and this is overseen by our safe staffing group (operating in line with National Quality Boards (NQB) guidance), which has enabled us to safely and significantly reduce our use of agency staffing and provide more consistency of staffing on our wards. Daily operational processes ensure that the training profiles of our staff are matched to the needs of the wards.

Every month an Executive Directors' Group meeting is focused on people and resources which, combined with deep dives in our performance meetings, enables us to focus on and collectively address any complex issues related to workforce which require action from multiple teams in the trust. The People dashboard is now established and enables anyone to review people measures across the trust for any service on an Integrated Information Centre (IIC). Key trustwide metrics from this dashboard are reflected in the trust Integrated Quality and Performance reports. We are fully engaged in the national review of mandatory and statutory training and have established a new Training and Education Governance Group to oversee the content, purpose and allocation of training for all colleagues. This helps us ensure that training is appropriately utilised to maximise the impact for the quality of care that we provide.

The staffing risk on the board assurance framework remains rightly high profile, given the changing context of employment in the NHS and the shifting patterns of uptake of pre-registration training, employment terms and conditions, the changing needs of our communities, and current sickness absence challenges.

Annual establishment reviews take place in line with NQB requirements including a report to the Board of Directors. 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 2025/26 progress has been made on the following areas:

- Developing and implementing the People Management Programme, to help strengthen leadership capability and improve staff experience.
- Moving the Reasonable Adjustments Team to be permanently funded - supporting staff and managers from the point of recruitment onwards.
- Ongoing reviews of mandatory and statutory training across all staff groups.
- Reviewing key HR policies around conduct/disciplinary, capability and health, and wellbeing and attendance to create a more streamlined process.
- New occupational health provider contracted who is more responsive and who has an offer more tailored to our needs.
- New Freedom to Speak Up service in place, which is available 24 hours a day, seven days a week, fully independent and offers a range of guardians to talk to if colleagues have specific needs.
- Making the internal transfer scheme a permanent process rather than two 'windows' a year, making it easier to recruit internal candidates.
- Continuing work on responses to violence and aggression, sexual misconduct and racism.

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 and overtime utilisation has dropped significantly both for WTE deployed and expenditure incurred; the former building on the previous two years' improvements.

- Appraisal rates remain above standard.
- Compliance with ALL mandatory and statutory training across the trust is above standard and areas of concern remain a priority for executives, with attention now focussing on team level compliance and DNAs.
- The leavers' rate has remained within what we see as a healthy turnover rate.

Testing of people controls by the Internal Auditors has provided the following assurances:

- Sickness absence achieved reasonable assurance. Director led panels are now in place to mitigate identified issues.
- Clinical supervision achieved a limited assurance rating. This did not reflect issues in accessing supervision, which remains above national average in the staff survey but does reflect issues with consistent recording and consistency of controls. At the time of writing a much more positive and improving picture has been reported through to Quality Assurance Committee.
- Appraisals returned a good level of assurance regarding timeliness, recording and compliance. We know from the staff survey that we now have work to do on the quality of those appraisals.

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

The trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past 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 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 an NHSE planning tool.
- Established annual processes, supplemented by quarterly Sustainability and Transformation workshops to set annual financial plans and to develop a trust 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 plan, the mitigation of in-year pressures and supporting delivery of the agreed financial plan.
- Breaking down the trust's overall national cost collection index to support benchmarking of costs and using comparison of unit costs by providers and at care group and team level 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, take forward Estates cost efficiencies informed by national ERIC benchmarks, and to make progress on sustainability targets for carbon reductions.
- Improving workforce productivity, including through innovation, technology and hybrid working.
- Benchmarking costs of corporate functions, using national returns and tools including Model System to inform forward CRES planning and demonstrate year on year benchmark improvements.
- Developing and deploying Quality Improvement (QI) and productivity capability and methodologies to review how the trust operates and then optimise efficiency and minimise waste.
- Working with partners to improve overall health economy 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 partners in Provider Collaboratives for specialist services, with voluntary and community sector partners and others through clinical sub contracts, and develops new services for people with learning disabilities through its subsidiary company Positive Individual Proactive Support Ltd (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 planned financial performance, it deems to be 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 each Resources and Planning Committee meeting.
- 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 major revenue and capital investment (and disinvestment).
- For plans in 2025/26 and 2026/27 the Board completed assurance statements, fulfilling national NHSE 2025/26 plan and 2026/27 Medium Term Plan submission requirements, both of which included the specific consideration of productivity and benchmarking information.
- Annually considering a recommendation (and the related rationale) from the Audit and Risk Committee as to the appropriateness of the trust producing annual accounting statements on a Going Concern basis.

On behalf of the Board, the Audit and Risk Committee has received:

- Substantial assurance on testing of key financial controls through this process.
- 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 and the action taken by Management to implement recommendations.
- External audit reports on specific areas of interest.

Information governance

There were 32 incidents reported in the Data Security and Protection Toolkit during the period 1 April 2025 to 31 March 2026, 16 of which the Information Commissioner's Office confirmed as being non-reportable.

Of the remaining 16 reported incidents:

- five were disclosures in error arising from sending information to the wrong person or wrong postal or email address.
- two incidents related to the inappropriate disclosure of 3rd party information.
- two concerns of privacy breach were reported due to the distress of the individual, but investigation was unable to confirm the concern as being an incident.
- four incidents were confidentiality breaches with a variety of causes.
- one incident was a failure to use BCC affecting c. 100 people.
- one reported incident relating to the disclosure of a staff member's leaving circumstances was found, on investigation, not to have been a breach of confidentiality, but was found to have been a breach of trust policy.

All the above incidents were investigated by the appropriate trust team.

No cases resulted in regulatory action by the Information Commissioners Office (ICO); however, a response is yet to be received from the ICO on one case where trust information was found is a filing cabinet donate to a charity by a local authority.

Data quality and governance

The trust has established a comprehensive framework of governance, controls and assurance mechanisms to ensure the accuracy, completeness and appropriate use of data across the organisation. These arrangements provide the Board with assurance that information used for decision-making, performance monitoring and external reporting is robust, transparent and subject to ongoing review.

Oversight of data quality is provided through a structured governance framework, including:

- Digital Performance and Assurance Group (DPAG):
  DPAG acts as the formal governance route for the escalation of significant data quality issues, ensuring that material risks, themes or concerns are escalated as appropriate to the Executive Directors Group for awareness, decision-making and assurance. This provides the Board with confidence that data quality issues are identified, managed and escalated through established governance arrangements. The group meets every two months and routinely reviews the trust's position against the National Data Quality Maturity Index (DQMI).
- Data Quality Working Group (DQWG):
  The DQWG operates on a monthly basis to monitor trust-wide data quality issues and oversee the development and delivery of action plans to address identified risks and issues. The group takes a proactive role in ensuring that information systems are used in line with agreed trust standards, and that data quality is routinely monitored and continuously improved.
- NHS England:
  External assurance of data quality is provided through national data quality assessment processes, including the NHS Data Quality Maturity Index (DQMI). The DQMI provides an independent assessment of the quality, completeness and consistency of data submitted by the trust to national datasets, including the Mental Health Services Data Set (MHSDS).

The trust uses a Data Quality Assessment Tool (DQAT) as a core component of its assurance framework. The DQAT provides structured assurance to the Board that:

- Measures and key performance indicators are clearly defined, robust and fit for purpose.
- Data sources are understood and appropriate.
- Measure construction is consistent and methodologically sound.
- Testing and validation processes are in place to ensure accuracy over time.

The results of data quality assessments are reported to the Board through the Integrated Performance Report. These results are overseen by the Data Quality Working Group to ensure that all identified improvement actions are progressed and completed.

Board-level performance measures are monitored using statistical process control (SPC) charts, enabling trends and variation to be assessed over time rather than through isolated data points. This approach supports early identification of statistically significant changes in performance and triggers further investigation where required.

Where SPC analysis highlights a material change, a structured deep-dive and root cause analysis is undertaken to determine whether the change reflects genuine service performance or whether any data quality or data flow issues may be contributing. This approach provides additional assurance to the Board regarding the reliability and interpretation of reported information.

The trust routinely reviews its position against the National Data Quality Maturity Index (DQMI), which provides an independent assessment of data quality across national submissions, including data submitted via the Mental Health Services Data Set.

The DQMI supports the identification of specific data quality issues and informs targeted improvement activity within the trust. Performance against national data quality measures, including areas identified for improvement, is reviewed through established data quality governance arrangements and contributes to the ongoing assurance provided to the Board.

In the most recent published results, the trust achieved an index score of 93%, providing further independent assurance regarding the quality of data submitted to national systems.

A comprehensive suite of policies and procedures relating to data quality, information governance, records management, access control and information security is in place. Together, these ensure that roles, responsibilities and standards are clearly defined and consistently applied across the organisation, and that individuals at all levels understand their responsibility for data quality.

Together, these arrangements provide the Board with assurance that appropriate governance and oversight of data quality are in place, alongside robust processes for the ongoing assessment, review and continuous improvement of data quality across the organisation.

Review of effectiveness

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

My review has specifically taken into account:

- The risk-based flow of assurances through, and robust oversight of internal control provided by, the Board's committees to the Board.
- The outcomes of:
    - The review on the embeddedness of actions taken in response to the Deloitte governance review undertaken in 2024.
    - The self-assessment against the recommendations of the Aubery Report
    - The self-assessment against the domains of NHS England's Provider Capability Assessment.

These, together, provide me with assurance that whilst further improvements are required to the trust's governance arrangements there are no significant weaknesses in internal control.

- The good assurance regarding the systems and processes for oversight, monitoring and progress with the Integrated Oversight Plan which covers CQC Mental Health Act Inspections, CQC/HMIP Inspections, CQC Registration, CQC Enquiries and HMC/Regulation 28 responses.
- 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 present position against the NHS Oversight Framework (segment 2)
- The action taken to address the internal control issues identified with the trust's electronic patient record system.
- The overall conclusions of the annual opinion of the Head of Internal Audit for 2025/26 that there is reasonable assurance on the design, operation and compliance with internal controls.

I understand that this opinion reflects the balance for assurance ratings across the controls tested and does not signify the existence of significant control weaknesses.

- 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. In particular, I have taken into account the substantial assurance rating provided on the following critical controls:
    - Risk management and Board Assurance Rating
    - Key finance and payroll controls

I have also considered the limited assurance findings relating to:

Emergency Preparedness Resilience and Response (EPRR):

The Internal Auditor's findings relating to EPRR are not considered significant control issues, as they highlight areas for improvement rather than pointing to any fundamental weaknesses in our control environment. The Trust continues to comply with core statutory requirements, with EPRR currently assessed at partial compliance (77%) and supported by clearly defined action plans that are actively tracked through our established governance arrangements.

The Trust recognises the associated risks to service continuity, quality of care, and regulatory compliance. These are explicitly managed through the Board Assurance Framework, and we are able to demonstrate our capability to respond effectively to significant incidents. The Audit and Risk Committee has reviewed these matters, taken assurance on the actions underway, and agreed that oversight remains appropriate, recognising that our current position reflects compliance rather than best practice. Internal Audit has provided an overall reasonable assurance Head of Internal Audit Opinion. Overall, our position is that these risks are understood, controlled, and subject to ongoing improvement within a robust governance framework.

Clinical Supervision:

There is no evidence that this issue has had an impact on meeting priorities or the standards expected of the accounting officer. The audit and risk committee has accepted that whilst lacking the assurance of a consistent reporting system there have always been locally held records and reassurance and that was reinforced by self-reporting levels of access to clinical supervision in the staff survey and assurance we have been able to provide during previous inspections. Whilst this is a position the trust is motivated to improve it is not a position that has materialised in a way that would triangulate with any of the issues raised. The detailed action plan in place, reporting in to the Audit and Risk committee has led to an improving trajectory of positive performance across teams; this triangulates with improvements in the staff survey, pulse surveys and the feedback from the recent child and adolescent services unannounced CQC inspection.

Neither limited assurance finding has implications regarding fraud or misuse of resources.

- The assurances provided to the External Auditors by Those Charged With Governance through the Chair of 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.

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.

Alison Smith

Chief Executive

25 June 2026

The external auditor's report and opinion

CONTENT TO FOLLOW

Foreword to the accounts

The accounts, for the year ended 31 March 2026, have been prepared by Tees, Esk and Wear Valleys NHS Foundation Trust Group in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006.

Alison Smith
Chief Executive
25 June 2026

Consolidated Statement of Comprehensive Income

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	550,238	519,903	535,542	506,578
Other operating income	4	35,279	30,592	35,266	30,592
Operating expenses	7,9	(594,224)	(569,142)	(580,066)	(556,054)
Operating deficit from continuing operations		**(8,707)**	**(18,647)**	**(9,258)**	**(18,884)**
Finance income	11	2,400	3,242	2,391	3,242
Finance expenses	12	(1,858)	(2,032)	(1,858)	(2,032)
PDC dividends payable		(2,115)	(2,246)	(2,115)	(2,246)
Net finance costs		**(1,573)**	**(1,036)**	**(1,582)**	**(1,036)**
Corporation tax expense		(141)	(59)	-	-
Deficit for the year		**(10,421)**	**(19,742)**	**(10,840)**	**(19,920)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	8	864	(720)	864	(720)
Revaluations	8	-	343	-	343
Total other comprehensive income for the period		**864**	**(377)**	**864**	**(377)**
Total comprehensive expense for the period		**(9,557)**	**(20,119)**	**(9,976)**	**(20,297)**

Statements of Financial Position

		Group		Trust	
		31 March 2026	31 March 2025	31 March 2026	31 March 2025
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	13	1,193	2,753	1,193	2,753
Property, plant and equipment	14	131,568	130,856	131,568	130,856
Right of use assets	15	6,483	7,000	6,483	7,000
Receivables	17	392	403	392	403
Total non-current assets		**139,636**	**141,012**	**139,636**	**141,012**
Current assets					
Inventories	16	1,259	1,223	1,259	1,223
Receivables	17	21,177	20,288	19,863	19,562
Non-current assets held for sale	18	1,135	-	1,135	-
Cash and cash equivalents	18	54,735	51,368	53,657	50,458
Total current assets		**78,306**	**72,879**	**75,914**	**71,243**
Current liabilities					
Trade and other payables	19	(57,032)	(51,091)	(55,725)	(50,170)
Borrowings	21	(3,454)	(3,179)	(3,454)	(3,179)
Provisions	22	(4,098)	(311)	(4,098)	(311)
Other liabilities	20	(710)	(759)	(624)	(624)
Total current liabilities		**(65,294)**	**(55,340)**	**(63,901)**	**(54,284)**
Total assets less current liabilities		**152,648**	**158,551**	**151,649**	**157,971**
Non-current liabilities					
Borrowings	21	(32,018)	(33,960)	(32,018)	(33,960)
Provisions	22	(3,119)	(3,233)	(3,119)	(3,233)
Total non-current liabilities		**(35,137)**	**(37,193)**	**(35,137)**	**(37,193)**
Total assets employed		**117,511**	**121,358**	**116,512**	**120,778**
Financed by					
Public dividend capital		171,632	165,922	171,632	165,922
Revaluation reserve		6,303	5,628	6,303	5,628
Income and expenditure reserve		(60,424)	(50,192)	(61,423)	(50,772)
Total taxpayers' equity		**117,511**	**121,358**	**116,512**	**120,778**

The notes form part of these accounts.

Name	Alison Smith
Position	Chief Executive
Date	**25 June 2026**

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**165,922**	**5,628**	**(50,192)**	**121,358**
Deficit for the year	-	-	(10,421)	**(10,421)**
Other transfers between reserves	-	(189)	189	**-**
Impairments	-	864	-	**864**
Public dividend capital received	7,276	-	-	**7,276**
Public dividend capital repaid	(1,566)	-	-	**(1,566)**
Taxpayers' and others' equity at 31 March 2026	**171,632**	**6,303**	**(60,424)**	**117,511**

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**

Statement of Changes in Equity for the year ended 31 March 2026

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**165,922**	**5,628**	**(50,772)**	**120,778**
Deficit for the year	-	-	(10,840)	**(10,840)**
Other transfers between reserves	-	(189)	189	**-**
Impairments	-	864	-	**864**
Public dividend capital received	7,276	-	-	**7,276**
Public dividend capital repaid	(1,566)	-	-	**(1,566)**
Taxpayers' and others' equity at 31 March 2026	**171,632**	**6,303**	**(61,423)**	**116,512**

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

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**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**

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

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating deficit		(8,707)	(18,647)	(9,258)	(18,884)
Non-cash income and expense:					
Depreciation and amortisation	7.1	6,052	6,134	6,052	6,134
Net impairments	8	14,931	20,407	14,931	20,407
Increase in receivables and other assets		(1,563)	(2,625)	(975)	(3,006)
(Increase) / decrease in inventories		(36)	63	(36)	63
Increase in payables and other liabilities		4,834	605	4,497	662
Increase / (decrease) in provisions		3,620	(2,645)	3,620	(2,645)
Tax paid		(141)	(59)	-	-
Net cash flows from operating activities		**18,990**	**3,233**	**18,831**	**2,731**
Cash flows from investing activities					
Interest received		2,400	3,242	2,391	3,242
Purchase of intangible assets		-	(593)	-	(593)
Purchase of property and equipment		(17,929)	(10,866)	(17,929)	(10,866)
Net cash flows used in investing activities		**(15,529)**	**(8,217)**	**(15,538)**	**(8,217)**
Cash flows from financing activities					
Public dividend capital received		7,276	2,958	7,276	2,958
Public dividend capital repaid		(1,566)	-	(1,566)	-
Capital element of lease liability repayments		(2,256)	(2,057)	(2,256)	(2,057)
Capital element of PFI		(954)	(982)	(954)	(982)
Interest paid on lease liability repayments		(255)	(207)	(255)	(207)
Interest paid on PFI obligations		(909)	(925)	(909)	(925)
PDC dividend paid		(1,430)	(2,771)	(1,430)	(2,771)
Net cash flows used in financing activities		**(94)**	**(3,984)**	**(94)**	**(3,984)**
Increase / (decrease) in cash and cash equivalents		**3,367**	**(8,968)**	**3,199**	**(9,470)**
Cash and cash equivalents at 1 April - brought forward		**51,368**	**60,336**	**50,458**	**59,928**
Cash and cash equivalents at 31 March	18	**54,735**	**51,368**	**53,657**	**50,458**

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 DHSC Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the DHSC. 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 (FReM), 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 International Accounting Standard (IAS) 27. The financial statements of the subsidiary are prepared for the same reporting year as the trust. The materiality level of all entities controlled by the trust was considered when preparing the 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 consolidated 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 2026 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 Financial Reporting Standard (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 Individual Proactive Support Limited (PIPS Ltd)", which prepares accounts under FRS 102 (the balances of which are consolidated into Group accounts), and "TEWV Estates and Facilities Management Limited", which prepares accounts under FRS 102, but was made dormant during 2019/20. The financial year end for PIPS Ltd was 31 March 2026.

Note 1.4 Revenue from contracts with customers

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

Revenue in respect of goods or services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods or 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 Board (ICB) 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. That income is earned at NHSPS prices based on actual activity. The fixed element of API contracts includes income for all other services covered by the NHSPS, including for services provided by the trust, and assuming an agreed level of activity, with 'fixed' in this context meaning income 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 ICB 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 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. Specialised assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the services' location requirements.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, 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 full MEA valuation was carried out on the trust's land and buildings as at 31 March 2026, and the assets have been treated as prescribed in the GAM. All of the trust's MEA valuations at 31 March 2026 have been completed by Cushman and Wakefield Inc. (an 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 have been reclassified as ‘held for sale’ cease to be depreciated upon their 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 circumstance 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 or 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 or grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Private Finance Initiative (PFI) transactions

PFI transactions which meet the International Financial Reporting Interpretations Committee (IFRIC) 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the group. 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 operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the Income and Expenditure reserve.

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

Impairments
Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure.

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 Years	Max life Years
Software licences	1	10

Note 1.10 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.11 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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 the Office for National Statistics (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, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs, except where the asset or liability is not measured at fair value through 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 the relevant accounting standard by HM Treasury for the public sector means that, for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases, where consideration paid is nil or nominal (significantly below market value), but in all other respects meet the definition of a lease. The group does not apply lease accounting to new contracts for the use of intangible assets.

The group determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the 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 4.81% applied to new leases commencing in 2025, and 5.32% to new leases commencing in 2026.

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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting, using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme. 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 23 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 23, 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 trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax

Positive Individual Proactive 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 2025/26.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted
The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations for the public sector are also not yet adopted:

Changes to valuations under IAS 16 Property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £128m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset' (MEA). This policy is not changing. In deriving the MEA, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical MEA will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £94m at 31 March 2026. The impact is expected to be material, and result in an increase in the carrying value of property assets of approximately £60m.

