Tees, Esk and Wear Valleys
NHS Foundation Trust

COUNCIL OF GOVERNORS' MEETING
WEDNESDAY 15 JULY 2026 AT 1.00PM

VENUE: THE WORK PLACE, HEIGHINGTON LANE, AYCLIFFE BUSINESS PARK, NEWTON AYCLIFFE, DL5 6AH

AGENDA

1.	Apologies for absence	Marie Burnham Chair	Verbal	1.00pm
2.	Welcome and introduction	Marie Burnham Chair	Verbal	
3.	To approve the minutes of the meeting held on 13 May 2026	Marie Burnham Chair	Draft Minutes	
4.	To receive declarations of interest	Marie Burnham Chair	Verbal	
5.	To review the Public Action Log	Marie Burnham Chair	Report	
6.	To receive an update from the Chair	Marie Burnham Chair	Verbal	1.10pm
7.	To receive an update from the Chief Executive	Alison Smith Chief Executive	Verbal	1.15pm
8.	To receive a report on the use of emergency powers	Marie Burnham Chair	Report	1.20pm
9.	To receive a report on the Trust's process for responding to Governors' questions - for ratification	Marie Burnham Chair	Report	1.25pm

10.	To receive updates from the Board of Directors' Committees: a. People, Culture and Diversity Committee (PCDC) b. Mental Health Legislation Committee (MHLC) c. Audit and Risk Committee (ARC) d. Quality Assurance Committee (QAC) Background Information on the business transacted by the Board of Directors in recent public meetings can be found on our Trust's website – https://www.tewv.nhs.uk/about/board/papers-previous-board-meetings/	Roberta Barker Non-Executive Director / Chair of PCDC Roberta Barker Non-Executive Director / Chair of PCDC Liz Romaniak Executive Director for Finance, Estates and Facilities Marie Burnham Chair	Report Report Report Report	1.35pm
11.	To receive an update on the Trust's 2026 Governor Elections	Anna Pridmore Interim Company Secretary and Corporate Governance Director	Verbal	1.55pm
12.	Any other business	Marie Burnham Chair	Verbal	2.00pm
13.	Date and time of next meeting: Wednesday 30 September 2026 at 1.30pm	Marie Burnham Chair	Verbal	2.05pm
14.	Exclusion of the public	Marie Burnham Chair	Verbal	

	The Chair to move: "That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below: Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006. Information which, if published would, or be likely to, inhibit - (a) the free and frank provision of advice, or (b) the free and frank exchange of views for the purposes of deliberation, or (c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs".			

Marie Burnham
Chair
7 July 2026

Contact: Karen Christon, Deputy Company Secretary, Tel: 01325 552001, Email: karen.christon@nhs.net

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Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD AT 1.30PM ON 13 MAY 2026 AT THE WORKPLACE, NEWTON AYCLIFFE AND VIA MS TEAMS

Present:
M. Burnham, Trust Chair
J. Aynsley, public Governor, Durham (MS Teams)
P. Beall, appointed Governor, Stockton on Tees Borough Council (MS Teams)
G. Birchwood, public Governor, North Yorkshire
M. Booth, public Governor, Middlesbrough (MS Teams)
J. Coles, appointed Governor, City of York Council
G. Emerson, public Governor, Stockton-on-Tees
K. Gillan, public Governor, Durham
J. Green, public Governor, North Yorkshire
C. Hodgson, public Governor, York (MS Teams)
N. Hutchinson, public Governor, Durham
C. Ing, staff Governor, Corporate Services
E. Kengne Tatuene, public Governor, Durham (MS Teams)
J. Kirkbride, public Governor, Darlington
H. Leeming, staff Governor, Durham, Tees Valley and Forensics Care Group (MS Teams)
T. Morris, public Governor, Middlesbrough (MS Teams)
G. Restall, public Governor, Stockton-on-Tees (MS Teams)
Z. Sherry, public Governor, Hartlepool (MS Teams)
R. Swiers, appointed Governor, North Yorkshire County Council (MS Teams)
S. Thomas, public Governor, Durham (MS Teams)
J. Wardle, public Governor, Durham (MS Teams)
J. Webster, public Governor, North Yorkshire (MS Teams)
J. Williams, public Governor, Stockton-on-Tees