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 trust'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 MEA valuation exercise every 3 to 5 years. The trust has made critical judgements in relation to the MEA revaluation. Cushman & Wakefield Inc. as the Trust's valuer carries out a professional valuation of the MEA 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 2026. The application of VAT on asset valuations reflects actual VAT charges and associated recovery levels from the original purchase.

• 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 professional external valuer and values will 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 Royal Institute of Chartered Surveyors (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 the equivalent of an increase £2.8m.

Adjustments for obsolescence:
Once the build rates for constructing a MEA 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 the equivalent of a decrease of £2.1m.

Adjustments for modern equivalent asset (MEA):
The assets have been valued on a 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 floor area (in 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 the equivalent 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 2026. 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 2026, 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's planned operational performance, as confirmed formally through national plan submissions for 2025/26, and excluding technical adjustments, was adjusted in-year from an opening break-even plan, to make a surplus of £3,276k following the distribution of unearned national Deficit Support Funding of an equivalent sum. The group reported adjusted financial peformance (excluding technical adjustments for Annually Managed Expenditure (AME) impairments, Statement of Comprehensive Income impact of peppercorn leases and the impact of IFRS 16 adoption on PFI accounting) of £3,763k surplus, which was £487k ahead of plan i.e. target achieved. Inclusive of technical adjustments, the accounts show an unadjusted deficit of £10,427k.

A reconciliation of the group's performance against the agreed breakeven plan is shown below:

	2025/26	2024/25
	£000	£000
Deficit for the year from SoCI	(10,421)	(19,742)
Add back net impairments	14,931	20,407
Remove I&E impact of peppercorn lease	20	19
Prior period adjustments to correct errors and other performance adjustments	-	402
Remove PFI revenue costs on an IFRS 16 basis	2,166	2,345
Add back PFI revenue costs on a UK GAAP basis	(2,927)	(2,814)
Actual surplus for performance assessment (Group)	**3,769**	**617**
Required performance (planned surplus)	3,276	-
Performance ahead of required level (Group)	**493**	**617**
Group financial performance comprising:		
Tees Esk and Wear Valleys NHS FT financial performance	80	37
PIPS Ltd (subsidiary) financial performance	413	580

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	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Mental health services				
Income from commissioners under API contracts*	426,218	397,963	419,765	393,078
Services delivered under a mental health collaborative	51,818	52,065	51,818	52,065
Clinical income for the secondary commissioning of mandatory services	17,893	17,736	17,893	17,736
Other clinical income from mandatory services	3,792	2,711	3,575	2,711
All services				
National pay award central funding**		536	-	536
Additional pension contribution central funding***	26,410	24,798	26,410	24,798
Other clinical income	24,107	24,094	16,081	15,654
Total income from activities	**550,238**	**519,903**	**535,542**	**506,578**

*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 2025/26 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 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

***Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded and paid directly by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid directly by NHS England on providers' behalf. The full cost of employer contributions (23.7%) including the related NHS England funding (9.4%) has been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
Income from patient care activities received from:	£000	£000	£000	£000
NHS England	38,817	35,881	38,817	35,881
Integrated care boards	431,933	405,152	425,263	400,267
Other NHS providers	55,381	54,776	55,381	54,776
Local authorities	10,824	11,231	2,811	2,791
Non NHS: other	13,283	12,863	13,270	12,863
Total income from activities	**550,238**	**519,903**	**535,542**	**506,578**
Of which:				
Related to continuing operations	550,238	519,903	535,542	506,578

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) (2024/25, £nil).

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	3,100	-	**3,100**	2,687	-	**2,687**
Education and training	21,741	1,513	**23,254**	21,096	1,731	**22,827**
Non-patient care services to other bodies	2,641		**2,641**	2,517		**2,517**
Income in respect of employee benefits accounted on a gross basis	1,776		**1,776**	875		**875**
Revenue from operating leases		287	**287**		645	**645**
Other income	4,221	-	**4,221**	1,041	-	**1,041**
Total other operating income	**33,479**	**1,800**	**35,279**	**28,216**	**2,376**	**30,592**
Of which:						
Related to continuing operations			35,279			30,592

*Other income includes a commercial settlement. Excluding this, the largest source of other income was £525k relating to income from service charges from property leases (non-rent) (2024/25, income from service charges for property leases £665k).

Note 5.1 Additional information on group contract revenue (IFRS 15) recognised in the period

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	759	655

Note 5.2 Transaction price allocated to remaining group performance obligations

	31 March 2026	31 March 2025
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	710	759
Total revenue allocated to remaining performance obligations	**710**	**759**

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 trust's 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	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Income from services designated as commissioner requested services	550,238	519,903	535,542	506,578
Income from services not designated as commissioner requested services	35,279	30,592	35,266	30,592
Total	**585,517**	**550,495**	**570,808**	**537,170**

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 3 leases, all for the rent of property, and the lessees comprise 2 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)

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	287	645
Total in-year operating lease income	**287**	**645**

Note 6.2 Future lease receipts (Group)

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	274	466
- later than one year and not later than two years	109	106
- later than two years and not later than three years	109	106
- later than three years and not later than four years	109	106
- later than four years and not later than five years	109	106
- later than five years	1,815	1,865
Total	**2,525**	**2,755**

Note 7.1 Operating expenses (Group)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,953	1,467	1,953	1,467
Purchase of healthcare from non-NHS and non-DHSC bodies	15,940	16,269	15,940	16,269
Staff and executive directors costs	483,184	448,978	469,794	436,634
Remuneration of non-executive directors	165	172	165	172
Supplies and services - clinical (excluding drugs costs)	3,320	4,191	3,312	4,187
Supplies and services - general	5,930	6,681	5,930	6,681
Drug costs	5,628	5,607	5,628	5,607
Consultancy costs	-	74	-	74
Establishment	3,950	4,425	3,806	4,213
Premises	24,955	28,159	24,507	27,781
Transport (including patient travel)	10,140	10,110	10,095	10,066
Depreciation on property, plant and equipment	5,593	5,772	5,593	5,772
Amortisation on intangible assets	459	362	459	362
Net impairments	14,931	20,407	14,931	20,407
Movement in credit loss allowance for contract receivables	62	157	(26)	95
Change in provisions discount rate	(85)	8	(85)	8
Fees payable to the external auditor				
audit services- statutory audit*	157	143	143	130
Internal audit costs	237	290	237	290
Clinical negligence	1,945	1,724	1,945	1,724
Legal fees	2,127	2,681	2,126	2,681
Insurance (as a policy holder)	685	480	685	480
Research and development	3,377	3,003	3,377	3,003
Education and training	7,251	7,828	7,144	7,735
Redundancy	379	-	379	-
Charges to operating expenditure for on-SoFP IFRIC 12 PFI schemes	914	866	914	866
Hospitality	52	51	52	51
Losses, ex gratia & special payments	363	11	363	11
Other services, eg external payroll	75	17	75	17
Other**	537	(791)	624	(729)
Total	**594,224**	**569,142**	**580,066**	**556,054**
Of which:				
Related to continuing operations	594,224	569,142	580,066	556,054

* Amount includes VAT

** Other includes the reversal of an unrequired accrual included in 2024/25 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 2026 (31 March 2025, £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 2025/26 or 2024/25.

Note 8 Impairment of assets (Group)

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	14,931	20,407
Total net impairments charged to operating surplus / deficit	**14,931**	**20,407**
Impairments charged to the revaluation reserve	(864)	720
Total net impairments	**14,067**	**21,127**

The group realised impairments totalling £14,067k during 2025/26 following an independent valuation of its sites and right of use assets (2024/25, £21,127k).

Note 9 Employee benefits (Group)

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	369,794	346,036
Social security costs*	43,073	32,770
Apprenticeship levy	1,675	1,611
Employer's contributions to NHS pensions	66,804	62,838
Pension cost - other	281	370
Temporary staff (including agency)	7,712	11,555
Total staff costs	**489,339**	**455,180**
Of which		
Costs capitalised as part of assets	610	1,290

*Employers' National Insurance contributions increased from 13.8% to 15% in 2025/26

Note 9.1 Retirements due to ill-health (Group)

During 2025/26 there were 3 early retirements from the trust agreed on the grounds of ill-health (8 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £47k (£720k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from HM Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 11 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	2,400	3,242
Total finance income	**2,400**	**3,242**

Note 12.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on lease obligations	255	207
Finance costs on PFI arrangements:		
Main finance costs	909	925
Remeasurement of the liability resulting from change in index or rate	641	858
Total interest expense	**1,805**	**1,990**
Unwinding of discount on provisions	53	42
Total finance costs	**1,858**	**2,032**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Total trust liability accruing in year under this legislation as a result of late payments	1,878	2,279

Note 13 Intangible assets - 2025/26

The group's only intangible asset is a bespoke software system that was developed by the trust. Asset balances as at 31 March 2026 were £1,193k (31 March 2025, £2,753k).

During 2025/26 the expected life of the software system was revised linked to an upcoming contract termination and an impairment was realised for £1,101k to revise its carrying value.

Note 14.1 Property, plant and equipment - 2025/26

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**11,262**	**110,358**	**486**	**3,680**	**11,847**	**137,633**
Additions	-	15,276	-	1,033	2,678	**18,987**
Impairments	(119)	(17,308)	-	-	-	**(17,427)**
Reversals of impairments	127	4,786	-	-	-	**4,913**
Revaluations	-	(2,573)	-	-	-	**(2,573)**
Reclassifications	-	486	(486)	-	-	**-**
Transfers to assets held for sale	(220)	(915)	-	-	-	**(1,135)**
Valuation/gross cost at 31 March 2026	**11,050**	**110,110**	**-**	**4,713**	**14,525**	**140,398**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**-**	**-**	**1,627**	**5,150**	**6,777**
Provided during the year	-	2,573	-	368	1,685	**4,626**
Revaluations	-	(2,573)	-	-	-	**(2,573)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**1,995**	**6,835**	**8,830**
Net book value at 31 March 2026	**11,050**	**110,110**	**-**	**2,718**	**7,690**	**131,568**
Net book value at 1 April 2025	**11,262**	**110,358**	**486**	**2,053**	**6,697**	**130,856**

Note 14.2 Property, plant and equipment - 2024/25

Group	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 - as previously stated	**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 - as previously stated	**-**	**-**	**-**	**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 14.3 Property, plant and equipment financing - 31 March 2026

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Owned - purchased	11,050	103,895	-	2,718	7,690	**125,353**
On-SoFP PFI contracts	-	6,215	-	-	-	**6,215**
Net Book Value (NBV) total at 31 March 2026	**11,050**	**110,110**	**-**	**2,718**	**7,690**	**131,568**

Note 14.4 Property, plant and equipment financing - 31 March 2025

Group	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	-	6,164	-	-	-	**6,164**
NBV total at 31 March 2025	**11,262**	**110,358**	**486**	**2,053**	**6,697**	**130,856**

Note 14.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Subject to an operating lease	114	3,346	-	-	-	**3,460**
Not subject to an operating lease	10,936	106,764	-	2,718	7,690	**128,108**
NBV total at 31 March 2026	**11,050**	**110,110**	**-**	**2,718**	**7,690**	**131,568**

Note 14.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Group	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 15 Leases - Tees, Esk and Wear Valleys NHS Foundation Trust as a lessee

The group has 35 property leases accounted for under IFRS 16 as at 31 March 2026. Two leases were extended in 2025/26, which is reflected in the liability increase in note 21.1. One leased property was vacated during 2025/26. All leases relate to the trust, so there is no separate note for trust only reporting.

Note 15.1 Right of use assets - 2025/26

Group	Property (land and buildings)	Total	Of which: leased from DHSC group bodies
	£000	£000	£000
Valuation at 1 April 2025 - brought forward	**7,000**	**7,000**	**1,509**
Additions	608	**608**	210
Remeasurements of the lease liability	294	**294**	44
Impairments	(996)	**(996)**	(77)
Reversal of impairments	544	**544**	73
Revaluations	(967)	**(967)**	(234)
Valuation at 31 March 2026	**6,483**	**6,483**	**1,525**
Provided during the year	967	**967**	234
Revaluations	(967)	**(967)**	(234)
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**
Net book value at 31 March 2026	**6,483**	**6,483**	**1,525**
Net book value at 1 April 2025	**7,000**	**7,000**	**1,509**
Net book value of right of use assets leased from other NHS providers			35
Net book value of right of use assets leased from other DHSC group bodies			1,490

Note 15.2 Right of use assets - 2024/25

Group	Property (land and buildings)	Total	Of which: leased from DHSC group bodies
	£000	£000	£000
Valuation 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	(132)	**(132)**	(10)
Valuation 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 15.3 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 a full valuation as at 31 March 2026. Cushman and Wakefield Inc. (independent qualified valuer) 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	
	2025/26	**2024/25**
	£000	**£000**
Carrying value at 1 April	**18,328**	**16,763**
Lease additions	608	3,759
Lease liability remeasurements	294	(5)
Interest charge arising in year	255	207
Early terminations	-	(132)
Lease payments (cash outflows)	(2,511)	(2,264)
Carrying value at 31 March	**16,974**	**18,328**

Note 15.5 Maturity analysis of future lease payments at 31 March 2026

	Group	
	Total	Of which leased from DHSC group bodies:
	31 March 2026	**31 March 2026**
	£000	**£000**
Undiscounted future lease payments payable in:		
- not later than one year;	2,638	831
- later than one year and not later than five years;	9,460	3,185
- later than five years.	6,566	1,630
Total gross future lease payments	**18,664**	**5,646**
Finance charges allocated to future periods	(1,689)	(209)
Net lease liabilities at 31 March 2026	**16,975**	**5,437**
Of which:		
Leased from other NHS providers		121
Leased from other DHSC group bodies		5,316

Note 15.6 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 finance 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 16 Inventories

	Group	
	31 March 2026	**31 March 2025**
	£000	**£000**
Drugs	302	257
Consumables	957	966
Total inventories	**1,259**	**1,223**

Inventories recognised in expenses for the year were £1,223k (2024/25: £1,286k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

Note 17.1 Receivables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Contract receivables	11,080	10,629	9,781	10,070
Allowance for impaired contract receivables	(435)	(373)	(281)	(307)
Prepayments	9,251	8,221	9,082	7,988
PDC dividend receivable	240	925	240	925
VAT receivable	1,030	877	1,030	877
Other receivables	11	9	11	9
Total current receivables	**21,177**	**20,288**	**19,863**	**19,562**
Non-current				
Other receivables	392	403	392	403
Total non-current receivables	**392**	**403**	**392**	**403**
Of which receivable from NHS and DHSC group bodies:				
Current	7,436	8,603	6,283	8,043
Non-current	373	383	373	383

Note 17.2 Allowances for credit losses - 2025/26

	Group Contract receivables and contract assets	Trust Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2025 - brought forward	**373**	**307**
New allowances arising	88	281
Changes in existing allowances	(26)	-
Reversals of allowances	-	(307)
Allowances as at 31 Mar 2026	**435**	**281**

Note 17.3 Allowances for credit losses - 2024/25

	Group Contract receivables and contract assets	Trust Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2024 - as previously stated	**216**	**212**
New allowances arising	157	95
Allowances as at 31 Mar 2025	**373**	**307**

Note 18 Non-current assets held for sale

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
NBV of non-current assets for sale at 1 April	**-**	**-**	**-**	**-**
Assets classified as available for sale in the year	1,135	-	1,135	-
NBV of non-current assets for sale at 31 March	**1,135**	**-**	**1,135**	**-**

The group had 2 assets held for sale as at 31 March 2026. Both assets are non specialised buildings that are no longer required by the group to ensure delivery of commissioned services, and both are anticipated to be sold by 31 March 2027.

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	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**51,368**	**60,606**	**50,458**	**60,198**
Net change in year	3,367	(9,238)	3,199	(9,740)
At 31 March	**54,735**	**51,368**	**53,657**	**50,458**
Broken down into:				
Cash at commercial banks and in hand	1,406	1,026	1,238	116
Cash with the Government Banking Service	53,329	50,342	52,419	50,342
Total cash and cash equivalents as in SoFP	**54,735**	**51,368**	**53,657**	**50,458**
Total cash and cash equivalents as in SoCF	**54,735**	**51,368**	**53,657**	**50,458**

Note 18.2 Third party assets held by the trust

Tees, Esk and Wear Valleys NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Trust	
	31 March 2026	31 March 2025
	£000	£000
Bank balances	987	752
Total third party assets	**987**	**752**

Note 19.1 Trade and other payables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Trade payables	2,689	1,448	2,239	1,134
Capital payables	4,597	3,539	4,597	3,539
Accruals	33,558	31,173	33,165	30,938
Social security costs	5,964	4,931	5,816	4,819
VAT payables	165	264	165	264
Other taxes payable	4,443	4,328	4,193	4,171
Pension contributions payable	5,616	5,408	5,550	5,305
Total current trade and other payables	**57,032**	**51,091**	**55,725**	**50,170**
Of which payables from NHS and DHSC group bodies:				
Current	3,096	3,792	3,096	3,222
Non-current	-	-	-	-

Note 20 Other liabilities

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	710	759	624	624
Total other current liabilities	**710**	**759**	**624**	**624**

Note 21.1 Borrowings

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Lease liabilities	2,313	2,256	2,313	2,256
Obligations under PFI contracts (excl. lifecycle)	1,141	923	1,141	923
Total current borrowings	**3,454**	**3,179**	**3,454**	**3,179**
Non-current				
Lease liabilities	14,662	16,073	14,662	16,073
Obligations under PFI contracts (excl. lifecycle)	17,356	17,887	17,356	17,887
Total non-current borrowings	**32,018**	**33,960**	**32,018**	**33,960**

Note 21.2 Reconciliation of liabilities arising from financing activities (Group)

Group - 2025/26	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2025	**18,328**	**18,810**	**37,138**
Cash movements:			
Financing cash flows - payments of principal	(2,256)	(954)	**(3,210)**
Financing cash flows - payments of interest	(255)	(909)	**(1,164)**
Non-cash movements:			
Additions	608	-	**608**
Lease liability remeasurements	294	-	**294**
Remeasurement of PFI resulting from change in index		641	**641**
Application of effective interest rate	255	909	**1,164**
Carrying value at 31 March 2026	**16,974**	**18,497**	**35,471**

Group - 2024/25	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2024	**16,763**	**18,934**	**35,697**
Cash movements:			
Financing cash flows - payments 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**

Note 22.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: injury benefits	Legal claims*	Pay-related	Redundancy	Other**	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2025	**1,918**	**121**	**-**	**-**	**1,505**	**3,544**
Change in the discount rate	(84)	-	-	-	(30)	**(114)**
Arising during the year	87	53	3,126	416	307	**3,989**
Utilised during the year	(156)	(17)	-	-	(11)	**(184)**
Reversed unused	-	(77)	-	-	(19)	**(96)**
Unwinding of discount	52	-	-	-	26	**78**
At 31 March 2026	**1,817**	**80**	**3,126**	**416**	**1,778**	**7,217**
Expected timing of cash flows:						
- not later than one year;	153	80	3,126	416	323	**4,098**
- later than one year and not later than five years;	568	-	-	-	34	**602**
- later than five years.	1,096	-	-	-	1,421	**2,517**
Total	**1,817**	**80**	**3,126**	**416**	**1,778**	**7,217**

*Legal claims relate to employer / public liability claims notified by NHS Resolution.

**Other provision balances relate to potential contract payments, employee tribunals and a provision for clinical pensions tax reimbursement.

Note 22.2 Clinical negligence liabilities

As at 31 March 2026 NHS Resolution included provisions of £5,888k for clinical negligence liabilities of Tees, Esk and Wear Valleys NHS Foundation Trust (31 March 2025: £5,255k).

Note 23 Contingent assets and liabilities

	Group	
	31 March 2026	**31 March 2025**
	£000	**£000**
Value of contingent liabilities		
NHS Resolution legal claims	(65)	(183)
Net value of contingent liabilities	**(65)**	**(183)**
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 contractual legal claim that could result in a future cash inflow to the trust.

Note 24 Contractual capital commitments

	Group	
	31 March 2026	**31 March 2025**
	£000	**£000**
Property, plant and equipment	10,121	2,722
Total	**10,121**	**2,722**

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 arrangement is recognised in the statement of financial position:

	Group	
	31 March 2026	**31 March 2025**
	£000	**£000**
Gross PFI liability	**24,386**	**25,384**
Of which liabilities are due		
- not later than one year;	2,003	1,802
- later than one year and not later than five years;	8,335	7,857
- later than five years.	14,048	15,725
Finance charges allocated to future periods	(5,889)	(6,574)
Net PFI arrangement obligation	**18,497**	**18,810**
- not later than one year;	1,141	923
- later than one year and not later than five years;	5,461	4,844
- later than five years.	11,895	13,043

Note 25.2 Total on-SoFP PFI arrangement commitments

Total future commitments under this on-SoFP scheme is as follows:

	Group	
	31 March 2026	**31 March 2025**
	£000	**£000**
Total future payments committed in respect of the PFI arrangement	**47,036**	**49,530**
Of which payments are due:		
- not later than one year;	3,376	3,241
- later than one year and not later than five years;	14,370	13,797
- later than five years.	29,290	32,492

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	
	2025/26	**2024/25**
	£000	**£000**
Unitary payment payable to service concession operator	**3,263**	**3,138**
Consisting of:		
- Interest charge	909	925
- Repayment of balance sheet obligation	954	982
- Service element and other charges to operating expenditure	914	866
- Capital lifecycle maintenance	486	365
Total amount paid to service concession operator	**3,263**	**3,138**

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 as is 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 (ICBs) and Foundation Trusts under contractual terms that require settlement of obligation within a time frame established generally by the DHSC. 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 Resources and Planning Committee, which is required to approve all methods used for investing trust cash balances. For the financial year 2025/26 most cash balances were held in Government Banking Service (GBS) accounts, with a small amount held in a Barclays current account to cover, for example, unpresented cheques etc.

Liquidity risk

The group's net operating costs are mainly incurred under legally binding contracts with ICBs 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 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	10,645	**10,645**
Cash and cash equivalents	54,735	**54,735**
Total at 31 March 2026	**65,380**	**65,380**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	10,256	**10,256**
Cash and cash equivalents	51,368	**51,368**
Total at 31 March 2025	**61,624**	**61,624**

Note 26.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	9,500	**9,500**
Cash and cash equivalents	53,657	**53,657**
Total at 31 March 2026	**63,157**	**63,157**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	9,763	**9,763**
Cash and cash equivalents	50,458	**50,458**
Total at 31 March 2025	**60,221**	**60,221**

Note 26.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	16,975	**16,975**
Obligations under PFI concessions	18,497	**18,497**
Trade and other payables excluding non financial liabilities	36,712	**36,712**
Provisions under contract	80	**80**
Total at 31 March 2026	**72,264**	**72,264**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	18,329	**18,329**
Obligations under PFI concessions	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**

Note 26.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	16,975	**16,975**
Obligations under PFI concessions	18,497	**18,497**
Trade and other payables excluding non financial liabilities	35,869	**35,869**
Provisions under contract	80	**80**
Total at 31 March 2026	**71,421**	**71,421**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	18,329	**18,329**
Obligations under PFI concessions	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**

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 26.7 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 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
In one year or less	41,433	36,935	40,590	36,386
In more than one year but not more than five years	17,795	17,422	17,795	17,422
In more than five years	20,614	23,680	20,614	23,680
Total	**79,842**	**78,037**	**78,999**	**77,488**

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.

	2025/26		2024/25	
Group	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	3	-	1	-
Total losses	**3**	**-**	**1**	**-**
Special payments				
Ex-gratia payments	20	6	32	6
Total special payments	**20**	**6**	**32**	**6**
Total losses and special payments	**23**	**6**	**33**	**6**

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 Individual 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.

Note 30 Better Payment Practice code (Trust)

Non-NHS Payables	2025/26 Number	2025/26 £000	2024/25 Number	2024/25 £000
Total non-NHS trade invoices paid in the year	62,457	108,088	72,660	114,904
Total non-NHS trade invoices paid within target	59,735	104,493	69,195	111,103
Percentage of non-NHS trade invoices paid within target	**95.6%**	**96.7%**	**95.2%**	**96.7%**
NHS Payables				
Total NHS trade invoices paid in the year	2,139	23,101	2,069	22,431
Total NHS trade invoices paid within target	2,076	22,610	2,012	21,439
Percentage of NHS trade invoices paid within target	**97.1%**	**97.9%**	**97.2%**	**95.6%**

The Better Payment Practice Code requires NHS bodies to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later), unless other payment terms have been agreed.

** 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

Draft Letter of Representation

Forvis Mazars

The Corner

Bank Chambers

26 Mosley Street

Newcastle upon Tyne

NE1 1DF

25 June 2026

Dear Mark,

Tees Esk and Wear Valleys NHS Foundation Trust - Audit for Year Ended 31 March 2026

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 2026 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 2025/26 (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 myself 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.

I confirm that there is no information provided to you as part of the audit that I consider legally privileged.

Draft Letter of Representation

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 the GAM and International Accounting Standard 8 and consider these policies to faithfully represent the effects of transactions, other events or conditions on the Trust and Group's financial position, financial performance and cash flows.

Accounting estimates, including those measured at 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 fair value, are appropriate to achieve recognition, measurement or disclosure that is in accordance with the applicable financial reporting framework.

I confirm that consideration has been given to the following matters in relation to the accounting estimates:

- the significant judgments made in making the accounting estimates have taken into account all relevant information of which management is aware;
- the consistency and appropriateness in the selection or application of the methods, assumptions and data used by management in making the accounting estimates;
- that the assumptions appropriately reflect management's intent and ability to carry out specific courses of action on behalf of the entity, when relevant to the accounting estimates and disclosures;
- that disclosures related to accounting estimates, including disclosures describing estimation uncertainty, are complete and are reasonable in the context of the applicable financial reporting framework;
- that appropriate specialised skills or expertise has been applied in making the accounting estimates;
- that no subsequent event requires adjustment to the accounting estimates and related disclosures included in the financial statements; and
- when accounting estimates are not recognised or disclosed in the financial statements, the appropriateness of management's decision that the recognition or disclosure criteria of the applicable financial reporting framework have not been met

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 and 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 has complied with all aspects of contractual agreements that would have a material effect on the accounts in the event of non-compliance.

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's financial statements communicated by employees, former employees, analysts, regulators or others.

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.

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 and intangible assets below their carrying value at the balance sheet date. An impairment review is therefore not considered necessary.

Charges on assets

All the Tees, Esk and Wear Valleys NHS Foundation Trust's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

Future commitments

The Tees, Esk and Wear Valleys NHS Foundation Trust 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.

Service Concession Arrangements

I am not aware of any material contract variations, payment deductions or additional service charges in 2025/26 in relation to the Trust and Group's service concession arrangements that you have not been made aware of.

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 military conflict including the Middle East and Ukraine

We confirm that we have carried out an assessment of the potential impact of military conflict including the Middle East and Ukraine on the business, 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 that there are no disclosures required in the financial statements.

Draft Letter of Representation

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 accounts.

Annual Governance Statement

I am satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust and Group'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 and Group's financial and operating performance over the period covered by the financial statements.

I confirm that all matters disclosed in the Annual Report relating to the Public Inquiry into the Trust's arrangements are accurate and represent the latest position of the inquiry.

Unadjusted misstatements

I confirm that the effects of the uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to this letter as an Appendix.

Arrangements to achieve economy, effectiveness and efficiency in Use of Resources (Value for Money arrangements)

I confirm that I have disclosed to you all findings and correspondence from regulators for previous and ongoing 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,

Alison Smith

Accounting Officer

Date: 25 June 2026

Appendix

Schedule of unadjusted misstatements

Unadjusted misstatements		SOCNE/SOCI		SOFP	
Description	Nature	Dr (£ '000)	Cr (£ '000)	Dr (£ '000)	Cr (£ '000)
Operating expenses Testing of transport expenditure identified one item spanning year-end that should have been partly recognised as a prepayment; however, no prepayment was recorded. The actual misstatement identified was £3k, which extrapolates to an misstatement of £480k. Dr Trade and other receivables (Prepayments) Cr Operating expenses (Transport)	Extrapolated		480	480	
Property, Plant and Equipment Testing of additions to buildings identified an misstatement arising from uncertainty over the allocation of costs between the current and prior financial year. The actual misstatement identified was £52k, which extrapolates to a misstatement of £650k. Dr Income and Expenditure Reserve Cr Property, Plant and Equipment (Building Additions)	Extrapolated			650	

					650
Aggregate effect of unadjusted misstatements		**0**	**480**	**1,130**	**650**

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Meeting of:	**Board of Directors**
Date:	**25 June 2026**
Title:	**Quality Account 2025/26**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**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 high quality care	✓
2: To be a great employer	✓
3: To be a trusted partner	✓

Relevant BAF risk/s	***Relevant control***
10 - Regulatory Compliance	There is a risk that failure to comply with our regulatory duties and obligations, at all times, could result in enforcement action and financial penalties and damage our reputation.

Executive Summary

Purpose

This report represents the final stage of the approvals process for the Quality Account 2025/26. As part of the process, the Board is asked to approve the Quality Account and authorise the submission to the Department of Health and Social Care, prior to publication.

Proposal

The Board is asked to approve the Quality Account, authorising submission to the Department of Health and Social Care and approve its publication.

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 healthcare services offered in order to demonstrate their commitment to continuous, evidence-based quality improvement, and to explain progress.

The draft Quality Account for 2025/26 is provided as **Appendix 1**. It is a requirement for the Quality Account to be approved by the Board and published on the Trust's external website by 30 June 2026.

The assurances provided to the Board to enable it to sign off the Quality Account include that the Quality Assurance Committee have considered feedback received from Stakeholders, and provided assurance to the Audit and Risk Committee that it provides a fair, accurate and understandable description of the quality of the Trust's services. This has been endorsed by the Audit and Risk Committee acknowledging that a robust process has been followed in compiling the document and it complies with the requirements set out in the relevant regulations.

The Board is asked to note that there continues to be no requirement for the Quality Account to be reviewed by the Trust's External Auditors.

Under the Regulations, key stakeholders (Integrated Care Boards, Local Authority Health Overview and Scrutiny Committees, local HealthWatch, etc.) are provided with an opportunity to formally comment on the Quality Account prior to publication. This is to support confidence in the accuracy of the data and conclusions drawn by the Trust. The consultation commenced 01 May 2026 and concluded 31 May 2026. Comments received to date have been included within Appendix 3 of the Quality Account.

Prior Consideration and Feedback

Feedback received from stakeholders is included within the appendices of the Quality Account.
In addition, presentations on the Quality Account have been provided to:

- Hartlepool BC Audit and Governance Committee, 17/03/2026
- Special Health and Housing Scrutiny Committee, Darlington, 14/05/2026

There has also been presentation of progress against the Trust's Quality Priorities to the Quality Assurance Committee and several Local Authorities during 2025/26.

The Quality Assurance Committee have reviewed the draft Quality Account 2025/26, considered the feedback received from Stakeholders, and provided assurance to the Audit and Risk Committee that it provides a fair, accurate and understandable description of the quality of the Trust's services.

The Audit and Risk Committee (22/06/26) have reviewed the Quality Account and have determined that a robust process has been followed and agree with its completeness, integrity and accuracy. Committee has recommended its approval.

Implications

The Trust is required to establish and implement systems and processes to identify risks and mitigate their occurrence. Failure to do so, may constitute a breach of the Provider licence.

Recommendations

The Board is asked to approve the Quality Account 2025/26, authorising submission to the Department of Health and Social Care and approve its publication.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust

Quality Account 2025/26

Contents

Part One: Introduction and context

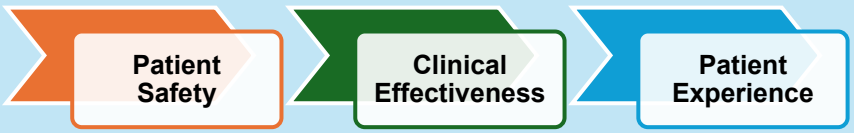
1.1 Welcome to the Quality Account and its purpose

Welcome to the 2025/26 Quality Account.

The 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 our 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, patient safety, clinical effectiveness and patient experience.



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 2025/26, our priorities for improvement in 2026/27 and the required statements of assurance from the Board
- **Part 3:** Further information on how we have performed in 2025/26 against our key quality metrics and national targets and the national quality agenda

We appreciate you taking the time to review the Quality Account and 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 Statement on quality from the Chief Executive

Welcome to the Quality Account for Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). This report provides an overview of the quality of the services we deliver across our mental health, learning disability and autism services, and it sets out our commitment to providing safe, effective and compassionate care.

As a provider of specialist services across County Durham and Darlington, Teesside, North Yorkshire and York, we are dedicated to improving outcomes and experiences for people who use our services, their families and carers. Our priorities are aligned with national guidance from NHS England, our local system partners, and most importantly, the insights and feedback of people with lived experience.

Over the past year, we have focused on strengthening patient safety, improving timely access to care, addressing health inequalities and embedding a culture of continuous quality improvement. This includes work across community and inpatient mental health services and enhancing support for people with learning disabilities through personalised, recovery-focused care.

We remain committed to transparency and accountability. This Quality Account sets out what we have achieved, where we still need to improve, and how we use data, feedback and evidence-based practice to drive measurable change.

Statement from the Chief Executive

As Chief Executive of Tees, Esk and Wear Valleys NHS Foundation Trust, I am pleased to present this year's Quality Account. It reflects the dedication, professionalism and compassion of our staff across all of our services.

This year has continued to present challenges across health and care, including rising demand for mental health services and the need to reduce inequalities in access and outcomes. Despite this,

our teams have remained focused on delivering high-quality, person-centred care, ensuring that safety, dignity and respect are at the heart of everything we do.

The announcement on 11th December of a Public Inquiry into our services was a significant and sobering moment for our organisation. We welcome it. We know that for some patients, their families, and carers, their experiences of our care have fallen short of what they deserved. The Public Inquiry gives us an opportunity - and an obligation - to listen, to learn, and to make the lasting improvements that will ensure better, safer care. Quality of care is not a measure on a page - it is felt by every person who encounters our services, and we are committed to ensuring that experience is consistently safe, compassionate, and effective. And to make the lasting improvements. We are committed to engaging with that process fully and openly.

Over the last year we have made important progress in key areas, including improving patient safety, strengthening service accessibility, and involving people with lived experience in shaping our services. We have continued to deliver our quality priorities, which were co-created with people with lived experience. We have also developed our approach to quality improvement, using data and learning from incidents and feedback to inform meaningful change.

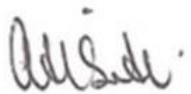
Tees, Esk and Wear Valleys NHS Foundation Trust priorities reflect the key ambitions of the NHS 10 Year Health Plan including:

- Expanding community-based care and access
- Strengthening mental health provision and parity of esteem
- Tackling health inequalities and prevention
- Embedding digital transformation and innovation
- Supporting the workforce and system integration

However, we recognise there is more to do. We are committed to reducing unwarranted variation in care, improving waiting times and continuing to strengthen the experience of people who use our services - particularly those who face the greatest inequalities.

I confirm that, to the best of my knowledge, the information contained within this Quality Account is accurate and presents a fair view of the quality of services provided by the trust.

On behalf of the Board, I would like to thank our staff, people who use our services, carers, and partners for their ongoing commitment and support as we continue our journey to deliver outstanding care.



Alison Smith
Chief executive

1.3 About our trust and the services we provide

We are a specialist mental health, learning disabilities and autism trust serving over two million people across 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.

We provide inpatient, community, and crisis services, including child and adolescent mental health services (CAMHS), adult mental health, older people's services, forensic services, and neurodevelopmental assessment services.

We support the recovery journey of anyone in need of our help. In our trust, everyone has a say in how they are supported and treated, we listen to every person in our care, we want people to feel understood. Our patients, their families and carers work together with us towards better mental health.

We're committed to new thinking that improves the wellbeing of the region we work in directly with service users and in partnership with others. We connect with our communities and partners to get mental health care right, in areas that really need it.

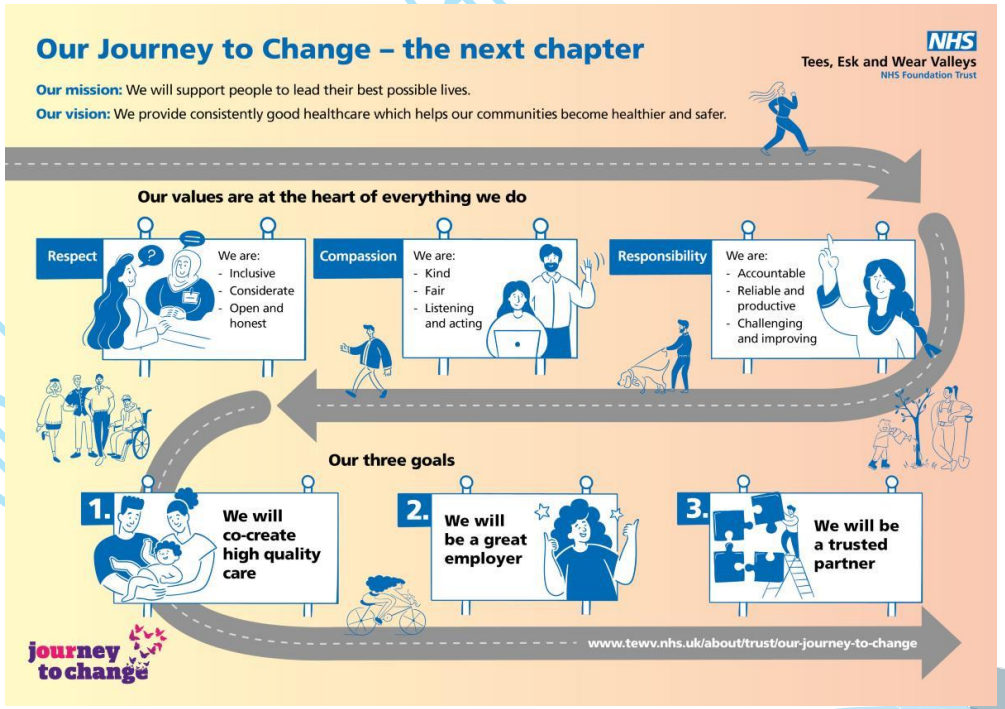
We will remain focussed on continuous improvement and the clinical and health outcomes of the communities we serve. We have a pivotal role in ensuring everyone in our region has the mental health care they need, to lead their best possible life.

1.4 Our Journey to Change: the next chapter

Our Journey to Change is our strategy, which we initially launched in 2021 and reviewed and refined in 2025. 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. It also outlines how we'll do this by living our values of respect, compassion, and responsibility all the time. Importantly, Our Journey to Change was co-created with people in our care, families and carers, our colleagues, partners and people in our communities.

Our focus remains on providing safe and kind care, continuously improving, and prioritising the health of our communities, in line with the 10 Year Health Plan. Whilst we've made significant progress since launching Our Journey to Change in 2021, we're committed to making changes that meet the evolving needs of our community, while keeping people at the heart of everything we do.

Following the publication of the NHS 10 Year Plan, we produced a five-year plan which sets out how we will deliver the three national shifts - hospital to community, sickness to prevention and analogue to digital. Our plan also included a section on how we will change how we work to support the shifts. A draft of the plan was submitted to NHS England in February along with our medium-term financial plan, workforce plans and our performance targets. The five-year plan will be published after our Board meeting in June 2026, although it will evolve and change over time and set out more detail on the specific planned changes.

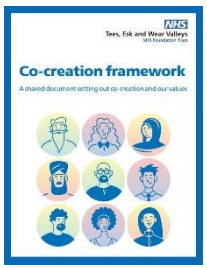


1.5 Co-creation

Co-creation is our word for working together towards shared goals. It applies to any situation where our trust works in equal partnership with people who use our services, carers, staff and partner organisations.

Throughout 2025/26 we have continued to strengthen how we listen to and work alongside our service users, carers and community partners. We have further embedded co-creation as a core part of how we design, deliver and improve our services.

Strengthening lived experience voice and leadership
We now have dedicated service user and carer groups across each of our clinical specialties. These groups work closely with services to shape everyday practice, influence our trust policies and support service redesign where needed. Over the last year, this approach has helped us continue to amplify lived experience voices and ensure they meaningfully inform how we deliver safe, compassionate and person-centred care.



Building on the launch of our co-creation framework in 2024–25, we refreshed our co-creation strategy to reflect the needs and aspirations of staff, service users and carers at different stages of their co-creation journey. This work also focused on removing barriers to involvement, including access to digital tools and support for people contributing through their lived experience. The updated strategy is now being operationalised in partnership with staff, service users, carers and system partners, supported by the co-development of new enabling structures.

Developing co-creation structures
Our co-creation boards, established in both care groups in 2023, have continued to grow and mature. We are seeing increased lived experience leadership, including service users and carers taking up roles on the Durham Tees Valley and forensic care boards. Their insight is helping shape how these boards conduct their business and strengthen their partnership approach across our geography.
Service users, carers and community partners have played a central role in major transformation programmes across our trust, including the urgent care programme and the Culture of Care work. Co-produced approaches continue to underpin safety planning, and during the next year we aim to progress the patient safety partner model, co-produced over the past 12 months.
Our patient experience service introduced the “I Want Great Care” platform this year, with all questions and structures co-produced with service users, carers, staff and voluntary and community sector partners.