In attendance:
N. Adetuberu, Non-Executive Director (MS Teams)
R. Barker, Non-Executive Director
P. Bellas, Company Secretary
D. Butcher, Associate Non-Executive Director
K. Christon, Deputy Company Secretary
K. Ellis, Interim Executive Director for Strategy and Transformation
E. Gorringe, Associate Non-Executive Director
A. Grant, Corporate Governance Officer (CoG and Membership) (minutes)
L. Hodge, Acting Deputy Director for People and Culture
A, Howe, Guardian - The Guardian Service
K. Kale, Executive Medical Director
N. Lonergan, Interim Managing Director
J. Maddison, Non-Executive Director
B. Murphy, Deputy Chief Executive and Chief Nurse
J. Preston, Non-Executive Director / Senior Independent Director (MS Teams)
B. Reilly, Deputy Chair / Non-Executive Director
L. Romaniak, Executive Director for Finance, Estates and Facilities (MS Teams)
A. Smith, Chief Executive
C. Wood, Non-Executive Director

Observing:
E. Thomas, public member

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

L. Alexander, appointed Governor, Durham County Council
R. Allison, appointed Governor, University of York
J. Bell, public Governor, Durham
S. Blackamore, staff Governor, North Yorkshire, York and Selby Care Group
M. Boddy, appointed Governor, Hartlepool Borough Council
D. Coombs, public Governor, Durham
K. Evenden-Prest, staff Governor, Durham, Tees Valley and Forensics Care Group
A. Goldie, public Governor, Darlington
C. Hague, public Governor, North Yorkshire
K. Kelly, appointed Governor, Darlington Borough Council
C. Lee-Cowan, appointed Governor, Sunderland University
J. McNulty, public Governor, Durham
O. Milner, public Governor, City of York and Rest of England
L. Robson, appointed Governor, Redcar and Cleveland Borough Council
J. Venable, public Governor, North Yorkshire

A. Bridges, Executive Director for Corporate Affairs and Involvement
H. Crawford, Executive Director of Therapies
S. Dexter-Smith, Executive Director for People and Culture

2. WELCOME AND INTRODUCTION

The Chair welcomed attendees to her first meeting as Trust Chair. She confirmed that the meeting would be recorded for the purpose of taking minutes, and recordings would be deleted following approval of the minutes.

She advised that Governor questions would be discussed in the private session of the meeting, but Governors would receive answers to their questions in due course.

P. Bellas advised that:

1. Governor elections had opened on 22 April 2026.
2. J. Kirkbride had been elected without contest for another term, to represent members in the Darlington constituency.
3. Governors M. Booth, G. Emerson, G. Restall and J. Webster had re-nominated themselves as candidates and would be taking part in contested elections.
4. Governors G. Birchwood, Z. Sherry, J. Wardle and J. Aynsley had terms of office ending on 30 June 2026.

3. MINUTES

Consideration was given to the accuracy of the draft minutes from the last meeting of the Council of Governors, held on 18 February 2026.

N. Hutchinson suggested the minutes had not accurately reflected a conversation she had with the Lead Governor, prior to the meeting in May [minute 42. (18/02/26) refers]. She advised the minutes had stated *"G. Emerson confirmed that he had spoken to N. Hutchinson before the*

meeting and that, as Lead Governor, it was his role to provide clarity to fellow Governors regarding their duties." She confirmed that she had spoken to him as Lead Governor, to gain clarity on leadership information.

B. Reilly confirmed that both she and the Chief Executive had been content with the accuracy of the minutes.

The Chair confirmed that, as other attendees were content with the accuracy of the minutes, they would be confirmed as a correct record and signed, but she invited N. Hutchinson to contact her outside the meeting to discuss her concerns.

Agreed: That the minutes of the meeting held on 18 February 2026 be agreed as correct records and signed by the Chair.

4. DECLARATIONS OF INTEREST

J. Coles advised that, as declared on the Council of Governors' register of interests, she was attending the meeting in her capacity as an elected Councillor for City of York Council and not in her role as the Deputy Mayor for Policing, Fire and Crime for North Yorkshire Combined Authority.

B. Reilly advised that she had accepted a role as the Deputy Chair of Humber and North Yorkshire Integrated Care Board.

The Chair thanked B. Reilly on behalf of the Trust for her work as the Interim Chair.

5. PUBLIC ACTION LOG

Consideration was given to the action log. It was noted that:

1. Most actions had been completed.
2. With regard to action 44. (18/02/2026), a meeting with J. Kirkbride and K. Kale would be arranged and J. Kirkbride was content with this.
3. Action 48. (18/02/2026) regarding leadership walkabouts would be addressed at the Council meeting in September 2026.
4. Action 49. (18/02/2026) would be addressed on the agenda.