Key areas of progress

We have continued to make significant progress across several priority areas:

- **Growing lived experience roles and leadership**

We continued to expand lived experience roles, including peer support workers, supported by system leadership and collaborative training with Teesside University. Peer networks are now established across Teesside, Durham and York, working closely with voluntary, community and social enterprise organisations.

- **Strengthening support for our involvement community**

We developed new induction, support and reflective practice training for involvement members. Work is underway to establish enhanced structures and resources to sustain and grow this community.

- **Leadership in national co-production**

We co-developed a national Community of Practice for strategic co-production—the first of its kind—bringing together leaders from NHS trusts and charities. Chaired by our head of co-creation, this group shares learning and resources on areas such as evaluation, diversity in co-production and strategic infrastructure.

- **Embedding co-creation across our trust**

Our internal co-creation community of practice continues to thrive, supporting staff to act as co-creation champions within their services. A co-developed train-the-trainer programme has been rolled out, enabling champions to build confidence, identify barriers and embed co-creation methodologies in their teams.

- **Establishing the lived experience education collective**

Launched in October 2025, the collective brings together mental health education services across our footprint, including voluntary sector partners. The group is now well established and has ambitious plans to extend lived experience education models to more communities.

- **Co-designing future services**

Throughout 2025, we co-developed the business case and service specification for a new crisis house service using Design Thinking methodology - rooted in personal stories and experience. This was the first time that the Trust used this methodology at scale, enabling staff at all levels to work alongside service users, carers and community organisations from the earliest stage of development.

- **Increasing lived experience involvement in trust-wide programmes**

Major transformation projects and policy development now routinely include lived experience leadership and input. This includes the LIO policy and procedure, the Positive and Safe Strategy, and the Personalised Care Planning Policy, all of which have been co-produced.

- **Embedding and Growing Co-Creation Across the Organisation**

Progress this year includes:

- **515 people** remain active on the involvement register. Recruitment continues, with a focus on engaging young people, autistic service users, and people with learning disabilities, alongside carers.
- The involvement and engagement team has strengthened relationships with voluntary and community sector partners to reach more diverse communities.
- **196 involvement opportunities** were shared during this reporting period, covering a wide range of activities including interviews, service redesign, quality improvement projects and training delivery.

1.6 Patient story

A former soldier from North Yorkshire has spoken about how ***co-creation has been life-changing*** for him.

Bob Etherton, whose artwork brings happiness to many of our patients, talked about the importance of co-creation in his wellbeing journey at an involvement event in York.

Bob, 81, a long-term involvement member with our trust, said: “Being part of TEWV has helped re-build my morale and confidence – two important aspects of human nature.

“It has made me a member of the team. I am accepted for who I am. My voice is valued, and my opinion taken into consideration. It also gives me a wider appreciation of the work involved.”

Bob was born in 1944 and served as a special operator in the Royal Corps of Signals. He retired as a major in 1992, then re-trained as a teacher – spending two decades in education.

In 2015, following a tragic experience, he became an inpatient at TEWV– but drew on his military background, the love of his family and the help of our trust staff to find a road to recovery.

“My five weeks as an inpatient were a kaleidoscope of experiences through the prism of mental illness,” he said.

Bob discovered he had a talent for art during his recovery, and his paintings now decorate the walls of Cross Lane Hospital in Scarborough and Foss Park Hospital in York.

Over the past ten years he has also worked hard to help others as an involvement member – taking part in workshops, focus groups, interview boards, recruitment drives and presentations.

“As a soldier I know how important confidence and morale are. From day one in the army these were built and reinforced into the individual and the team,” he said. “But those who have experienced mental health issues know how these aspects can fly away when we go down into the negativity of a psychotic episode or other debilitating illness.”

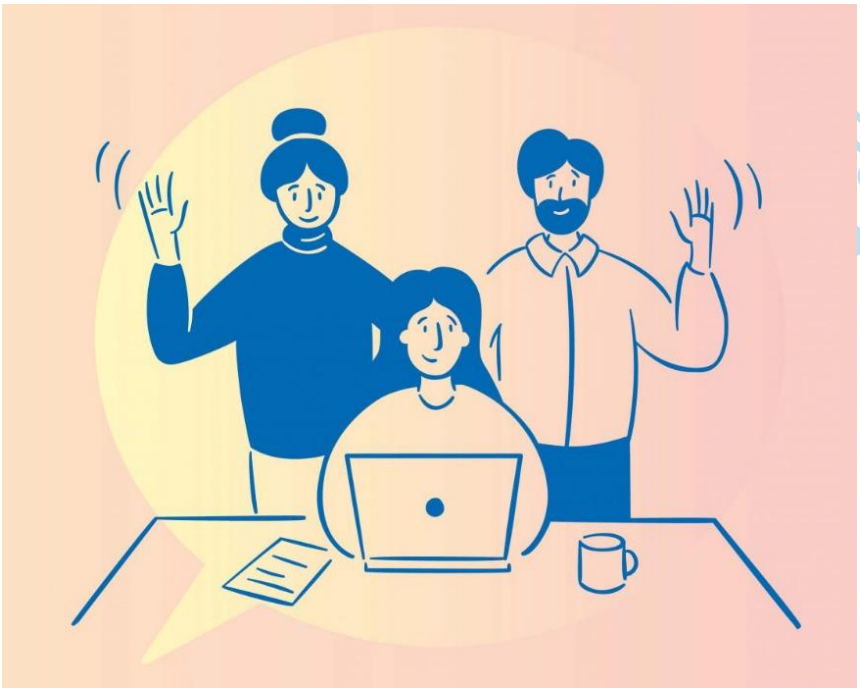
Bob was invited to share his story, and several of his paintings, during the community involvement day in June 2025 – and used his speech to highlight the importance of co-creation for all. “I’ve participated in many co-creation activities, each one different and many quite mentally challenging, and this has helped to enable me to overcome my fears and apprehensions,” he said.

1.7 The services we provide

We deliver care under six clinical directorates across our care groups:

- 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

There is further detail about our trust and the services we deliver in section 1.3.

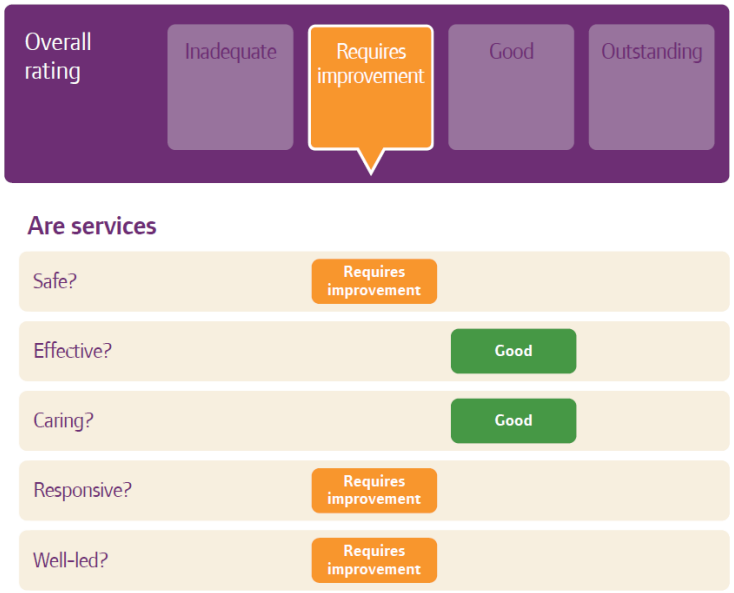


1.8 Our CQC ratings

CQC's current ratings for our Trust overall and for each key domain is as follows:

Overall rating: **Requires improvement**
For each key domain our Trust is rated:

- Safe: **Requires improvement**
- Effective: **Good**
- Caring: **Good**
- Responsive: **Requires improvement**
- Well-led: **Requires improvement**



Further information can be viewed within section 2.10: What the Care Quality Commission (CQC) says about us.

1.9 What we have achieved in 2025/26

We are committed to putting people and communities at the heart of everything we do, working in partnership to improve access, support prevention and deliver safe, compassionate care.

Over the last 12 months, this has included:

- Continued delivery of the community mental health transformation programme across North Yorkshire, York, the Tees Valley and County Durham. For some of our services this has improved access, reduced waiting times and enhanced patient experience through closer partnership working.
- We were part of the opening of a new community wellbeing and mental health hub in York, delivered in partnership to improve access to support.
- Employment support from our Individual Placement and Support (IPS) has helped 800 patients who have experienced severe and complex mental health conditions. This supported 320 patients into paid employment opportunities in the last year.
- An increase in the number of lived experience roles, including peer support workers. This has been supported by training with Teesside University.
- National recognition for the Tees crisis triage and assessment hub, which received the 2025 Seni Lewis Award from the Royal College of Psychiatrists
- Working with partners across York to open a wellbeing and mental health hub in Acomb Garth. Plans are in progress to extend the hours of the Acomb Garth hub to 24-hours a day, seven-days-a-week.
- Launching our You Matter campaign, developed in collaboration with people who have lived experience of mental health challenges to encourage others to seek support early.
- The opening of Hummingbird House, our new community base for child and adolescent mental health services, adult mental health and North Yorkshire Talking Therapies in Harrogate.
- We used our trust research capability funding to support the development of 13 new research studies.
- We opened a new state-of-the -art medical simulation suite at Lanchester Road Hospital, in Durham, designed to support workforce development and high-quality mental health training.
- In the latest GMC National Training Survey we were ranked 6th nationally for trainees and 9th nationally for trainers. This meant we were in the top 10 nationally for both categories for the first time in our trust's history.
- Our finance team supported the development of our medium-term plan and started schemes to deliver shifts of care from hospital to community, treatment to prevention, and the use of analogue to digital.
- We contributed to several successful NIHR applications, including a £1.8m NIHR Work and Health Programme Award and a Research for Patient Benefit (RfPB) programme looking at Behavioural Activation in patients undergoing haemodialysis (treatment for kidneys).

- We were placed fifth nationally for the number of recruiting ‘interventional’ mental health research studies.
- We now have dedicated service user and carer groups across each of our clinical specialties. These groups work closely with services to shape everyday practice, influence trust policies and support service redesign where needed.
- People in our care, carers and community partners have played a central role in major transformation programmes across our trust, including the Urgent Care Programme and the Culture of Care work.
- To improve how patients can share feedback with us, we introduced the “I Want Great Care” experience platform this year. All the questions were co-produced with people in our care, families and carers, staff and voluntary and community sector partners.
- We co-developed a national Community of Practice for strategic co-production—the first of its kind—bringing together leaders from NHS trusts and charities.
- We completed a research project evaluating the impact of the national NHS Talking Therapies Employment Advisors programme. The project focused on understanding how employment support integrated within mental health services can help people move closer to or into work while receiving treatment.
- We co-developed an Augmented Reality mental health crisis simulation training app with Teesside University. The project aims to enhance training through immersive technology.
- Our digital and data team was shortlisted for an HSJ Digital Award for its Centralised Asset Management Project, recognising innovation in improving back-office efficiencies through digital solutions.
- We held our second annual TEWV 10k event, encouraging community participation and fundraising.
- Children and young people supported by our trust took part in interview training, helping to recruit new staff and shape services.
- We were part of a partnership approach that led to the opening of a new respite service for adults with learning disabilities at Levick Court in Middlesbrough.
- We received positive feedback from NHS England’s National Education and Training Survey (NETS), which highlighted strong learner and trainee experiences for inductions, supervisions, facilities, learning opportunities and teamwork.

Thank you to everyone involved with our trust over the last year for your important contribution.

1.10 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 body	Awarding status	Category	Team / individual
Positive Practice in Mental Health National Awards	Winner (joint)	Children and Young People's Mental Health Services	The Ridings - Redcar community CAMHS
Positive Practice in Mental Health National Awards	Highly commended	Peer Support	Arch Recovery College
Positive Practice in Mental Health National Awards	Highly commended	Mental Health Rehabilitation and Recovery	Arch Recovery College
Positive Practice in Mental Health National Awards	Highly commended	Quality Improvement / Service Transformation	Wellbeing unit team - HMP Hull
Positive Practice in Mental Health National Awards	Highly commended	Older Adult Mental Health / Dementia	Woodside Dementia and Wellbeing Unit
Positive Practice in Mental Health National Awards	Winner	Special Award for Outstanding Work in Forensic Services	Ridgeway Education Team
Positive Practice in Mental Health National Awards	Highly commended	Inpatient care	Elm ward
Positive Practice in Mental Health National Awards	Highly commended	Mental Wellbeing of the Workforce	Reasonable adjustments team
Positive Practice in Mental Health National Awards	Winner	Education and Employment Services	Individual Placement & Support Service
Positive Practice in Mental Health National Awards	Winner	All Age Crisis Care Pathways	Teesside Crisis Services
Positive Practice in Mental Health National Awards	Highly commended	Suicide Prevention category	Teesside Crisis Services
Positive Practice in Mental Health National Awards	Winner (joint)	NHS Peer support	NHS Peer Support Service
PharmaTimes Nursing Industry Excellence Awards	Winner	Educator Excellence	STOMP
Healthwatch South Tees	Winner	Spotlight Award	STOMP
Carers Trust	Accreditation	Triangle of Care Star 2	Tees, Esk and Wear Valleys NHS Foundation Trust
British Psychological Society	Certified	Working with Older People for contributions to research	James Olvanhill
Lived Experience Awards	Winner	Community & Collaboration category	Borrow and Buy - Ridgeway service users
Healthcare Financial Management Association (HFMA) - Northern Branch	Winner	Northern Branch Colleague of the Year Award	Alex Pederson

Award body	Awarding status	Category	Team / individual
Healthcare Financial Management Association (HFMA) - Northern Branch	Winner	Unsung Hero	Gill Duffield
Healthcare Financial Management Association (HFMA) - Northern Branch	Winner	Unsung Hero	Daniel Staples
Healthcare Financial Management Association (HFMA) - Northern Branch	Winner	Unsung Hero	Sarah Griffiths
RC Psych Awards 2025	Winner	Psychiatric Team of the Year: Older-age Adults	Trustwide MHSOP Clinical Network
RC Psych Awards 2026	Honoured	President Medal	Dr Mani Krishnan
Inclusion North - Project Innovation Award	Won	-	-
HPMA Excellence in People Awards 2025	Won	Health and Wellbeing category	Reasonable adjustments team
Nursing Times Workforce Summit and Awards 2025	Highly commended	Nurse preceptee of the Year Award	Mollie Urwin
Royal College of Psychiatrists	Won	Seni Lewis Award	Tees crisis triage and assessment hub

Part Two: Quality priorities for 2025/26 and required statements of assurance from the Board

2.1 Introduction – purpose of this section

In part two of our Quality Account, we review the progress we have made in relation to our 2025/26 quality priorities we set ourselves and provide a series of statements of assurance from the Board on mandated items as required by NHS England.

In addition, we outline our planned quality improvement priorities for the next financial year.

2.2 Our approach to quality governance and improvement

During 2025/26, we have continued to strengthen our established approach to quality governance and improvement, ensuring that safe, effective, and person-centred care remains at the forefront of everything we do. Our direction of travel builds on the foundations and progress demonstrated in previous years where we set out clear structures for monitoring quality and driving improvement across services.

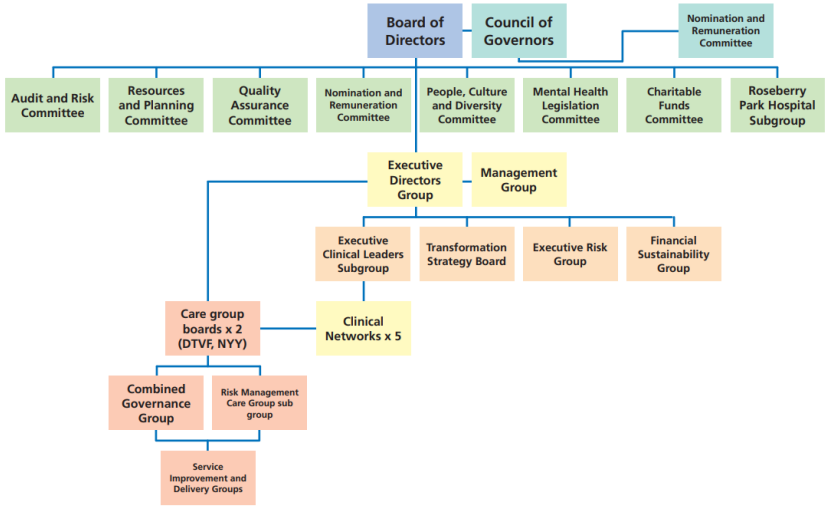
Our quality governance arrangements in 2025/26 remain underpinned by a comprehensive framework that supports transparency, accountability and consistent oversight. This includes established reporting routes through our Board of Directors, Quality Assurance Committee, the Care Group Board and clinical governance forums - mechanisms that ensure quality, risk and safety are continuously monitored and escalated appropriately. These structures were outlined and strengthened in previous reporting years and continue to evolve as part of our improvement journey. As we enter the next financial year, we are strengthening these governance arrangements.

Our strategic direction, **Our Journey to Change,** continues to guide our 2025/26 quality governance and improvement approach. We have continued to focus on five key areas: **clinical models**, **quality and safety**, **people**, **co-creation**, and **infrastructure**, ensuring that the decisions we make support safer care, better outcomes and more positive experiences for patients, families and staff.

Our governance structure supports the delivery of Our Journey to Change by ensuring that we are:

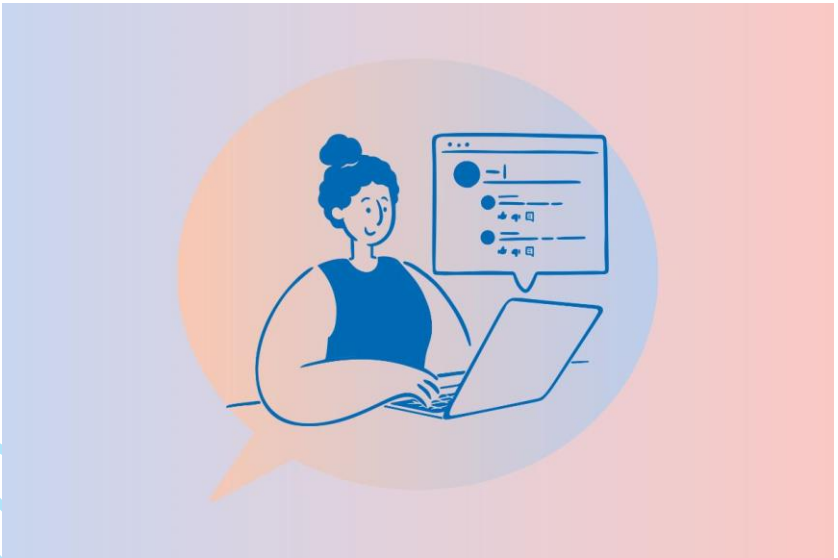
- **Clinically led and supported by strong operational systems**, so that the care we provide is shaped by clinical expertise and enabled by effective processes.
- **Well aligned with the two Integrated Care Systems we work within**, helping us respond to regional developments and work seamlessly with our partners.
- **Clear about our responsibilities**, both individually and across the wider system, so that everyone understands their role and can carry it out confidently and consistently.
- **Organised in a simpler and more straightforward way**, with patient leadership formally built into how we work, ensuring the voices of people with lived experience are central to our decision-making.

The governance structure in place during 2025/26 is shown as follows:



Our Trust Board oversees strong and effective quality governance through the Quality Assurance Committee, which is one of its key sub-committees. The Quality Assurance Committee is led by a non-executive director. Its purpose is to give the Board assurance about the quality, safety and effectiveness of our clinical and operational services. It does this by reviewing how well our systems, structures and processes are working and by highlighting where improvements are needed.

Strengthening co-creation and lived experience leadership
Co-creation remains central to our quality improvement philosophy. Co-creation boards and the development of a diverse peer workforce are just a few innovations which have continued to be a key driving force to ensure that patients, carers and families help shape priorities, policies, and service design at all levels of the organisation. In addition, the lived experience directors continue to play a critical role in embedding lived experience perspectives into governance, decision-making and quality improvement activity.



Embedding learning and improving patient safety
We use a quality governance framework aligned with PSIRF (Patient Safety Incident Response Framework), with Board oversight and quality improvement methodologies. Our new incident reporting and quality management system is working well and these represent major improvements in how we learn from incidents and have enabled faster identification of themes and strengthened learning processes.