6. UPDATE FROM THE CHAIR

Governors considered a verbal update from the Chair regarding her first weeks in post. She confirmed that leadership walkabouts and Governor locality meetings remained on hold and highlighted that the purpose of leadership walkabouts was to provide quality insight. Governors needed more information regarding quality and this would be discussed later in the private session of the meeting.

It was noted that:

- J. Kirkbride was disappointed at the length of time leadership walkabouts had been on hold as it was her only opportunity to meet with staff.

A. Smith confirmed that she would facilitate Governors to meet staff and this could be incorporated into the new process for leadership walkabouts.

The Chair advised Governors played a vital role in the Trust. She had spoken to the Lead Governor about the future and if the government removed the statutory requirement for NHS Trusts to have Governors, as stated in the NHS 10-Year Health Plan, there was still a need for the insight Governors provided. She hoped to hold an event in summer 2026, to engage with Governors about future plans, improving the relationship between Governors and the Board, and on holding the Board to account.

7. UPDATE FROM THE CHIEF EXECUTIVE

Governors considered a report from the Chief Executive.

A. Smith advised that:

1. The new Electronic Patient Record System would help address issues with the current system, and implementation was planned for 2027.
2. The selection of a Chair for the statutory public inquiry was still awaited and this had caused understandable frustration for the parents and families involved. NHS England were keeping the Trust updated on this issue and Governors would be notified when the information was available.
3. Dr Nick Broughton had been appointed as the new national Director for Mental Health, Learning Disabilities and Autism.

It was noted that:

- J. Kirkbride expressed surprise that another new electronic patient record system was being implemented to replace CITO. She asked whether the Trust had made enquiries with other Trusts about issues with the new suggested system, RIO.

  Both A. Smith and the Chair advised that they had used RIO in the previous Trusts they had worked for.

  K. Kale advised that he had used RIO for 15 years in a previous role, and it was a well-known and commonly used system which many clinicians were familiar with.

  The Chair asked whether Governors would appreciate a demonstration of how RIO worked and Governors confirmed they would.

  Action – N. Black

  A. Smtih advised that, as RIO was not yet implemented in the Trust, a trial version of the system would need to be used in the short term.

- J. Coles highlighted details in the report on strategic risks linked to workforce, and pressures from demands on services. She asked whether there was a sense of proportionality with regard those risks and whether there were positive things the Trust was doing to manage those risks.

  A. Smith advised that there were ongoing innovations including the community mental health transformation programme, mental health hubs ran in partnership with other organisations, and the crisis assessment suite in Middlesbrough. All were examples of working differently to meet demand. TEWV was committed to innovation, open access

and aligning its workforce to demand without significantly increasing the workforce. Community Mental Health Transformation brought significant benefits and these were being assessed. She hoped to bring more information on this to Governors at some point in the future. NHS organisations, including the Trust, had been asked to reduce costs but the Trust was trying to make innovative changes without adversely affecting those in need of its services.

8. UPDATES FROM BOARD OF DIRECTORS' COMMITTEES

The Chair advised that verbal updates from the Board's committees provided Governors with re-assurance, but not assurance. Governors needed triple A reports (Alert, Assure and Action) to see how the committees interacted and those would be provided to Governors in the future. Governors were also invited to observe Board of Directors' meetings held in public.

People, Culture and Diversity Committee

R. Barker advised that:

1. The Committee had held a development session and a meeting since the last Council of Governors' meeting and the development session had allowed the Committee to deep dive into critical issues.
2. The Committee had considered the results of the staff survey and noted how staff had reported feeling there had been a reduction in opportunities to develop and there was a need for more flexible working. Other issues considered were how to reduce long term sickness, racial discrimination and violence in the workplace.
3. The Committee considered which risks could be included in the Board Assurance Framework and considered the wider culture of the Trust and how that could be aligned with safer staffing.
4. Workforce plans had been reviewed to support changing clinical models, with the introduction of detailed workforce data reports to aid decision-making.
5. In terms of assurance, TEWV was the second most improved mental health Trust on staff survey completion, with 52% of staff completing it. Access to supervision had been above the national average and appraisal completions had improved. Focus was needed on management capabilities and staff experience.
6. The Committee had received good assurance from the workforce strategy delivery report and had also received workforce data reports.
7. A deep dive into the Trust's new Freedom to Speak Up Service had been carried out. The Committee had noted positive outcomes from the use of the service, which operated 24/7, and staff engagement had improved month by month.
8. The Committee received good assurance regarding digital Human Resources systems.

The Chair thanked R. Barker for the update.

It was noted that:

- With regard to the lack of opportunities for career progression in the Trust, G. Emerson suggested this was something the Trust could act on and asked what could be done to improve the situation.