In addition, we have an established organisational learning group which plays a central role in ensuring learning is shared effectively across the organisation, there is triangulation of information, and improvements are driven in care quality and safety. We are always building on our commitment to delivering safe, kind and clinically effective care.

External assurance, performance monitoring and accountability

In 2025/26, we continue to engage with external regulators, including the Care Quality Commission (CQC), NHS England, Integrated Care Boards and local partners.

Quality and safety performance is monitored through a comprehensive suite of quality metrics and mandatory indicators, covering patient safety, effectiveness and experience - reflecting national priorities and ensuring transparency for all stakeholders.

Quality assurance and improvement

Our **quality assurance and improvement programme** helps us focus on key quality and safety priorities and has supported improvements such as strengthening patient care documentation. The programme uses a range of tools, such as **peer quality reviews**, **leadership walkabouts**, and **inpatient / community / prison services quality reviews** to support in the services that we deliver. These tools have been reviewed in 2025/26 to ensure that they reflect current quality and safety priorities.

The programme helps us monitor how well we meet key quality and safety standards for our patients, and it provides valuable data and feedback that helps to drive sustained improvements.

During 2025/26, we have successfully began integrating parts of the programme into our electronic **InPhase system**, which will continue to develop during the next year.

Progress and findings from the Programme are reported through our **Integrated Care Group Governance Group**, **Executive Directors Group** and the **Quality Assurance Committee**.

2.3 Our progress on implementing our quality improvement priorities

In April 2024, our Quality Assurance Committee endorsed a new co-creation approach to developing quality priorities, with each priority co-led by people with lived experience. This ensures that the voice of service users, carers and families is at the heart of quality improvement. The three priorities align with the domains of quality – patient experience, patient safety, and clinical effectiveness.

Our priorities build on previous years, focusing on embedding practices over three years (2024/25, 2025/26, and 2026/27).

All three priorities have active workstreams with multidisciplinary and service-user involvement. Co-creation forums have continued to review progress and have provided further feedback to guide their direction. Work will continue to identify emerging priorities and ensure that these initiatives truly improve people's day-to-day care experiences.

Quality priority one
Patient experience: Promoting education using lived experience

Quality priority two
Patient safety: Relapse prevention

Quality priority three
Clinical effectiveness: Improving personalisation in urgent care

Key progress against the three priorities and how they are being sustained and embedded is included within this section.

Priority one
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, we will establish a cycle of learning, which will be shared with key partners.

What we said we would do and what we have done to deliver this quality priority since last year:

1) We will develop a programme of training that can be offered. This will include facilitating training sessions as well as some formal workshops, in addition to referring to online resources accessible via our trust intranet and other associated communications. We will ensure that the personalised care training is delivered both internally and externally.

Our peer lead for inpatient services and the Culture of Care Programme has developed, in partnership with our involvement and engagement training lead, co-creation for our inpatient wards. This training has been developed with services users and carers. Roll out of the training commenced with our inpatient wards, with three wards receiving training between December 2025 and January 2026.

Our lived experience director (in our Durham, Tees Valley and forensic, care group) and our peer co-ordinator for Ridgeway, successfully piloted Dialogical and relational training on Bilsdale and Esk Wards. This training focused on introducing skills of open dialogue and embedding reflective practice in the care and governance of the wards.

Leadership development sessions facilitated by Lived Experience Leaders from our Peer Leadership Team took place in February 2026, with Birch ward. The programme of work started to support the leadership team to approach their team development using reflective, relational and lived experience skills. An overarching evaluation and feedback work was completed which evidenced significant positive impact and experience of the team.

2) We will deliver the identified training programme throughout quarter 3 and quarter 4 to internal and external colleagues and partners (considering voluntary services).

Our peer lead for health and justice and co-production manager for Rethink, through the jointly commissioned partnership in health and justice, have established a lived experience learning network with partner organisations, Spectrum, Waythrough and Rethink.

Our lived experience director for DTVF and the head of co-creation have facilitated the establishment of a lived experience education collective with York St Johns University, Teesside Mind and Arch Recovery College.

Trustwide carers strategic exploration has commenced. Initial meetings have brought together patient safety, family liaison, the working carers network, patient experience, peer leads, allied health professionals, voluntary, community and social enterprise partners and clinical networks to map existing activity and to clarify gaps. An event took place in February 2026 to establish clearer oversight and define a strategic direction. This work will inform executive oversight and the development of a formal trust-wide carers strategy.

Further areas in progress to support delivery of this priority include:

- **The launch of the co-produced patient safety, experience and learning group.**
  - The patient safety learning and experience group operates as a structured trust-wide learning forum, embedding lived experience alongside multidisciplinary leadership. The group works to a defined six-month learning cycle model (exploratory, solution and implementation phases) to ensure that learning from incidents, complaints and safeguarding activity leads to tested and implemented change.
  - Communication has been prioritised as the first theme following analysis of 102 communication-related learning themes across services. This includes communication with families and carers, confidentiality decision-making and multi-agency information sharing. Breakout sessions have identified some staff uncertainty, variability in follow-up and cultural barriers as key safety risks.
  - The group is now moving from exploratory insight to defined tests of change, with outputs feeding into our trust's organisational learning group and service governance structures. This represents a more disciplined approach to translating lived experience and safety data into improvement.
  - This provides strengthened oversight of cross-cutting safety themes. Evidence of sustained implementation will be monitored through the learning cycle and governance reporting routes.

Priority 2
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 patients' safety and care plans.

What we said we would do and what we did for this quality priority:

1) We will review how patients' safety and care plans are used for people in community services, and establish best practice standards for these plans.

Work during this year has moved from review toward operational embedding of personalised relapse prevention within community services.

Roll-out of DIALOG-informed review conversations has been led by community modern matrons via our care group quality standards groups. This strengthens structured, person-centred review of wellbeing, risk and relapse prevention within routine contacts and supports shared decision-making within named worker relationships.

In parallel, a co-produced community operational framework for adult mental health services has been developed. This framework sets out a consistent model for personalised care, formulation, multidisciplinary team oversight, named worker continuity and transitions across community services. Patient, carer and staff representatives have contributed to its development and colleagues across our trust have been engaged in the working group.

2) We will co-create an audit tool to review the plans

Our quality assurance and improvement programme tools continue to include regular review of patients' safety plans 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.

Audit activity has increasingly focused on the quality and practical usability of safety and care plans, rather than solely confirming their presence. This includes consideration of whether plans are personalised, accessible and meaningful during periods of deterioration. Findings continue to demonstrate improvement across the majority of relevant metrics for both inpatient and community services, with robust oversight maintained through our governance structures.

Further areas in progress to support delivery of this priority include:

- Engagement at executive director group level regarding the personalised care framework as a behavioural quality discipline, ensuring relapse prevention is embedded within operational governance rather than treated solely as a documentation requirement.
- Continued co-creation board challenge, reinforcing the need to strengthen post-discharge continuity, carer involvement and practical accessibility of safety plans during periods of deterioration.
- Alignment with the NHS England personalised care framework (Modern CPA) has progressed from exploratory discussion to executive-level consideration. A structured session with our executive directors group (24 February 2026) reframed the personalised care framework as a behavioural quality discipline rather than a standalone programme.

Priority 3
Clinical Effectiveness: Improving personalisation in urgent care

Why it is important:

This priority focuses on embedding personalisation in practice at urgent and inpatient interfaces, ensuring that care is relational, coordinated and safe, particularly during admission, crisis and discharge transitions. This aligns with the NHS England Culture of Care standards and supports consistent application of the “My Story Once” principles in real-world settings.

What we said we would do and what we did for 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.

Delivery has progressed from policy incorporation to behavioural embedding through the Culture of Care Programme.

Six inpatient wards are actively engaged in structured Culture of Care roll-out, using a defined quality improvement methodology and PDSA cycles (Plan, Do, Study, Act).

- 37 change ideas completed
- 23 change ideas currently in testing
- 18 change ideas planned

Change ideas directly linked to urgent and inpatient personalisation include:

- Appointment slips and meeting preparation tools
- Discharge and formulation leaflets
- Sensory and reasonable adjustment tools
- Protected medication conversations
- Environmental safety improvements

These changes are co-produced and measured using both proxy safety indicators and patient-reported experience data.

2) We will review and update the associated training through ward-based Culture of Care exploration sessions and cross-organisational learning structures, including reflective spaces and leadership engagement.

Rather than relying solely on online modules, embedding is occurring through:

- Ward Improvement huddles
- Defined implementation leads and improvement leads
- Regular governance reporting routes
- Executive and cross-organisational engagement structures

This strengthens accountability for behavioural change in practice.

3) Staff will have undertaken training and embed practice.

A rapid culture of care review was undertaken on one of our Lanchester Road Hospital inpatient wards between September and November 2025. The review used structured listening, anonymised staff interviews, patient and carer feedback, ward observation and data triangulation.

Key findings identified:

- Strong therapeutic relationships as a core strength
- Some communication gaps and staffing pressures affecting continuity
- The need to strengthen psychological safety and transparency
- The importance of structured follow-through and governance clarity

The review generated defined short, medium and long-term actions and established ongoing monitoring through ward-level governance and leadership oversight.

This provides direct evidence of the Culture of Care methodology being applied as a structured, measurable improvement process rather than a conceptual framework.

2.4 Statement of assurances from our trust

In this section of the Quality Account, we are 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 2025 Community Mental Health Survey results
- Our 2025 National NHS Staff Survey results
- Clinical audit: participation in clinical audits and national confidential inquiries
- Clinical research
- What the Care Quality Commission (CQC) says about us
- Information governance
- Freedom to Speak Up
- Learning from deaths
- Complaints
- Data quality
- Mandatory quality indicators

2.5 Review of services provided by or contract by our trust

During 2025/26 our trust provided and/or subcontracted 48 relevant health services. Our trust reviewed all the data available to us on the quality of care in 48 of these relevant health services.

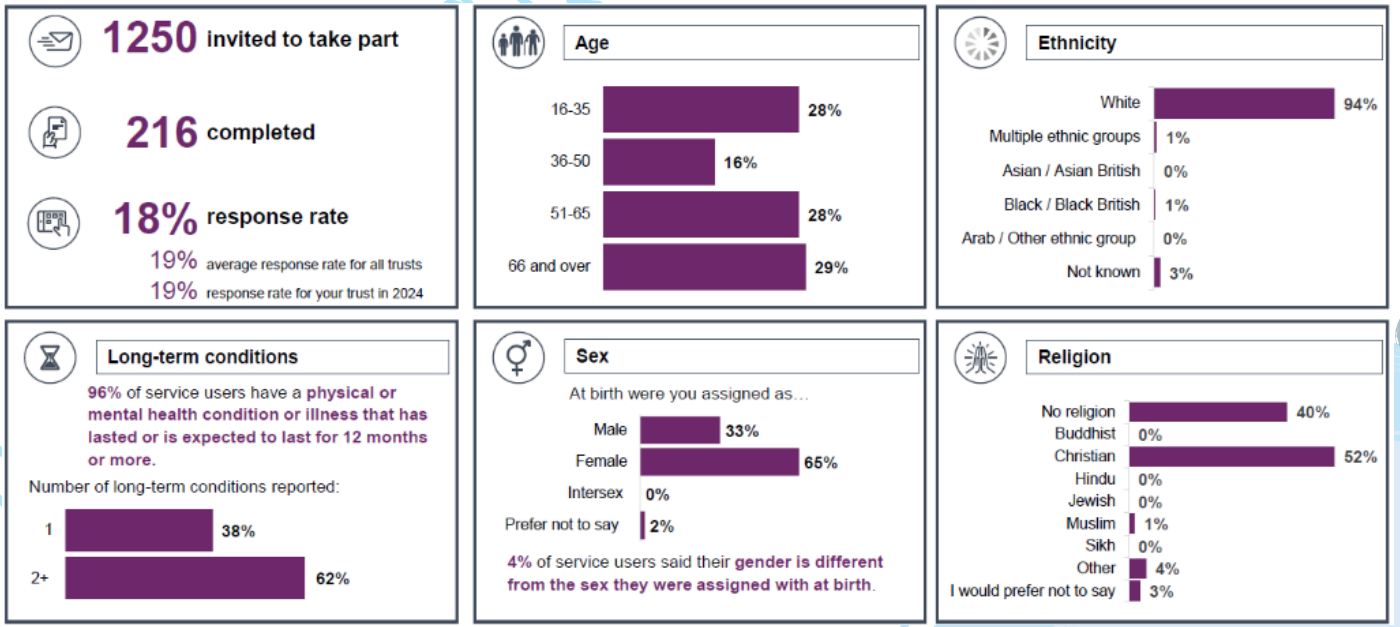
The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant health services by our trust for 2025/26.

2.6 Our 2025 Community Mental Health Survey results

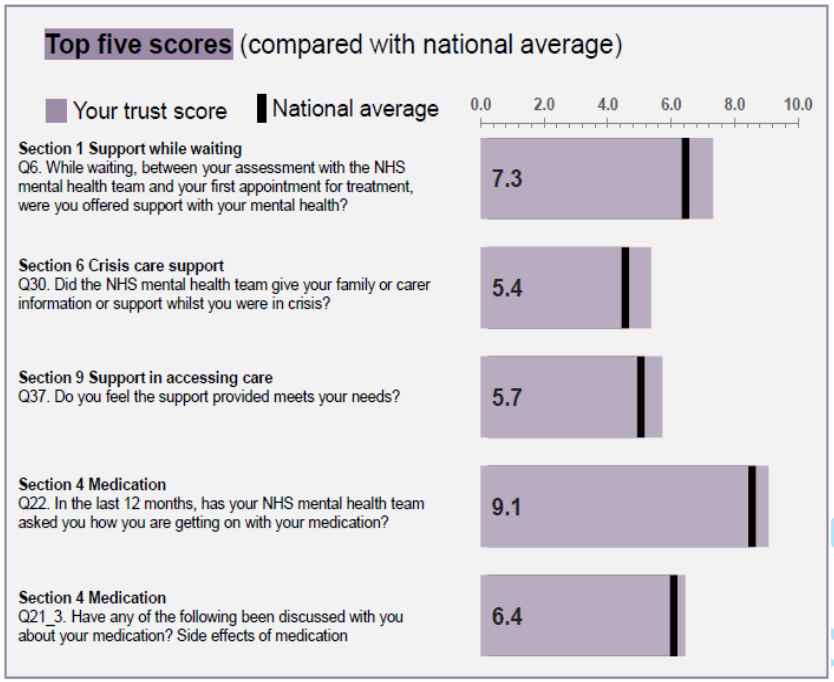
Results of the 2025 Community Mental Health Survey were published 27 March 2026. Feedback was shared from people if they were aged 16 or above at the time of drawing the sample and were seen by someone face-to-face at the trust, via video-conference (e.g. using Attend Anywhere, MS Teams, etc.) or via telephone call between 1 April and 31 May 2025 (sampling period), and had at least one other contact (face-to-face, video conference, phone or email) either before, during or after the sampling period (excluding calls to query appointment times). The survey was undertaken between 18 August 2025 and 28 November 2025 and participants were offered the choice of responding online or via a paper-based questionnaire.

There were **216** completed surveys returned within our Trust for the 2025 Community Mental Health Survey, a response rate of 18%. This is within the same range as to the national average response rate (19%).

The following image illustrates the population of our patients who took part in the survey:

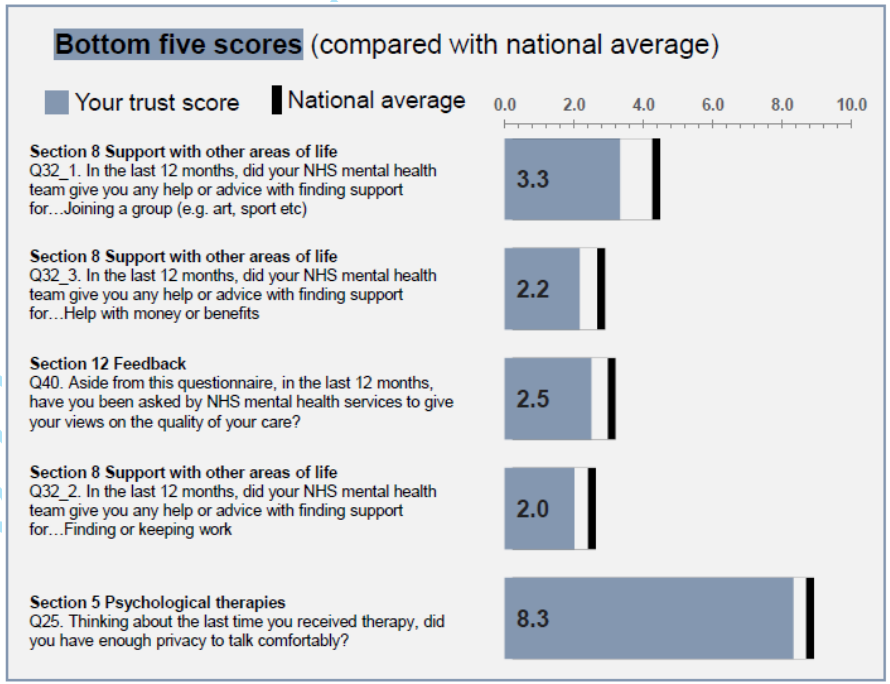


The following top five and bottom five scores (compared with the national average) are illustrated as follows:



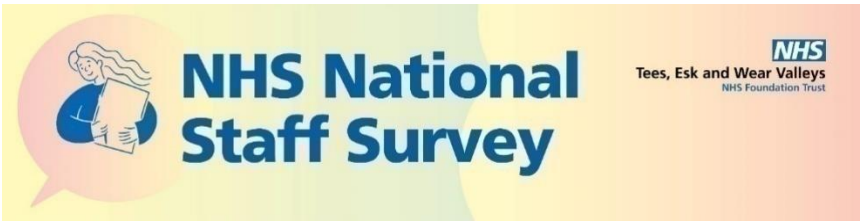
We are actively addressing areas highlighted in the National Community Mental Health Survey by strengthening co-produced care planning, improving access and communication, and enhancing continuity of care through named coordinators. Services are embedding patient feedback into continuous improvement processes and working closely with our patients, carer and staff to ensure meaningful change.

To increase response rates, we are expanding survey promotion, improving accessibility, and demonstrating how feedback directly influences service development through 'You said, we did' initiatives.



Full results of the survey for our trust can be found at: https://www.cqc.org.uk/search/site?fulltext=Mental%20Health%20Survey

2.7 Our 2025 National NHS Staff Survey results



The **2025 NHS National Staff Survey** results were made available on 13 March 2026, with a total of 4239 responses received from colleagues who shared their thoughts and experiences of working at our Trust.

Key highlights of the survey results:

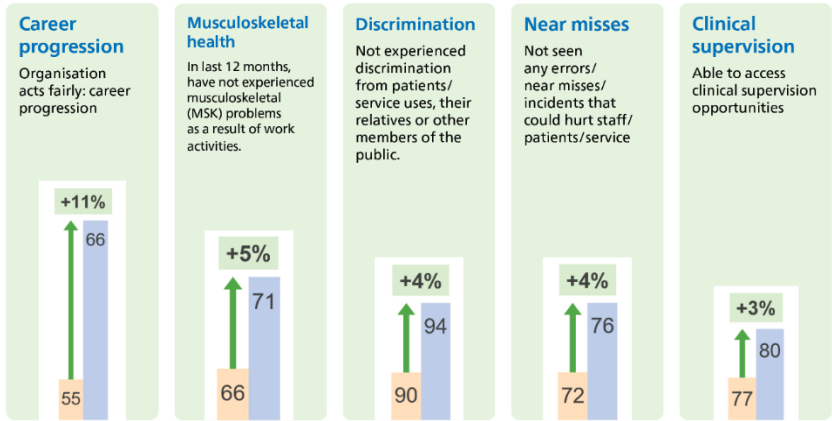
- The final response rate was 52%, compared to 44% in 2024.
- We are ranked number 11 against 19 Mental Health Trusts for overall positive score.
- We were recognised as having the second-largest positive score increase for 2025.

Where we've most improved

We've made meaningful progress in several important areas including:

- Feedback on changes after incidents
- Availability of nutritious food at work
- Ensuring errors/incidents are not repeated

Where we're performing better than the national average



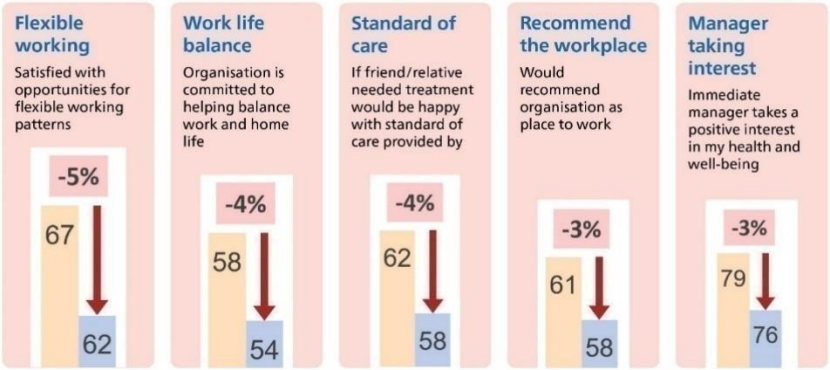
We're proud to be outperforming national averages in key areas including:

- Fewer colleagues experiencing musculoskeletal issues due to work
- Fairness in career progression
- Opportunities to access clinical supervision

Where we need more focus

Only a single area – career development – showed a decline of more than 3% against our previous organisational average. This is a result we can be proud of.