  L. Hodge advised that the Trust had a Career Development Programme and a Leadership Academy, but it was also considering how to improve development opportunities for existing and new staff and having a clear progression structure.

  B. Murphy advised that the government had announced 2,000 additional registered nurse degree apprenticeships and was considering funding for that. Many Health Care

Support Workers were able and motivated to improve and develop their skills but did not have the opportunity to do so and apprenticeships would be helpful. She had been delighted to hear that funding for similar apprenticeships in Learning Disability roles might also be possible.

- G. Birchwood asked whether it was possible to identify staff who were ready to progress.

  B. Murphy confirmed it was possible through the annual appraisal system and the Trust had oversight of this by team.

  J. Green added that, speaking as a former student nurse, it was better to have apprenticeships with a paid wage than for students to get into debt.

The Chair confirmed it had been International Nurses Day the day before the meeting and thanked all nurses for their work in the Trust.

She advised that the Mental Health Legislation Committee was really important in a mental health trust as it was the only one that could take people's liberties away. It was important that an experienced Non-Executive Director like R. Barker was Chair of that Committee.

<u>Mental Health Legislation Committee</u>

R. Barker advised that:

1. The committee had conducted a deep dive into the implications of the new Mental Health Act 2025 and had a full review of its workplan for the coming year. She had also met with the Chair of the Mental Health Legislation Committee at Humber and North Yorkshire Integrated Care Board and hoped to share insights and produce benchmarking information with them regarding the new Mental Health Act. Good assurance had been received by the Committee that clinical teams were proactively preparing for phased implementation of changes to the Act over the coming years.
2. The Committee had worked with the InPhase team to create a dashboard of required information in one place. The Committee was keen to get this implemented as soon as possible.
3. The Committee had held a development session on how to hear the patient voice. Chris Morton, Lived Experience Director, regularly attended meetings of the Committee to ensure a clinical and patient perspective was present. The Committee had considered case studies of clinically focused patient stories. These had been important to hear as it gave insight into each person's experience of that clinical process. C. Morton and his team were focused on gathering the patient voice from across the Trust to contribute to a future development meeting for the Committee on how to integrate that information into the Committees discussions and decision making.
4. A deep dive on the use of advocacy across the Trust had been carried out and some of the advocacy providers had met with the Committee.
5. Risks had been identified in relation to implementing changes linked to the change in the Mental Health Act, project management, training for clinical staff, addressing workforce gaps and integrating opportunities for people with lived experience. The Committee needed to consider how the Trust could provide better support for minority ethnic individuals, but better-quality data was required to do this.
6. Good assurance was received on the operational and multi-agency group supporting the Committee and the improved data and feedback it provided.
7. The Committee would progress the implementation of the dashboard, seek better understanding on how to gather the patient voice and obtain improved data to understand how to better support minority ethnic individuals. It would consider benchmarking with other

Mental Health Legislation Committees in other organisations and had already reached out to the Chair of that Committee at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.

[N. Lonergan left the meeting]

It was noted that:

- J. Green asked whether information could be shared with Governors on the changes that had been made to the Mental Health Act.

  The Chair confirmed a simple guide for Governors, with key changes to the Act, would be provided.

  Action – K. Kale

Resources and Planning Committee

J. Maddison advised that:

1. At its last meeting, the Committee had considered the Trust's Medium-Term Financial Plan, a review of the Integrated Performance Report Data Quality Assessment and financial matters linked to capital opportunities for improvements to the Trust's estate, particularly in relation to the Roseberry Park rectifications.
2. Good assurance had been received with regard to the management of the Trust's financial position and it was confirmed that the Trust was on plan for the 2025/26.
3. A comparatively good settlement had been agreed with the Humber and North Yorkshire Integrated Care Board, although there were some issues with comparative funding levels for the two care groups.
4. There were on-going operational pressures regarding demand, waiting times and a significant number of people who were clinically ready for discharge but could not be transferred into the community. N. Lonergan was working on a project to relieve blockages in the discharge process.
5. The Committee had received good assurance regarding the Board Assurance Framework and the Corporate Risk Register and noted that those risks were being regularly reviewed by the Executive team.
6. Good assurance had been received regarding internal audit findings.
7. Two important areas were considered by the Committee. Those were the national cost collection exercise relating to mental health funding and Patient-led Assessments of the Care Environment (PLACE) which related to estates, environmental issues and catering. More work was needed in these areas, but they were going in the right direction of travel.
8. Digital improvements had been highlighted in the government's 10 Year Health Plan and there had been significant investment made to improve the Trust's Wi-Fi and reduce issues with Wi-Fi and the Electronic Patient Record System losing connection.
9. It was agreed that the Committee would hold a development session in the summer of 2026, by which time a new Chair of the Committee would be appointed. An evaluation of the Committee's annual assessment was required, which would feed into improving the effectiveness of the Committee and provide assurance to Governors.
10. He thanked L. Romaniak for her support as Executive lead to the Committee.