Where we're performing lower than the national average



While we're proud of our achievements, we also recognise that there's still work to do to support our work colleagues to:

- Feel satisfied with flexible working opportunities
- Balance work and home life
- Feel involved in work-related changes and help make improvements.
- Ensure the trust is a great place to work, and that you are confident with the services we provide

What we achieved together following the results of last year's survey

We have taken significant steps to address staff feedback and make meaningful changes across our Trust. Some of our key initiatives have included:

- Developing and implementing the people management programme, to help strengthen management capability and improve staff experience
- Moving the reasonable adjustments team to be permanently funded - supporting staff and managers from the point of recruitment onwards
- Ongoing reviews of mandatory and statutory training across all staff groups to ensure we make the most of the time we commit to training
- Reviewing key HR policies around conduct/disciplinary, capability and health, and wellbeing and attendance to create a more streamlined process
- Establishing a new occupational health provider who is more responsive and tailored to our needs
- Implementing a new Freedom to Speak Up service, which is available 24/7, fully independent and offers a range of guardians to talk to if colleagues have specific needs
- Making the internal transfer scheme a permanent process rather than two 'windows' a year, making it easier to recruit internal candidates
- Continuing work on responses to violence and aggression, sexual misconduct and racism
- Holding aspiring leaders and personal/professional growth programmes

Looking to the future

Our people and culture directorate will be focusing on two key priorities over the next year:

Flexible working

Why: Concerns were highlighted relating to flexible working arrangements. While we slightly improved on the *I can approach my immediate manager to talk about flexible working* question, our scores remain below the national average.
Focus: Ensure flexible working is fair to all staff while maintaining service delivery. This includes supporting managers to have constructive conversations and embedding consistent processes across teams.

People management skills programme

Why: This is the second year we scored under the national average in all areas of *experience of my immediate manager*. We know the role of team or ward manager is a difficult one and we need to support people in these roles to do their job well.
Focus: Strengthen leaders' capability in people management skills to improve staff experience, engagement and development conversations. This programme is already underway and will be a major element of cultural change.

2.8 Clinical audit: Participation in clinical audits and national confidential inquiries

During 2025/26, **8** 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%** of national clinical audits and **100%** of 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 2025/26 are as follows:

- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (NAD)
- National Audit of Eating Disorders (NAED)
- National Clinical Audit of Psychosis (NCAP)
- POMH Topic 20c: Improving the quality of valproate prescribing in adult mental health services
- POMH Topic 18c: Use of Clozapine
- POMH Topic 22b: Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services
- POMH Topic 17c: Use of antipsychotic medication for relapse prevention in patients with a diagnosis of schizophrenia

The national clinical audits and national confidential enquiries that Tees, Esk and Wear Valleys NHS Foundation Trust participated in during 2025/26 are as follows:

- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (NAD)
- National Audit of Eating Disorders (NAED)
- National Clinical Audit of Psychosis (NCAP)
- POMH Topic 20c: Improving the quality of valproate prescribing in adult mental health services
- POMH Topic 18c: Use of Clozapine
- POMH Topic 22b: Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services
- POMH Topic 17c: Use of antipsychotic medication for relapse prevention in patients with a diagnosis of schizophrenia

The national clinical audits and national confidential enquires that we participated in, and for which data collection was completed during 2025/26, 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	% registered cases required
National Audit of Care at End of Life (NACEL)	16	**100%**
POMH Topic 18c: Use of Clozapine	24	**100%**
POMH Topic 20c: Improving the quality of valproate prescribing in adult mental health services	39	**100%**

Audit Title	Cases Submitted	% registered cases required
POMH Topic 22b: Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	110	**100%**
National Audit of Dementia	15 *(team level questionnaires)*	**100%**
National Audit of Eating Disorder	10 *(team level questionnaires)*	**100%**
National Clinical Audit of Psychosis	N/A *(data sourced directly from Mental Health Services Data set -MHSDS)*	**-**
National Confidential Inquiry into Suicide and Homicide by People with Mental illness (NCISH)	81 Questionnaires sent to trust clinicians with 56 returned.	**69%**

The reports of the **5** national audits were reviewed by the provider in 2025/26 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Key requirements of the Trust's Rapid Tranquilisation policy will be ~~reinforced~~ emphasised through inclusion in a future Medicines Optimisation Messages of the Month (MOMM) and Medicines Matters update, including signposting to relevant Trust guidance (e.g. MSS21).
- The existing internal post-event audit process led by Modern Matrons will be maintained. This will include structured data capture via InPhase, with monthly reporting to service-level governance meetings and the Trust-wide Positive & Safe Group to ensure ongoing oversight and assurance.
- An assurance report will be submitted to the Drug & Therapeutics Committee, highlighting that the findings of this audit are contrary to outcomes identified through the internal post-event audits undertaken by Modern Matrons.
- Local formularies, prescribing algorithms, and shared care guidelines will be reviewed and updated to ensure licensed preparations are promoted as first-line treatment options.
- Prescribing algorithms and shared care guidelines will be harmonised across the Trust to ensure these requirements are clearly articulated and consistently applied.
- The Pain Assessment and Management Guidelines will be revised to strengthen pain assessment on admission, ensure documentation of the continuation and review of existing analgesia within the Electronic Patient Record (EPR), and promote timely advice from physical health practitioners.
- A Trust-wide communication will be issued regarding methadone and buprenorphine guidance, alongside the Medicines Safety Standard (MSS) for medicines reconciliation.

The reports of **111** local clinical audits were reviewed by the provider in 2025/26 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Improving Physical Health Monitoring and Early Deterioration Recognition

- Strengthening the consistent use of the National Early Warning Score (NEWS) across inpatient wards, including leadership oversight and multidisciplinary discussion.
- Enhancing venous thromboembolism (VTE) risk assessment processes through improved induction, policy alignment, and reassessment of mobility where clinically indicated.
- Improving pain assessment by updating Trust policy and standardising assessment on admission, particularly within older people's mental health services.
- Enhancing routine checks of emergency response equipment using an environmental checklist (e.g. defibrillators and emergency response bags) to support rapid response to physical health emergencies.
- Reviewing equipment-related risks (e.g. mattress compression and entrapment) to reduce the risks of avoidable physical harm through safer equipment use and staff training.

Safer Use of Medicines and Medicines Optimisation

- Introducing structured annual medication review checklists, including side-effect monitoring, to strengthen the safe and effective use of long-term medicines.
- Revising medicines safety standards for diabetes care to reduce the risk of omitted medication and ensure effective prescribing, including clear guidance on hypoglycaemic agents.
- Sharing learning and good practice through pharmacy-led education, supervision, newsletters, and targeted training for prescribers and data collectors.
- Promoting awareness of cardiometabolic health risks for people with serious mental illness through audit feedback, communications, and clinical engagement.

Strengthening Safeguarding, Public Protection, and Risk Management

- Improving identification and recording of multi-agency public protection (MAPPA) concerns within the electronic patient record, including staff training and clearer admission processes.
- Enhancing domestic abuse identification and response by embedding risk assessment tools into care planning, refreshing staff training, and improving clarity of documentation.
- Promoting robust safeguarding record keeping, "making safeguarding personal," and ensuring the voice of the child is considered through training, supervision and regular communications.
- Strengthening Mental Capacity Act (MCA) documentation to support clear evidence of decision-making and capacity assessments in patient records.

Improving Response to Missed Appointments and Engagement with Care

- Improving staff understanding of the Did Not Attend / Was Not Brought (DNA/WNB) policy through Trust-wide education.
- Introducing a standardised checklist to ensure risk is assessed consistently following missed appointments, supporting safer follow-up and continuity of care.

Enhancing the Quality and Consistency of Clinical Assessment Processes

- Refreshing and standardising core assessment processes such as frailty assessments and ensuring appropriate oversight and review at ward level.
- Supporting consistent use of structured assessment tools through training, supervision, and follow-up record reviews to monitor compliance and improvement.

Promoting Health Improvement and Prevention

- Strengthening identification of smoking status on admission and ensuring timely support from tobacco dependency advisors in line with policy.
- Using audit data to inform awareness campaigns, local improvement actions and staff engagement around long-term health risks and prevention.

Learning, Assurance, and Sustained Improvement

- Using targeted record reviews and follow-up audits to assess whether changes have been embedded and are improving care quality.
- Ensuring learning from audits is shared clearly across teams and professional groups to support continuous improvement and organisational learning.

In addition to those local clinical audits reviewed (i.e. those that were reviewed by our quality assurance committee), we undertook a further **171** clinical audits in 2025/26 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 continues to implement and embed a new electronic application – **InPhase** across our trust. Our quality assurance schedule for inpatient and community services, along with infection prevention and control (IPC) audits, is now fully delivered through InPhase. Audit results are available in real time via interactive dashboards, providing improved visibility of clinical quality information enabling teams to make informed changes to improve practice.

We continued to implement an extensive quality assurance and improvement schedule during 2025/26. 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.

2.9 Participation in clinical research

Our trust participates in and develops research activity, given the vital role of research in providing new knowledge to help transform services and improve outcomes for patients. It is important that 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 2025/2026 that were recruited during that period to participate in research approved by a research ethics committee was **627** across **28** National Institute for Health Research (NIHR) portfolio research studies. Of all NHS trusts nationwide, this year we ranked fifth place for number of recruiting 'interventional' mental health research studies.

We successfully set up and are currently recruiting to two commercial clinical trials, one in early Alzheimer's Disease and the other for adults with bipolar disorder.

The NIHR released a nationwide article recognising the team's efforts in streamlining the information governance review process to set-up studies faster, supporting the UK's drive to cut clinical trial set-up times to 150 days.

We have hosted new successful NIHR grant applications, including a £1.8m NIHR Work and Health Programme Award and a Research for Patient Benefit (RfPB) programme looking at behavioural activation in patients undergoing haemodialysis.

Our research and development department regularly collect responses to the participant in research experience survey, which shows very positive feedback regarding participants' experiences of being involved in research.

Join dementia research

We are continuing to help secure hundreds of new sign-ups to join dementia research, making our trust the leading site for most sign-ups.

2.10 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 our trust. Our trust is therefore licensed to provide services.

The CQC has not taken enforcement action against Tees, Esk and Wear Valleys NHS Foundation Trust during 2025/26.

Tees, Esk and Wear Valleys NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

2.11 Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

There were no 2025/26 CQUIN requirements.

2.12 Information Governance

The NHSE Data Security and Protection Toolkit (DSPT) reporting year runs from 1st July to 30th June each year. TEWV have submitted an **Approaching Standards** DSPT-CAF submission for the period July 2024 - June 2025. We are working with NHS England (NHSE) on a submitted action plan to ensure that all indicators of good practice are met. Progress against this is monitored quarterly by NHSE.

It is confirmed that a baseline DSPT-CAF submission for the period July 2025 to June 2026 was submitted in December 2025 in line with normal practice, however, the DSPT toolkit portal has not yet been updated to reflect this at the time of reporting.

Organisation code: RX3

Address: TRUST HEADQUARTERS, WEST PARK HOSPITAL, DARLINGTON, ENGLAND, DL2 2TS

Primary sector: NHS Trust

Publication history

Status	Date Published
2024-25 (version 7) - Approaching standards	25 June 2025
2023-24 (version 6) - Standards met	28 June 2024
2023-24 (version 6) - Baseline	28 February 2024

2.13 Freedom to Speak Up

Colleagues have multiple ways in which they can raise concerns. Most people talk to their manager or supervisor or someone else in a senior role, and all staff in management roles undertake the national training on listening to colleague concerns. We also have our staff networks, the employee support service, union colleagues, people officers and partners, and multiple colleagues in teams such as safeguarding and training who listen and support anyone with concerns about care or employment. We have intentionally increased the professional support e.g. through professional nurse advocates and coaches, so that the expectation of sharing concerns, and listening and acting become increasingly embedded in our culture.

We have also appointed a new external and completely independent **Freedom to Speak up Guardian** with **The Guardian Service**. This began from 17th November 2025, and we are very pleased to see that there has been an increase in colleagues accessing this service, building on what was already a strong provision. This service is now available 24 hours a day throughout the year. Both they, and the Guardian of Safe Working, who hears concerns from resident doctors, report directly and independently into our board of directors.

On the board is a non-executive director who is the Freedom to Speak Up Champion. We have a very rigorous process in place with their oversight to investigate any situation where someone feels they have experienced detriment as a result of speaking up. This is rare but is investigated thoroughly and reported to that non-executive director.

2.14 Community mental health transformation

The community mental health transformation programme aims to modernise how mental health support is delivered across North Yorkshire, York, Tees Valley and County Durham. It focuses on creating services that are **easier to access**, **more joined up with other organisations** and **better aligned to the needs of local communities**. The overall vision is to provide earlier intervention, timely and joined up care without the need for multiple referrals across different organisations, and to improve experience of care and outcomes for people with severe mental illness. This is a significant challenge in light of the diversity of the many places and communities that we serve. This diversity includes urban and rural settings, and communities who don't identify with discrete geographical boundaries.

To support the aims described above, across North Yorkshire, York, the Tees Valley and County Durham, community mental health teams are at various stages of redesign. The previous split between Affective and Psychosis Teams in parts of the Trust no longer exists. We have Community Mental Health Teams that are aligned to geographical boundaries and local systems at place, and we are continuing the redesign process to reduce internal boundaries and to better integrate our services into local systems. New roles such as wellbeing practitioners, peer support workers and care navigators help people navigate services more easily.

Our trust and our partners have made strong progress in developing specialist pathways. This includes enhanced support for people with complex emotional needs and eating disorders, introducing a range of new 'system-wide' specialist roles supporting the wider system with an aim to ensure people get the help they need as quickly as possible. Collaborative work with voluntary and community organisations has strengthened access to tailored support, while evolving multi agency huddles help professionals coordinate care more effectively as part of an integrated mental health system, involving partners from social care, substance use services, talking therapies, voluntary, community and social enterprise (VCSE) support, housing and employment services. In Tees Valley and County Durham, development of community rehabilitation teams has complemented the inpatient offer and means more people are supported in their normal living environment, and when admission is required, the length of stay in hospital has decreased. Plans are underway to develop a similar service in North Yorkshire and York through service redesign. We have also worked with our partners to develop and implement a trauma informed approach across a broad range of services and organisations including the local authorities in North Yorkshire and the City Of York, North Yorkshire Police, Primary Care Networks and a range of VCSE organisations including Mind.

These changes have dramatically reduced waiting times for community services, in County Durham and Teesside from three months to 28 days, and only a small number of people now need to be stepped up to specialist care. County Durham has introduced a new "gateway" approach, ensuring people receive contact through a collaborative model with primary care and

VCSE. Enhanced roles in GP surgeries provide more support close to home, and partnerships with voluntary sector organisations offer targeted help for older adults, younger people and those with physical health needs linked to mental illness. Waiting times in North Yorkshire and York have not decreased as dramatically but are also beginning to improve and further opportunities are evident as a result of York's further development of neighbourhood services, including the Acomb Garth Neighbourhood Mental Health Resource Centre. Acomb Garth is formally participating in the 24/7 Neighbourhood Mental Health Resource Centre Pilot (one of only six in the country) and the impacts of this development are subject to national evaluation. Neighbourhood Mental Health Resource Centres are a key component of the new 10 Year Plan for the NHS, and the evaluation of the pilot sites will inform the specification and implementation of these centres country-wide. The neighbourhood services offer same day access to a range of local authority, VCSE and mental health services. These services include not only planned care services but also seek to offer a range of crisis alternatives with the aim of supporting the 'left shifts' from hospital to community, and from sickness to prevention. The neighbourhood hubs receive very positive feedback from people using these services. There are good links with a broad range of organisations (as well as the formal delivery partners). There are plans to open similar centres across North Yorkshire, Teesside and County Durham over the next few years.

As stated, the programme has delivered significant measurable improvements. Referrals into planned care in Durham and Tees Valley have reduced, waiting lists for assessment have reduced significantly and caseloads are beginning to decrease after large increases following the COVID-19 pandemic. Average waiting times for a first appointment are reducing in North Yorkshire and York. In County Durham and Tees Valley more than 90,000 mental health appointments are now delivered each year in primary care through our specialist mental health practitioners based in GP surgeries, most people seen in their local GP practice within a week or two and not requiring a further referral to secondary care, helping reduce the flow into secondary care by 15–20%. In North Yorkshire and York more than 55,000 mental health appointments have been delivered in primary care settings with less than 5% of those contacts leading to a subsequent referral for a person into secondary care.

Patient experience remains very positive, with **94% of patients rating their care as good or excellent**. Local hubs and pop-up facilities in rural areas have increased the options for patients to access help. Lived experience forums are now active across both regions, ensuring people who use services help shape how they evolve.

There is still work to do, including simplifying communication about our new pathways, increasing access to psychological therapies, improving data sharing (in the neighbourhood developments in York all partners are now using the same electronic record), and managing financial pressures - particularly for voluntary sector partners. Ensuring suitable community spaces, supporting early intervention approaches, and improving joint working across children's, adult and older adult services are also key priorities as the programme moves forward.

2.15 Learning from deaths

During 2025/26, **1,974** deaths were reported to Tees, Esk and Wear Valleys NHS Foundation Trust's incident reporting system, with the majority of these considered to be from natural causes. We recognise that each number represents an individual person, and extend our sincere condolences to families, carers, and loved ones affected. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- Quarter 1 - **517**
- Quarter 2 - **503**
- Quarter 3 - **546**
- Quarter 4 - **408**

Of the 1,974 deaths, in line with the national guidance on learning from deaths, **630** deaths fit the criteria for further review, of which **434** were case record reviews or investigations. We aim to ensure that any review is undertaken in a way that is proportionate, considerate of those affected, and focused on understanding care experiences as well as identifying opportunities for learning. This comprised of the following number of case record reviews and investigations (after action reviews and/or patient safety incident investigations) which were completed in each quarter of the reporting period:

- Quarter 1 – **110**
- Quarter 2 – **113**
- Quarter 3 – **108**
- Quarter 4 – **103**

In mental health and learning disability services, we have a number of older people who are cared for within the community and their needs are such that 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 1,974 patient deaths during the reporting period 2025/26 1.16% of the deaths occurred where a problem in care was identified and considered 'more likely than not' to have contributed to the death. In relation to each quarter, this consisted of 11 (2.12%) in the first quarter; 6 (1.19%) in the second quarter; 4 (0.73%) in the third quarter and 2 (0.49%) in the fourth quarter. We recognise that behind these figures are individuals and families, and we approach each case with care, openness and a commitment to understanding what happened.

During 2025/26, 113 case record reviews or investigations were completed which related to deaths that occurred during the previous reporting period (2024/25). Of the 113, 14 were where a problem in care was identified and considered 'more likely than not' to have contributed to the death. Total deaths for 2024/25 were 1,744. When all the case record reviews and investigations of deaths in 2024/25 are considered, a total of 37 (2.12%) of the deaths that occurred in 2024/25 were where a problem in care was identified and considered 'more likely than not' to have contributed to the death.

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).

During 2025/26 the number of learning points identified from case record reviews and investigations were as follows:

- **126** in the first quarter
- **169** in the second quarter
- **121** in the third quarter
- **102** 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 **12** learning themes identified during 2022/23 and 2023/24. These are:

- Clinical effectiveness/personalised care
- Communication
- Infrastructure (environment/estates/digital)
- Legislation and policy compliance
- Medicines management
- Our people and culture
- Patient safety
- Patient, carer, family involvement and experience
- Physical healthcare
- Recording keeping/care documents
- Risk assessment/management/contingency planning
- Safeguarding

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 our inpatient, community and prison services. Ongoing quality assurance processes where specific learning themes have been highlighted have been presented through a monthly system wide quality meeting.

We continue to strengthen arrangements for organisational learning via the organisational learning group which has multi-disciplinary and executive level membership.
The group's role is:

- To develop and maintain processes to learn and improve after patient safety incidents, complaints, safeguarding, leadership visits, investigations etc.
- To alert our 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 review and investigations can be discussed within the organisational learning group. Learning will be disseminated via clinical networks, quality standards meetings briefings where appropriate, to ensure that learning feeds into existing improvement work. During 2025/26, themes explored in this forum included medicines management, physical healthcare, clinical effectiveness and personalised care, our people and culture.

25 patient safety briefings have been circulated trust wide during 2025/26 as a result of learning. Examples of these briefings include:

- Recording of reasonable adjustments on CITO (our electronic patient record system)
- Automated external defibrillator (AED) pads
- Environmental risks
- Updates on the functionality of systems such as LIO (formally Oxehealth)
- Saving patient information outside of the Electronic Patient Record (EPR)
- Printed EPMA prescriptions: Stopped Titrations Appearing Active
- Empressa profiling bed frame braking mechanisms

The briefings circulated are specific about any assurance required from services. On receipt of completed actions these are documented on the trust-wide alert system. All briefings are available to all staff via the learning library which can be accessed via the trust intranet.

The environmental risk group receives information where environmental factors may have contributed to harm, as well as progression of initiatives to reduce harm. Any urgent learning identified through this group is distributed trust-wide via patient safety briefings. The annual environmental survey programme with multi professional input from estates, health and safety and clinical services continue. The ligature reduction programme is monitored through this group with assurance provided through the Trusts quality governance structures. Significant investment has been dedicated to assistive technology in the form of LIO and door sensors to make wards safer.

Suicide prevention training and being with distress workshops, continue, 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 upon request.

The learning from deaths policy is aligned to PSIRF and 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.

2.16 Local resolution and complaints

All complaints are managed in accordance with national guidance, and our trust is dedicated to ensuring that patients, carers, and families have accessible avenues to seek advice, request information, raise concerns, or submit complaints regarding the services provided. Our complaints policy clearly outlines the process for doing so, enabling individuals to feel assured that their concerns will be heard and addressed with the utmost seriousness.

Our approach to complaints handling is designed to ensure an effective process for service users, delivering optimal outcomes efficiently. This approach is fully aligned with the standards set by the Parliamentary and Health Service Ombudsman (PHSO) for NHS Complaint Standards (2022).

We encourage individuals to raise any issues or concerns with staff directly involved in their care, as this often enables prompt and satisfactory resolution without the need to escalate to a formal complaint. This process, known as local issue resolution, is intended to resolve matters either immediately or within ten working days. All feedback at this level is electronically recorded via InPhase, capturing the nature of concerns, outcomes, actions taken, and any identified learning.

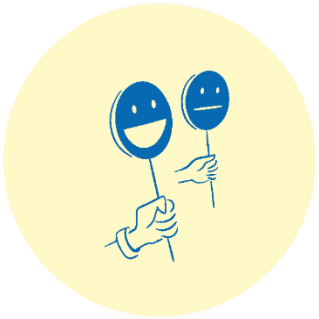
We acknowledge that not all concerns can be resolved immediately, and there will be occasions when a complaint is necessary. All complaints are managed through a pathway of either 'early resolution complaint' or 'formal complaint', determined locally by the complaints team. We adhere to the principle of 'investigate once and investigate thoroughly', ensuring that complainants receive an open and honest written response which details any learning and demonstrates our commitment to listening and taking their complaint seriously.

We recognise that all complaints provide essential insights into the quality of our services. Ward and team managers have full visibility of all concerns and complaints, which are utilised in governance discussions as part of our learning processes. Additionally, learning is triangulated with other sources of intelligence, such as patient safety incidents and is shared with our trust's organisational learning group to support continual improvement.

Our activity in 2025/26 can be summarised as follows:

Financial Year	Local Issue Resolution	PALS	Complaints	Total
2025/26	917	N/A	698	1,615
2024/25	748	N/A	479	1,227
2023/24	206	1,773	498	2,477

917 concerns were managed locally at ward or team level whilst the complaints were managed as an early resolution complaint (553 in total) and 145 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 medication and communication issues. This can be compared to the previous financial year whereby it was the same type of issues that were identified as the highest reported themes.

We have also seen an increase in the number of complaints that have been responded to within our originally agreed timeframes (69% in 2024/25 and 86% in 2025/26).

The complaints team has received a number of positive feedback messages following complaints handling, examples are as follows:

Thank you for the response to our complaint. I am very grateful that the Trust has responded in such detail which is appreciated and also wish to express thanks for responding so speedily. I will have some comments to feedback when I am able to. ***Family Member***

I have 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 present situation. ***Patient/Carer***

A huge thank you for managing a very complex complaint recently. Not only have you listened to and given compassion to a frustrated family, but you have also been very thoughtful in listening to the team who are trying too. You have heard and had some very difficult conversations, and you are not a clinician who deals with sad and worrying cases daily. Your kindness and care has been worth noting. The response you pulled together for the family has been thorough, clear and compassionate, and you have taken considerable time in endeavouring to meet the complaint detail in full. A big thank you. ***Staff Member***

2.17 Data quality

The latest published Data Quality Maturity Index (DQMI) score is **93.4%**. This is for November 2025.

Tees, Esk and Wear Valleys NHS Foundation Trust did not submit records during 2025/26 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 2025/26 by the Audit Commission. We have had our annual external clinical coding audit for the data security and protection toolkit. The results were 87% accuracy for primary diagnosis and 88% accuracy for secondary diagnosis.

We stopped making commissioning dataset 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 2025 were 99.8% and 100% respectively.

2.18 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 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, **2995** patients were discharged between 1 April 2025 and 31 March 2026, of those:

- **2802 (93.56%)** were followed up
- **193** were not followed up within 72 hours between April 2025 and March 2026.

Patients' experience of mental health teams

For 2025, we have reported the mental health section score of the NHS Community Mental Health Survey Benchmark. Our Trust has reported a score of 6.82 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 2025	National average 2025	TEWV mean score 2024	TEWV mean score 2023
Were you given enough time to discuss your needs and treatment?	**6.98**	**7.05**	6.7	6.9
Did you feel your NHS mental health team listened to what you had to say?	**6.99**	**7.18**	6.9	*Question updated from 2024*
Did you get the help you needed?	**5.99**	**6.12**	6.0	6.0
Did your NHS mental health team consider how areas of your life impact your mental health?	**6.72**	**6.68**	6.5	6.7
Did you have to repeat your mental health history to your NHS mental health team?	**4.71**	**4.71**	4.1	4.7

National patient safety incident reports

We continue to report into the National Learning from Patient Safety Incidents (LFPSE) system. 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. NHS England now produces a patient safety event data quarterly publication, providing a national overview of events recorded as well as some high-level summary data by organisation.

Part Three: Further information on how we have performed in 2025/26

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 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.

NHS Oversight Framework

Five performance domains were scored and published as part of the Quarter 4 release in June 2026, with the Trust placed in Segment 2, ranking 15th out of 61 trusts.

Domain	Quarter Units	Q4 2025/26		Q3 2025/26		Q2 2025/26		Q1 202526	
		Metric score	Rank	Metric score	Rank	Metric score	Rank	Metric score	Rank
People & Workforce	Segment	4.00		4.00		4.00		4.00	
	Score	3.44	50 out of 61	3.68	27 out of 61	3.59	56 out of 61	3.44	54 out of 61
Patient Safety	Segment	1.00		2.00		2.00		2.00	
	Score	1.81	17 out of 61	2.11	20 out of 61	2.44	32 out of 61	2.41	33 out of 61
Effectiveness & Experience	Segment	1.00		1.00		1.00		1.00	
	Score	1.50	5 out of 60	1.53	3 out of 60	1.53	3 out of 60	1.57	6 out of 59
Finance & Productivity	Segment	1.00		1.00		1.00		1.00	
	Score	1.45	14 out of 61	1.45	12 out of 61	1.45	12 out of 61	1.11	5 out of 61
Access to Services	Segment	3.00		4.00		4.00		4.00	
	Score	2.57	35 out of 59	2.91	41 out of 59	3.35	52 out of 58	3.37	49 out of 58

For all identified areas for improvement, remedial actions are in place, supported by robust scrutiny and oversight from both Board Committees and the Board through the Integrated Performance Report.

Quality metrics:

Patient Safety indicators	Target	Whole Trust 25/26	Whole Trust 24/25	Further comments
Percentage of patients who report 'yes to the question 'do you feel safe on the ward?'	75.00%	**79.56%**	**80.66%**	In September 2025 we implemented I Want Great Care as our new Patient & Carer Experience system, and in response to service user feedback we have reduced and simplified the number of responses available on our patient and carer surveys.
Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	**0.12**	**0.06**	-
The number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	**30.72**	**27.86**	-
The number of medication errors with a severity of moderate harm and above	2.5	**4**	**4**	-
The number of Patient Safety Investigation Incidents (PSII) reported on STEIS	-	**10**	**27**	In January 2024 the Trust transitioned to the National Patient Safety Incident Framework (PSIRF), which advocates a more proportionate approach to investigations.

Clinical Effectiveness Indicators	Target	Whole Trust 25/26	Whole Trust 24/25	National Benchmark
Percentage of Service Users under adult mental illness specialities who were followed up within 72 hours of discharge from psychiatric inpatient care	85%	**93.56%**	86.12%	-

Clinical Effectiveness Indicators	Target	Whole Trust 25/26	Whole Trust 24/25	National Benchmark
Adults with a long length of stay over 60 for adult admissions	N/A	**67**	10.02%	The governed measure for 2025/26 reported the number of patients rather than reflecting that as a percentage of discharges
Older adults with a long length of stay over 90 days for older adult admissions	N/A	**46**	35.11%	The governed measure for 2025/26 reported the number of patients rather than reflecting that as a percentage of discharges

Patient Experience indicators	Target	Whole Trust 25/26	Whole Trust 24/25	National benchmark
Percentage of patients who reported their overall experience as very good or good	92%	**93.58%**	93%	England average (including Independent Sector Providers) was 89.83% as at January 2026. In September 2025 we implemented I Want Great Care as our new Patient & Carer Experience system.
Percentage of patients that report that staff treated them with dignity and respect	94%	**94.37%**	87.6%	-
Number of complaints raised	-	**698**	501	-

Additional supporting comments on areas for improvement

The number of medication errors with a severity of moderate harm and above:

Since May 2025, a coordinated programme of medicines optimisation communication and education has been implemented to strengthen staff awareness, promote safe and effective medicines use, and support consistent practice across our trust. This includes the introduction of medicines optimisation: messages of the month, a suite of monthly summary documents highlighting six key priority areas for staff. Topics include clinical guidance, medication safety, medicines procedures, EPMA updates, and medicines optimisation and cost effectiveness messages, all accessible centrally.

In parallel, a number of trust guidelines and resources have been developed or refreshed. This includes the introduction of a medication safety series document on Serotonin Syndrome; review and update of existing guidance such as the anxiety pathway and Clopixol Acuphase guideline; and an extensive review and refresh of clozapine related processes to strengthen safety and consistency of care.

To support sustained learning, medicine matters training has been developed and made available via e-learning, with nursing and pharmacy staff completing this on a rolling four monthly cycle. Any additional or emerging medicines related issues are addressed through a coordinated programme of communications via the monthly medicines management group, ensuring organisational oversight and timely dissemination of learning.

All moderate harm medication incidents are reviewed through our trust's patient safety processes, with professional guidance and specialist support provided by the medication safety team on request, ensuring clinical review, learning and assurance of appropriate individual action plans.

3.3 Other external reviews/ publications

Tees, Esk and Wear Valleys NHS Foundation Trust Public Inquiry
On 11 December 2025 the Secretary of State announced a public inquiry into our trust, following a meeting with families who have lost loved ones in our care.

We will co-operate fully with honesty, openness, grace and kindness. It's an opportunity to hear and learn what we could have done better, how we improve the experiences for our patients, families, carers and staff and most importantly, enabling those who have been affected to hear how sorry we are.
We must keep reflecting, challenging ourselves, and holding compassion and respect alongside responsibility in our minds. This will be our approach as we plan, prepare and respond to the public inquiry.

Martha's Rule – core standards implementation
In line with the publication of NHS England's Martha's Rule core standards, our trust is progressing a programme of work to ensure full alignment with the national requirements for timely escalation and independent clinical review. Second opinion arrangements, including Martha's Rule, are being embedded within all clinical teams' operational policies and supported through amendments to the electronic patient record (EPR) system to enable consistent recording, monitoring and reporting. These changes will strengthen oversight through routine reporting via the Integrated Information Centre (IIC) and inclusion in our clinical audit programme. A second opinions procedure has been developed to ensure that there is clear and accessible guidance for patients, families, carers and staff. Trust-wide dissemination is being delivered through established line management briefings to all our employees.

3.4 External audit

Under guidance from NHS England, the Quality Account 2025/26 is not subject to review by external audit.

3.5 Our stakeholders' views

We recognise 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 2025/26 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 and Wellbeing Boards
- Local Healthwatch organisations

All the comments we have received from our stakeholders are included verbatim in Appendix 3. Comments received will support our trust in achievement of its Strategic Goals and will inform delivery of the Trust's Quality Priorities for 2026/27. Stakeholder comments will also inform key learning for the development of the next year's Quality Account.

Appendix 1: 2025/26 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 2025 to March 2026
    - Papers relating to quality reported to the Board over the period April 2025 to March 2026
    - Feedback from the Commissioners, Overview and Scrutiny Committees, and 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 27 March 2026
    - The latest national staff survey published 13 March 2026

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.

Marie Burnham
Chair
To be confirmed following Board of Directors 25/06/26

Alison Smith
Chief Executive
To be confirmed following Board of Directors 25/06/26

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

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 patients' records.

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 within NHS Trusts in England over a specific period during the year. It measures experiences of care covering areas including crisis care, treatment, and support - to identify improvements and ensure high-quality, patient-centred care.

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.

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.

Department of Health: The government department responsible for health policy.

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.

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 patients' 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.

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.

LIO: (formerly Oxehealth) is a vision-based patient monitoring system that enhances patient safety and improves both quality of care and patient experience on our inpatient wards. It uses an infrared sensitive camera that can measure a patient's vital signs, how active they have been and where they are in their room. LIO technology has been rolled out by several NHS Trusts across England.

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.

Multidisciplinary: 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 multidisciplinary 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 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.

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.

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.

Our 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

Healthwatch County Durham, Hartlepool and Stockton (received 28/05/2026)

Healthwatch County Durham:
We recognise that the Trust has faced some significant challenges over the past year, and ongoing pressures on resources add further complexity to improvements and developments. We would like to note the following specific points:

- We are pleased to see the progress and ongoing work to embed co-creation within all elements of the Trust – the voice of those with lived experience is crucial to improving quality of care, and it is encouraging to see steps taken to ensure that voice is represented at both strategic and operational levels, and also within training. We would particularly like to commend the efforts of Chris Morton and the Lived Experience team in continuing to maintain a dialogue and partnership working with Healthwatch.
- We note that 'some' services have seen improved access, waiting times and patient experience following the Community Mental Health Transformation programme, and would hope to see that extend to 'all' over the next year. Community services continue to be what we hear most frequently about with regards to mental health.
- We welcome the introduction of a community operational framework for adult mental health services and look forward to hearing how this impacts patient experience.
- We welcome the roll out of the Culture of Care approach, and the introduction of co-produced change ideas. We wonder whether this approach will be rolled out across community-based care, where we hear of concerns around similar issues.
- We are pleased to see the list of intended actions following local clinical audits, particularly those reflecting improvements in patient safety. Further information such as timescales and an update on progress would be welcomed.
- While pleasing to see that TEWV performed higher than the national average in some aspects of the Community Mental Health survey, we noted that *Section 8 – Support With Other Areas of Life* fared poorly, suggesting that there is still significant work to do in terms of providing holistic care and partnership working across communities.

Healthwatch Hartlepool:
Following discussion and input from members of the Healthwatch Hartlepool Volunteer Steering Group we wish to make the following comments:

- Overall, we were pleased to note significant progress in the previous 12 months. This has been particularly noticeable in the areas of patient safety and the extent to which co-production and patient and carer lived experience are now embedded into both strategic and operational aspects of service delivery.
- We were particularly pleased to note the progress that has been made and the commitment demonstrated in putting communities at the heart of everything TEWV does, and the progress made in developing strong and effective community partnerships. We were however disappointed that the successful delivery of services at the Central Hub in Hartlepool was not referenced in the account.
- We were pleased to see that progress has been made around safer use of medicines and medicines optimisation. This includes the introduction of structured annual medication review checklists, including side-effect monitoring, to

strengthen the safe and effective use of long-term medicines. However, we did note that the Trust's patient safety quality metric indicates the number of medication errors with a severity of moderate harm and above is still higher than the trust target, indicating further work is needed.

- We were pleased to note the developments which have taken place to promote and support a learning culture within the Trust which enhances patient safety, service delivery and staff development. Greater use of targeted reviews and the sharing of subsequent learning will support continuous improvement, organisational learning and improved patient experience of care.
- We were pleased to note the progress which has been made in improving personalisation in urgent care and found the short case study of a rapid culture of care review which was undertaken at Lanchester Road Hospital to be informative and helpful.
- Overall, we felt that the presentation of the report can be significantly improved in future years. We found much of the language used to be complex and at odds with the Trust's aim to be accessible, transparent and inclusive. We felt that many of the graphics added little value, and some tables were very hard to follow due to design and font size. We also felt that a more concise Quality Account could have been produced without detracting from the value and content of the document. Once again, we are left feeling that this must be addressed if TEWV are to encourage greater co-production and public input to all aspects of ongoing service 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.
- Finally, whilst we recognise and acknowledge the important progress which has been achieved in the development of community based services, we find the absence of short term crisis bed provision in Hartlepool to be of ongoing concern.

Healthwatch Stockton-on-Tees:
We would like to recognise and commend TEWV for the quality and consistency of its engagement across the Tees Valley, particularly the meaningful involvement of people with lived experience. The peer support offer is a notable strength, with the leadership of Chris Morton, Lived Experience Director, and Liam Corbally, Head of Co-Creation, demonstrating the value of a well-embedded lived experience approach.

There is evidence of a person-centred approach, with an emphasis on listening, co-production, and tailoring support to individual need. We also welcome the Trust's proactive approach to improving access and addressing inequalities.

We recognise that this progress contrasts with some of the feedback we continue to hear from people using services. However, there is a growing sense that a corner is being turned, and it will be important that this is sustained and translated into consistently improved experiences.

Partnership working continues to strengthen, with community insight increasingly informing service development. We also welcome the Trust's openness in learning from deaths and its continued focus on patient safety, reflecting a culture of transparency and improvement.

Durham County Council's Adults Wellbeing and Health OSC (received 28/05/2026)

The Adults Wellbeing and Health Overview and Scrutiny Committee welcomes Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust's Quality Account 2025/26 and the opportunity to provide comment on it. The Committee is mindful of its 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 a number of areas in 2025/26 in respect of the Trust's CQC inspection results and associated Improvement Action Plans and provided a response in relation to each of the priority areas identified when considering the 2024/25 Quality Account. Additional engagement with the Trust has also been undertaken by the Children and Young People's OSC in respect of Child and Adolescents Mental Health Services (CAMHS) with members recognising the significant demand pressures placed on CAMHS but raising concerns regarding assessment and waiting times, alongside similar concerns in relation to neurodevelopmental assessments for ADHD and Autism. In addition, the members of the Children and Young People's OSC have received a briefing report on Consett Supporting Neurodivergent Children and Young People in Schools Project 2023-24 Project Review with the findings of the review well received by members, with members noting the positive feedback from families and schools in relation to the project.

In relation to the Quality Account for 2025/26 it is evident that the Quality Account is clearly set out and progress against the 2025/26 priorities is clearly evidenced.

Members were supportive of the approach undertaken by the Trust in relation to all three priorities, ensuring that the priorities have active workstreams with multidisciplinary and service user involvement with co-creation forums continuing to review progress and provide further feedback to guide direction.

Concerning Priority One: Patient Experience: Promoting education using lived experience, the development and rollout of training for inpatient wards, with input from service users and carers is welcomed with support from the committee for the continued rollout of the programme. It is recognised that that the continued input of service users and carers is essential to this particular training programme.

In addition, recognising the importance of carers, the work of the Trust in commencing the Trustwide Carers Strategic exploration is welcomed bringing together various groups to map existing activity and clarify gaps. The committee is very supportive of the development of a formal trust-wide carers strategy in the future.

Going forward the committee agrees with the Trust's proposal for the launch of a patient safety, experience and learning group, which recognises the importance of patient safety, the contribution of lived experience and the need for organisational learning, and will hopefully ensure continued improvement and implement change going forward.