The Chair confirmed that the Finance Report for May 2026 had been circulated to Governors for information prior to the meeting.

It was noted that:

- In relation to people who were considered clinically ready for discharge but could not be released into the community, J. Coles asked whether 'system partners' referred to housing only or other partners as well. She also asked whether local authorities assisting with discharges.

  A. Smith advised that N. Lonergan and her team had been working with local authorities, housing and voluntary sector partners to address delays in discharging patients who were clinically ready for discharge. They had been trying to understand how to speed up the process and improve relationships with partners. Disparities had been identified between the care groups, but the majority of delays related to a lack of suitable care home placements and packages of care. It would be helpful for N. Lonergan to bring a report to the Council of Governors at a later date to discuss the matter in more detail.

  Action – N. Lonergan

- J. Coles asked whether the care of patients in TEWV was 'health funded' and care provided by care homes or supported housing was 'local authority funded'.

  A. Smith advised that it was sometimes both, depending on the reasons for a person's detention under the Mental Health Act. People sometimes lost their accommodation after being detained and this was very unhelpful to the individual. There was also a shortage of care providers in some areas. The aim of N. Lonergan's project was to identify issues earlier in the process, but not to apportion blame. The Trust and the Local Authority needed to work together in partnership to provide the right care to people at the right time.

- G. Emerson advised that the Council of Governors had discussed disparities between different Integrated Care Boards in the past, but it would be beneficial to understand what those disparities were and what new funding could achieve.

  The Chair advised it was difficult to know how money had been spent historically by mental health trusts but there was a national problem in understanding this. However, the Trust was extremely well managed financially.

  G. Emerson congratulated the Finance Team on this achievement.

<u>Quality Assurance Committee</u>

B. Reilly advised that:

1. She welcomed the Chair's decision to use triple A reports to advise, alert and assure Governors regarding business transacted at Board committees.
2. She had reflected on her time as Chair of the Committee and advised that the Committee had become more focused on important issues over the last four years and some fantastic work had taken place in the Trust during that time.
3. She wished to alert Governors to concerns regarding the use of restrictive interventions and the use of prone restraint. There had been 15 episodes of prone restraint for patients in secure services and those had related to one patient. The Committee had focused on whether the Trust was in a position to care for that person safely and also

avoid harming staff. Their care was found to be appropriate, but more assurance was required.

4. A second regulation 28 letter had been issued to the Trust by the coroner with regard to Section 17 leave. Although the coroner had recognised progress was being made, there were still inconsistencies with how Section 17 leave was being applied and recorded in some areas.
5. The Committee were advised of teams in the Trust requiring additional support. The Involvement and Engagement Team had been one of those, and plans were in place to address concerns. More assurance had been requested regarding a team in Ripon.
6. The Trust needed to consider pathways of care and issues with the primary care network, but it needed help from partners too.

The Chair advised that Governors would be given opportunities in the future to observe Board committees, but some thought was needed as to how to do that.

It was noted that:

- With regard to Section 17 leave, K. Kale advised that a discussion had been held in the Board's Mental Health Legislation Committee where it was agreed that the policy would be reviewed and actions would be developed as there were still issues recording Section 17 leave. With regard to primary care networks, he advised that it related to the Additional Roles Reimbursement Scheme, Primary Care Mental Health Workers and GPs not co-operating with the Trust in relation to that. However, the Trust had nationally recognised mental health community hubs and also two GP Liaison Advisors.

  L. Romaniak advised that K. Kale had asked the Board's Audit and Risk Committee to conduct an audit on Section 17 leave, to consider issues highlighted by the Quality Assurance Committee. The outcome of that would feed into both the Audit and Risk and the Mental Health Legislation Committees.

- With regard to prone restraint, B. Murphy advised that, historically, the Trust would have expected to have one or two incidents per month due to accidental positioning, however, the service was now in escalation regarding quality, the Committee were sighted on it and the Care Quality Commission had been kept informed of the situation.

- G. Emerson advised he had been concerned to hear there had been 15 episodes of prone restraint as it should only be used in exceptional circumstances.

  B. Reilly confirmed the 15 episodes had related to one person.

  The Chair confirmed that NHS trusts should take a zero-tolerance approach to prone restraint but recognised that it may still occur in exceptional circumstances. Sometimes restraint was required to ensure the safety of a patient or staff, but it was essential to understand the reasons for using it. 15 episodes relating to one patient does suggest it is a highly complex case, but that would be carefully considered by the Quality Assurance Committee.

  Following questions from Governors, B. Murphy clarified that there were on-going issues at Bankfields Court which the Trust was under close scrutiny for and an ethics committee had been created in relation to that. Separately, there were 15 episodes of prone restraint that related to one patient in secure inpatient services and work was underway to establish which staff were involved and the exact circumstances. The Trust did not accept the practice and recognised the physical healthcare risks associated and it was important to fully understand the circumstances and get to a better position.

G. Emerson asked that a report on the use of prone restraint be brought back to the Council of Governors in six months.

Action – B. Murphy

9. UPDATE ON THE TRUST'S OPERATIONAL SERVICES

Consideration was given to a report on the Trust's operational services.

The Chair advised that N. Lonergan had left the meeting during the updates on the Board's committees. She asked whether Governors had any questions and if they were content to receive the report.

Governors confirmed they were content with the report.

10. GOVERNOR ELECTIONS 2026

With regard to the Governor elections for 2026, P. Bellas advised that:

1. Nominations had closed and the final date for candidates to withdraw from the Governor elections was 13 May 2026.
2. Contested elections would be held in Middlesbrough, Stockton-on-Tees, North Yorkshire and City of York and Rest of England. There were uncontested elections in Darlington, Durham and Hartlepool and in the staff Durham, Tees Valley and Forensics Care Group. No nominations had been received for Redcar and Cleveland.
3. Voting packs were being circulated on 29 May 2026 and the election was to close on 18 June 2026.

The Chair confirmed it was really positive to see so few vacancies on the Council of Governors. She also advised that the Trust's membership would be a point of discussion at a future development session for Governors.

11. FREEDOM TO SPEAK UP PROVISION IN TEWV

Consideration was given to a report on the Trust's Freedom to Speak Up service.

L. Hodge advised that:

1. A report on the Freedom to Speak Up provision in the Trust had been requested by Governors at their last meeting held in February 2026.
2. Adam Howe was the Freedom to Speak Up Guardian, and it was an independent and confidential, 24/7, service. A. Howe also had a team supporting him. It was an independent service which had integrated well into the Trust. Support was available in person and online and A. Howe had visited a number of sites and had met approx. 2,000 members of staff. Since starting in the post, he had attended a number of staff events including leadership and management networks, staff network meetings and had accessed some areas where the trust had not heard from staff previously.
3. A clear escalation process was in place and a table in the report contained the agreed escalation time frames. The report also touched on response times.
4. The Director for People and Culture, S. Dexter-Smith, received monthly updates regarding the service and this touched on themes and outcomes, but no individuals were identified in the information. Also, quarterly meetings were held with the Chair, Chief Executive and Non-Executive Directors to discuss emerging themes or issues.

5. There had been 68 concerns raised in the last six months and 35 of those had been closed. The rest were on-going.
6. Staff were encouraged to speak to their line manager of senior manager in the first instance but there was support for staff raising a complaint and the guardian service adopted a coaching approach to this and stayed in touch with people until their situation was resolved. There was also a process in place if staff felt they had received detrimental treatment.

A. Howe advised that:

7. He was visiting the secure inpatient service B. Murphy had spoken about earlier, as an area of concern, to assist in the triangulation of data that was required and also planned to visit teams in Ripon and Harrogate

It was noted that:

- The Chair advised that J. Preston was the Non-Executive Director representative for Freedom to Speak Up in the Trust.

  J. Preston advised that having an independent Freedom to Speak Up service had worked well and had proven to be effective.

  The Chair confirmed she had met with A. Howe and advised that many trusts did not have an independent, 24/7, service and it was a really forward-thinking approach. There were also still Freedom to Speak Up Champions in the Trust.

12. CARE QUALITY COMMISSION ACTIVITY AND DELIVERY OF THE TRUST'S IMPLEMENTATION PLAN

Consideration was given to a report on Care Quality Commission activity and delivery of the Trust's implementation plan.