In relation to Priority Two: Patient Safety: Relapse prevention: The committee was pleased to see that the Trust had moved from reviewing safety and care plans within community services towards operational embedding of personalised relapse prevention within community services. This work is seen as a major step to reduce relapse. In addition, the development of an audit tool to regularly review patients' safety plans and its co-

production with the patient is seen as a major improvement to maintaining patient's safety. The committee welcomed the findings which continue to demonstrate improvement across the majority of relevant metrics for both inpatient and community services with robust oversight maintained through the Trust's governance structure although the Committee emphasises that the Trust cannot be complacent and will need to continually monitor the performance and relevance of the audit tool.

In relation to Priority Three: Clinical Effectiveness: Improving personalisation in urgent care: The use of the 'My Story Approach' was previously supported by the committee in the 2024/25 response to the Quality Account. The committee has noted that delivery had progressed from policy incorporation to behavioural embedding through the culture of care programme with six inpatient wards actively engaging in structured Culture of Care roll-out using a defined quality improvement methodology and Plan, Do, Study, Act. The committee is supportive of this approach and the use of both proxy safety indicators and patient reported experience data. In addition, concerning training the committee welcomed the approach of not relying solely on online modules with embedding occurring through various measures which strengthens accountability for behavioural change in practice. The committee noted the methodology used and the key findings of the Rapid Culture of Care Review undertaken on an inpatient ward at Lanchester Road Hospital and welcomed the establishment of short, medium and long-term actions and the use of continued monitoring.

The committee recognised the work undertaken by the Trust detailed in the Quality Account however as commented by the Trust, the committee feels that there is more work to be undertaken and was pleased to see this acknowledged within the Quality Account in relation to reducing unwarranted variation in care, improving waiting times and continuing to strengthen and improve the experience of people who use the services.

Finally, to ensure that it continues to provide a robust health scrutiny function and to provide assurances to the residents of County Durham, the Committee would request a progress report on delivery of 2026/27 priorities and associated performance targets for inclusion within its 2026/27 work programme.

Darlington Borough Council (received 29/05/2026)

Members of the Health and Housing Scrutiny Committee welcomed the opportunity to consider the draft Quality Account 2025/2026 for Tees, Esk and Wear Valleys NHS Foundation Trust and had the following comments to make:

The Committee considered that the Quality Account is clearly set out and noted the work undertaken to progress 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 multitude of achievements and national awards achieved by the Trust in 2025/26.

Members did raise concerns regarding inequalities in access to services and sought clarification as to how this is being addressed by the Trust. Members were pleased to note the dedicated work of the Trusts Public Health lead and the Black, Asian and Minority Ethnic (BAME) link worker with community groups, the male peer support workers working within forensic services and the initiatives undertaken to identify and address barriers and challenges relating to patients' access to appointments.

In relation to Priority 3, Members sought further clarification as to whether the workforce is adequate to continue to deliver this priority. Members acknowledged the work undertaken as part of the culture of care programme and were pleased to note that the Trust's reliance on temporary workforce has significantly reduced in the last 12/18 months. Members also acknowledged that the Trust will continue to develop its workforce plan as part of the NHS 10 Year Plan.

The Committee continues to be concerned about capacity issues in relation to neurodevelopmental assessments. Members accepted that this is a nationally recognised issue and that work is ongoing to streamline the process.

Members welcomed the work being undertaken with the voluntary, community and social enterprise sector (VCSE) to improve the community-based care offer and look forward to future updates on the development of a community hub in Darlington.

The Committee was keen to note the positive work being undertaken by the Trust, particularly the progress relating to lived experience, which has made a palpable difference.

Overall, the Health and Housing Scrutiny Committee welcomed the opportunity to comment on the Trust's Quality Accounts. Members would like to continue to receive regular reports on the progress being made, to enable them to provide a more detailed and valuable contribution to the Quality Accounts in the future.

Tees Valley Joint Health Scrutiny Committee (received 03/06/2026)

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 12 March 2026.

The Committee welcomed the Trust's continued commitment to co-production, particularly the meaningful involvement of individuals with lived experience, carers and wider stakeholders in shaping quality priorities. This approach is recognised as fundamental to ensuring that service developments are responsive to the needs and experiences of those accessing services.

The Committee notes the Trust's three overarching quality priorities:

- Improving patient experience through education and the use of lived experience;
- Enhancing patient safety through a focus on relapse prevention; and
- Strengthening clinical effectiveness through personalised approaches to urgent care.

The Committee recognised the positive progress made across these areas, including the embedding of lived experience within training and governance, the development of personalised safety and wellbeing plans, and the implementation of the "My Story Once" approach to support more joined-up care. Improvements to information sharing, digital systems and workforce training were also acknowledged.
The Committee noted that assurance across all three priority areas was currently assessed as "reasonable", reflecting demonstrable progress whilst recognising that further work was required to ensure consistency, sustainability and measurable impact. In particular, the Committee highlighted the need for continued development in relation to post-discharge support, carer involvement, and consistent implementation of new approaches across the organisation.

While welcoming progress, the Committee also expresses a number of concerns. These included the increasing demand for children and young people's mental health services, long waiting times for neurodevelopmental assessments and CAMHS services, and the impact of delays on service users and their families. The Committee further noted concerns regarding communication and ongoing support for individuals awaiting assessment or treatment, and the need for stronger engagement with schools and community settings to support early intervention and prevention.
The Committee also noted that further work is required to strengthen equality, diversity and inclusion, including improving cultural competence and addressing health inequalities. In addition, the Committee recognised the challenges associated with data sharing and multi-agency working and emphasised the importance of continued progress towards more integrated and accessible care systems.
The Committee acknowledged the Trust's response to these challenges, including ongoing work to reshape pathways, improve communication and strengthen partnership working, while recognising the impact of wider system pressures and resource constraints.

Overall, the Committee was assured by the progress made by the Trust in developing its Quality Account and advancing its quality priorities. However, this assurance was tempered by the expectation that the Trust will continue to address the identified challenges, particularly in relation to waiting times, communication, consistency of delivery, and support for children and young people.

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NHS Foundation Trust

For General Release

Meeting of:	Board of Directors
Date:	25 June 2026
Title:	CAF-Aligned Data Security and Protection Toolkit – Addendum
Executive Sponsor(s):	Nick Black, Chief Information Officer
Author(s):	Beverley Smith, Information Compliance Manager and acting Data Protection Officer

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

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

1: To co-create high quality care	**X**
2: To be a great employer	**X**
3: To be a trusted partner	**X**

BAF ref no.	***Risk Title***	***Context***
5	Digital & Data	• 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.
7	Digital security & 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.

Executive Summary

The Trust has now received the draft DSPT-CAF external audit report, which confirms that a 'Standards Met' submission will not be achieved for 30 June 2026, and that an 'Approaching Standards' position supported by an action plan will be required for the second consecutive year. The action plan is currently in development and will be submitted to Audit One, DPAG and the subsequent ARC meeting for oversight and assurance.

AuditOne has assigned a 'High' level of confidence in the Trust's self-assessment; however, the audit highlights key gaps impacting compliance, primarily in relation to the definition and implementation of Essential Functions.

What are essential functions?

The things the organisation must keep doing, no matter what, to keep patients safe and keep the Trust running. This isn't just IT systems. It's the whole service: care delivery,

appointments, staffing, finance, estates, etc. These are agreed by EDG in the essential functions register in December 2025. Defining our essential functions to ensure critical care can continue and services don't stop during an incident.

The Trust is also aware of evidence gaps in relation to Indicators of Good Practice which relate to the Security Information and Event Management (SIEM) and Information Asset Registers (IAR).

Essential Functions underpin approximately 70% of DSPT-CAF evidence requirements, and the audit confirms that this activity is not yet fully realised across the organisation, limiting the Trust's ability to successfully evidence compliance across multiple CAF indicators.

This has Impacted on being fully compliant which the requirements of the following indicators all of which rely on the Trust fully understanding the Essential Functions:

- B5a Resilience Preparation
- B5c Backups
- D1a Response Plan

In addition, the Trust is currently unable to fully evidence:

- C1.a PA1 (SIEM capability), with implementation of the national solution planned by 31 October 2026
- B3.a PA4 (Information Asset Registers), with full organisational coverage now forecast by December 2026

As a result, the Trust will submit a DSPT-CAF return at 'Approaching Standards', supported by a comprehensive action plan. This action plan will address:

- Completion and embedding of Essential Functions across the organisation
- Implementation of SIEM capability
- Completion and assurance of Information Asset Registers

The action plan will be subject to formal governance and oversight, including monitoring by AuditOne, quarterly review by NHS England, and regular reporting through Executive governance routes including ARC.

Purpose

The purpose of this paper is to update Board on the outcome of the DSPT-CAF external audit and to outline the Trust's current position, identified gaps, and proposed action plan required to support submission by 30 June 2026.

The paper highlights that the Trust will submit at 'Approaching Standards', supported by a formal action plan, reflecting the findings of the external audit and areas requiring further development, particularly in relation to Essential Functions, SIEM, and Information Asset Registers.

An external audit was completed in March 2026 by AuditOne a draft report has been received as detailed above. This paper identifies the areas of concern discussed with AuditOne where the ability to meet the requirement for Essential Functions has not been fully realised.

The paper also discusses Indicators of Good Practice where the Trust has self-assessed and is unable to evidence that the expected criteria has been met (SIEM [C1.a PA1] & Information Asset Registers [B3.a PA4])

Board is advised that a 'Standards Met' toolkit will not be achieved by 30 June 2026 and that an 'Approaching Standards' submission will be made with a supporting action plan in relation to:

1. Essential Functions

The action plan will reflect the actions, agreed activities, responsible officers and timelines demonstrated in the Emergency Planning Rapid Response Audit document to support how the Essential Functions requirement will be met at an organisational level. One Emergency Planning Rapid Response audit action requires all Business Impact Assessments (BIA) to be completed by March 2027. Essential Functions can then be fully understood across the whole organisation with a view to Business Continuity Plans (BCP) being fully completed by September 2027.

Responsible Officers for the Emergency Planning Rapid Response activities have fed into the draft Management Response for the DSPT-CAF audit which will be shared with AuditOne. Key activities include Completed Essential Functions register, BIA's, BCP's and any supporting Trust incident response plan. Mapping exercises are to be completed along with Recovery Point Objectives (RPO's) Recovery Time Objectives (RTO's) which are yet to be defined.

2. Security Information and Event Management (SIEM)

A SIEM is a cybersecurity solution that aggregates, analyses, and correlates log and event data from across an organization's entire network in real-time. It acts as the central hub for Security Operations Centres (SOCs) to detect, investigate, and respond to cyber threats.

The Trust are required to employ a SIEM to evidence C1.a PA1 and are planning to implement by 31 October 2026. This is a previously agreed timeline, in-line with the delivery of a National SIEM as evidenced in a paper agreed at DPAG in October 2025 (Appendix 1).

3. Information Asset Registers

EDG are already monitoring compliance with the request for Information Asset Registers to be completed by 30 June 2026. Modelling based on current activity levels suggests this activity will not be completed before December 2026.

Proposal

The actions proposed provide good assurance:

1. To submit a DSPT-CAF on or before the 30 June 2026 deadline.
2. The submission will be of 'Approaching Standards' level and will be supported by an action plan.
3. The action plan will be monitored by AuditOne periodically in line with the defined achievement timescales
4. The action plan will be monitored by NHSE quarterly in line with the national practice.
5. Reporting to the Trust on activities listed within the action plan will be provided at regular intervals as required.

Overview

In 2023 the health and care cyber security strategy committed to adopt the CAF as the principal cyber standard. The DSPT-CAF is split into five outcome measures:

Section A – Managing Risk
Section B – Protecting Against Cyber Attack & Data Breaches
Section C – Detecting Cyber Security Events
Section D – Minimising the Impact of Incidents
Section E – Using and Sharing Information Appropriately

Each measure is supported by indicators of good practice grouped into levels of achievement – 'Not Achieved', 'Partially Achieved' or 'Achieved'.

1. Essential Functions

70% of the indicators of good practice reference Essential Functions. To complete this the organisation needs to clearly understand and define their Essential Functions, agreeing these at Trust Board. More information is available here Scoping Essential Functions - NHS England Digital

It is important to appreciate that 'Essential Functions' are those of the full organisation, and not solely those of Digital and Data Services (D&DS).

In summary, Essential Functions are:

- Any essential services that underpin the operation of essential services designated under the Network and Information Systems (NIS) Regulations
- Any statutory purposes for statutory organisations
- The purposes for which your organisation is constituted
- All information, systems and networks which support your Essential Functions which could result in a significant impact on the continuity of an essential service if compromised by an incident

In practise, the theme is around defining essential business services. These could be anything from critical care systems to patient transport, administration, finance and human resource systems. To understand how the business can continue to operate, if that function were to be compromised or otherwise incur failure. This would be through a well scoped Business Continuity plan that is not reliant on the recovery of an underpinning digital system.

During the Audit feedback meeting it was acknowledged that the work undertaken by teams within the Digital & Data Services has been significant and relevant providing demonstrable evidence that IT systems and their dependencies are fully understood.

It was discussed that the Trust needs to further demonstrate if these systems are indeed Essential Functions as defined above. Undertaking the organisational wide activity in relation to Emergency Preparedness, Resilience and Response (EPRR) would support fulfilling the criteria. The Business Impact Assessments element of this larger piece of work would capture service level priorities allowing visibility of the Essential Functions and the information, systems and networks supporting them. These will then feed into information held by D&DS. The outcome will be a clear, demonstrable and risk-based justification of the scope, which will be agreed by the organisation and embedded into business as usual (BAU). The document will be considered a 'live' and evolving document that will change over time in response to increased knowledge, changes in operating systems or following incidents.

An external audit conducted by AuditOne explored activities in relation to EPRR. As part of this report several findings and recommendations were made which will feed into the Essential Functions activity. It should be noted that some of these actions will not be completed until September 2027 which will overlap the DSPT-CAF submission for 2026-2027 and 2027-2028. Activity from this audit will be monitored through EDG.

2. The SIEM [C1.a PA1]

The inability to fully evidence the indicator of good practice: "C1a Monitoring Coverage PA4 You monitor traffic crossing your network boundary (including internet protocol (IP) address connections as a minimum)" was acknowledged last year.

The Technology team currently retain security and event logs for digital systems but do not currently employ a SIEM to correlate this data. A paper (Appendix 1) was reviewed and approved at Digital Performance & Assurance Group to delay the introduction of a Trust operated SIEM until the introduction of the National Microsoft Sentinel SIEM in Q2 2026. The team are now preparing to onboard to the national SIEM under the advice and direction of the CSOC team as part of a wider directive from Phil Huggins, National Chief Information Security Officer. The data flowing into the platform will have oversight of the CSOC team enhancing the NHS's ability to defend as one whilst enjoying a 70% discount in cost.

The Sentinel SIEM implementation will be completed by 31 October 2026. A separate report is being prepared for DPAG and then EDG to approve SIEM approach and funding required. Key activities and milestone dates will inform the toolkit action plan.

3. Information Asset Registers [B3.a PA4]

The Trust is currently unable to evidence that "B3a Understanding Data PA4 You have identified all mobile devices and media that hold data important to the operation of the essential function(s)".

Evidence requires that we have a comprehensive suite of Information Asset Registers. EDG are already monitoring compliance with the request for Information Asset Registers to be completed by 30 June 2026. Modelling based on current activity levels suggests compliance with this activity will not be completed before December 2026.

Prior Consideration and Feedback

A high-level gap analysis between the Trust's prescribed CAF profile and our current position was carried out and presented in November 2025. This report identified where the Trust was able to provide evidence which exceeds, meets or does not meet the profile requirements. It also confirmed that NHSE had released a 5-yr plan confirming that the submission for 2025-26.

A further report was shared in January 2026 advising the audit arrangements. This report detailed the mandatory Indicators of Good Practice identified by NHSE for external Audit and those identified locally by the organisation after consideration of the changing self-assessment DSPT-CAF profile.

This report was considered by Audit and Risk Committee on 22 June 2026. The paper was accepted.

Implications

If an organisation does not meet its mandatory requirements, this would be reported to the CQC, DHSC and NHSE. DSPT-CAF status forms part of mandatory national assurance frameworks and failure reflects on the Trusts capability and that of the ICS.

Although unlikely, consequences of not achieving DSPT-CAF could limit regional/National funding opportunities, prevent the Trust from bidding for contracts and restrict the ability to exchange data through regional platforms such as Great North Care Record (GNCR).

Recommendations

That the Board of Directors considers the report a suitable level of assurance in relation to the DSPT-CAF submission and agrees to the recommended actions below:

1. The Trust submits the DSPT-CAF return by 30 June 2026 at 'Approaching Standards'
2. The Trust submits as per the NHSE guidance a time bound action plan to support movement towards a 'Standards Met' return
3. The Trust agrees that the proposed monitoring of the action plan is sufficient to provide organisational confidence:
    - External monitoring by AuditOne
    - Quarterly monitoring by NHSE
4. To monitor progress via Digital Performance Assurance Group, with formal reporting to EDG in the bi-monthly BAF 7 report

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Appendices

Appendix 1 – DPAG paper October 2025

07a. Cyber Security - SIEM Decision.docx

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Tees, Esk and Wear Valleys
NHS Foundation Trust

Meeting of:	**Board of Directors**
Date:	**25 June 2026**
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 31 March 2026.

Proposal: To receive and note the Register of Interests of the Board of Directors as at 31 March 2026.

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-v4.3. 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 31 March 2026, is attached to this report.

It has been updated based on information submitted by individual Directors via the ESR system.

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 22 May 2026.
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 receive and note the Register of Interests of the Board of Directors as at 31 March 2026.

Register of Interests of the Board of Directors 2025/26

Last Name	First Name	Position Title	Interest Category	Interest Situation	Interest Description
Burnham	Marie	Chair of the Trust	I have no interests to declare		
Smith	Alison	Chief Executive	I have no interests to declare		
Adetuberu	Niniola	Non Executive Director	Non-financial professional interest	Outside employment	Associate Non Executive Director at Newcastle Upon Tyne Hospitals NHS Trust
					Non Executive Director of North East Ambulance Service Trust.
Barker	Roberta	Non Executive Director	I have no interests to declare		
Bridges	Ann	Director of Corporate Affairs and Involvement			
Butcher	David	Associate Non Executive Director	Non-financial professional interest	Outside employment	Board member at Bradford and Craven MIND (mental health charity) - unremunerated
					Board member at North Star Housing Group (social housing provider) - remunerated
Crawford	Hannah	Director of Therapies	I have no interests to declare		
Dexter-Smith	Sarah	Director of People and Culture	Financial interests	Shareholdings and other ownership interests	I occasionally receive a small payment for royalties for a book I co wrote and which some of our teams use. I gift any royalties to the Trust charitable funds.
Ellis	Kathryn	Interim Executive Director of Transformation and Strategy	Indirect interests	Shareholdings and other ownership interests	I am sole director of a company which provides organisational coaching/consultancy. Whilst employed full time at TEWV I may provide occasional, adhoc work with clients out of work hours. None of this work is directly to TEWV as an organisation, nor to employees of the organisation. Nor is it for services that would otherwise represent a direct commercial conflict of interest for TEWV
Gorringe	Edward	Associate Non Executive Director	Non-financial professional interest	Outside employment	I am a Trustee of a national mental health charity, Rethink Mental Illness, Rethink has a number of contracts with TEWV for the provision of services within prisons.
Kale	Kedar	Medical Director	Indirect interests	Clinical private practice	My spouse currently carries out pvt clinical practice. I do not not carry out private practice. However I am a co-director with her on a private ltd company.
Lonergan	Naomi	Managing Director	I have no interests to declare		
Maddison	John	Non Executive Director	I have no interests to declare		
Murphy	Beverley	Chief Nurse	Financial interests	Outside employment	Consulting into organisations and coaching individuals outside of NHS employment as a sole trader. The business name is Practice Partnership.
			Non-financial professional interest	Outside employment	Unpaid member of the Council of the national forum of Mental Health and Learning Disability Directors of Nursing. As a part of this role I serve as the Company Secretary.
Preston	Thomas	Non Executive Director	Financial interests	Outside employment	Chair of a Charity, Boroughbridge Community Charity, which has a service delivery contract with Harrogate District Hospital
Reilly	Bev	Non Executive Director	Indirect interests	Loyalty interests	Please note the drop down bar in "situation" does not fit my COI. I would like to declare that a close family member is in receipt of care from TEWV Community services. This has been declared in the Board COI register which is open to the public.
Romaniak	Elizabeth	Executive Director of Finance and Estates/Facilities Management	I have no interests to declare		
Wood	Catherine	Non Executive Director	Non-financial professional interest	Outside employment	From November 2025 I will also hold a second Non Executive Director post for Care Housing Association in addition to my NED role at TEWV. Care Housing provide housing for people with learning disabilities and autistic people across the North and are a Community Benefit Society and therefore not for profit.

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