B. Murphy advised that:

1. The report provided good assurance on embedded systems and processes for monitoring the Trust's Integrated Oversight Plan and CQC activity.
2. The overall assurance level with regard to the embeddedness of the CQC Improvement Plan had been determined by a report produced by AuditOne in 2025. It was a substantial achievement for the Trust to achieve good assurance in the audit.
3. The report showed the comparison between inspection activity and how the Trust rated in 2021 and again in 2023. Good assurance had been received regarding crisis and health-based place of safety inspections, which had resulted from an unannounced visit in 2025 and the Trust had received a good rating for that.
4. Areas of improvement had been identified from inspections held in 2023 with regard to:

   - Staffing
   - Mandatory and statutory training
   - How the Trust responded to complaints related to compassion
   - How supervision was recorded
   - Waiting times and response times for serious incident investigations

5. NHS England and the Integrated Care Boards were assured that the Trust had delivered its commitments.

6. There was information in the report on a positive inspection carried out in April 2026 on the Trust's community Child and Adolescent Mental Health Services. The Board had been understandably proud of what staff had been able to demonstrate across the three-day, unannounced, inspection.
7. Areas for improvement had been identified, but there was nothing to escalate as a concern or to change immediately. The draft outcome inspection report was awaited.
8. She regularly held engagement meetings with the Care Quality Commission and a range of clinical and operational staff and also spoke to the inspection lead approx. once per week.
9. The Trust did not have any services that were rated inadequate or had warning notices.
10. An inspection of Trust services was expected within the next year for those rated as requires improvement and which have not been inspected for three years or more.
11. Following the Public Inquiry into the Nottinghamshire Healthcare NHS Foundation Trust, the Care Quality Commission had committed to inspecting all community-based mental health services within a set period of time.

The Chair confirmed that the report had provided a good level of assurance and thanked B. Murphy for the information.

It was noted that:

- J. Kirkbride advised that it had been reassuring to see so many good ratings for Trust services. However, it would have been helpful to have the services inspected in 2021 and 2023 listed in the same order in the report, so that a comparison could be more easily made.

In conclusion, the Chair confirmed that the Trust was not failing but recovering, and the work undertaken had been substantial. She thanked B. Murphy, her team and all staff involved in inspections, for their work and efforts.

13. APPOINTMENT OF A MEMBER OF THE COUNCIL OF GOVERNORS' NOMINATION AND REMUNERATION COMMITTEE

Governors considered a report on the appointment of a new member of the Council of Governors' Nomination and Remuneration Committee.

P. Bellas advised that a nomination had been received from J. Venable. Public Governor for North Yorkshire, and the recommendation was to appoint him as a member of the Council of Governors' Nomination and Remuneration Committee.

Agreed – That John Venable be appointed as a member of the Council of Governors' Nomination and Remuneration Committee for a period of three years.

14. REPORT OF THE COUNCIL OF GOVERNORS' NOMINATION AND REMUNERATION COMMITTEE

Consideration was given to a report from the Council of Governors' Nomination and Remuneration Committee.

The Chair advised that following the departure of Jane Robinson, and impending departure of B. Reilly, the Trust had decided to start a recruitment process to appoint two new Non-Executive Directors. One required digital expertise and the other required a clinical background in order to chair the Board's Quality Assurance Committee. Shortlisting would be held in due course but

volunteers were needed to be part of the stakeholder groups and interview panel, expected to be held on 17 or 18 June 2026.

P. Bellas confirmed that expressions of interest from Governors would be welcomed.

15. FUTURE GOVERNANCE / ASSURANCE ARRANGEMENTS OF THE COUNCIL OF GOVERNORS

With regard to future governance and assurance arrangements, the Chair advised that:

1. As Governors were aware, they held the Chair and the Non-Executive Directors to account and she and the Non-Executive Directors held the Chief Executive and Executive Directors to account. It was essential Governors received appropriate information in order to gain that assurance and undertake their statutory duties and responsibilities.
2. At present it did not appear to her that Governors were in a position to fully hold her, or the Non-Executive Directors, to account as they did not have many opportunities to observe them in their roles or take part in the Board's committees. There were some opportunities to observe her as Chair at Board meetings that were held in public and at Council of Governors' meetings, and to observe Non-Executive Directors when presenting updates from committees at Council of Governors' meetings.
3. Governors needed to be aware of the competencies of Non-Executive Directors in both chairing Board committees and delivering triple A reports, but this was not possible at present.
4. Governor training needed to improve, as did Governor attendance of training.
5. She did not want acronyms used in Council of Governors' reports, or in verbal updates, as there was mixed understanding of those acronyms in the public domain. She gave an example of how she had attended the Trust's induction session for new staff members and had observed how acronyms had been used in that session too. Although she had found the presentations helpful, she did not feel she had left the session with a full awareness of the services TEWV provided. She suggested that other members of staff in that session who were non-clinical might also have felt the same and this needed to be improved.
6. She and the Chief Executive planned to make improvements to the Trust's assurance system and this would be shared with Governors in due course.
7. Governors' views would be sought as part of a development session on identifying good governance and assurance and how best to hold the Chair and Non-Executive Directors to account. It was important Governors were assured that she and the Non-Executive Directors were carrying out their role correctly.
8. Since her appointment, she had been impressed with the quality of care in the Trust.
9. There had been a number of changes to Chairs and Chief Executives in the Trust over the last three years and the Trust faced a statutory public inquiry. This had caused a lot of pressure in the organisation, but she and Chief Executive were committed to providing long-term stability for TEWV and sought Governors' support in doing so.

It was noted that:

- J. Coles advised that, as a City of York Councillor, her role was to seek assurance and hold to account for her local area but sometimes working within artificial boundaries made it difficult to carry out the job.

  The Chair advised that she and the Chief Executive had discussed the benefits of assessing quality standards across whole services, rather than by locality, given the variation in services provided across different areas.

- G. Birchwood requested that the Integrated Performance Report be written in more simple terms.

  As part of improving governance in the Trust, A. Smith confirmed that she and K. Ellis were considering how changes could be made to that report to provide a performance overview.

- J. Kirkbride welcomed the focus on managing whole services and sharing good practice beyond localities, as well as the wider changes outlined by the Chair. She noted that she had declined to contribute to a Non-Executive Director appraisal in 2025 because she was not familiar with that particular Board member. She also reflected that Governors had previously valued informal engagement with Non-Executive Directors before Council meetings, but that this had reduced in recent years. In relation to past leadership walkabouts, she observed that staff had sometimes appeared unfamiliar with the Directors leading the visits. In addition, J. Kirkbride expressed appreciation for B. Reilly in her role as Interim Chair, and for the positive environment she created.

  The Chair advised that some concerns would be discussed in the private session and, while further changes were needed, TEWV was a very good organisation and progress had already been made.

The Chair advised that in 12 months time, she hoped Governors would be able to confidently hold her and the Non-Executive Directors to account.

16. EXCLUSION OF THE PRESS AND PUBLIC

AGREED: *that representatives from of the press and other members of the public be excluded from the remainder of the meeting on the grounds that the nature of the business transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution.*

The meeting finished at 3.24pm.

_____

Marie Burnham
Chair
7 July 2026

Public Action Log

RAG Ratings:

	Action completed/Approval of documentation
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Council.
	Action outstanding and the timescale set by the Council having passed.
	Action superseded
	Date for completion of action not yet reached

Date	Minute No.	Action	Owner(s)	Timescale	Status
18/02/2026	44	To provide the Council of Governors with a brief summary of actions taken in relation to concerns raised by J. Kirkbride about the misdiagnosis of Emotionally Unstable Personality Disorder (EUPD)	KK	–	Meeting to be arranged between K. Kale and J. Kirkbride
18/02/2026	48	A presentation on the revised Leadership Walkabout process to be provided to Governors at a future Council of Governors' meeting	SDS	30/09/2026	For consideration at the meeting on 30/09/26
18/02/2026	49	A report on the Trust's Freedom to Speak Up service to be provided to the Council of Governors	SDS	13/05/2026	Completed
13/05/2026	7	Demonstration of how RIO works to be provided to Governors	NB	27/01/2027	For consideration at the meeting on 27/01/2027
13/05/2026	8	A simple guide to be provided to Governors on recent changes to the Mental Health Act	KK	–	
13/05/2026	8	A report on the use of prone restraint to be brought back to the the Council of Governors in six months	BM	27/01/2027	For consideration at the meeting on 27/01/2027
13/05/2026	8	Report to be provided to the Council of Governors on issues relating to delays in discharging people from Trust services who clinically ready for discharge and update on outcome of project led by N. Lonergan to address those issues.	NL	30/09/2026	For consideration at the meeting on 30/09/2026

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Tees, Esk and Wear Valleys
NHS Foundation Trust

25 June 2026 (MS Teams)

Use of Emergency Powers - Council of Governors' Standing Order 5.1 of the Trust's Constitution

Present:
G. Birchwood, public Governor, North Yorkshire
M. Booth, public Governor, Middlesbrough
M. Burnham, Trust Chair
J. Coles, appointed Governor, City of York Council
K. Evenden-Prest, staff Governor, Durham, Tees Valley and Forensics Care Group
J. Green, public Governor, North Yorkshire
C. Hague, public Governor, North Yorkshire
J. Kirkbride, public Governor, Darlington
J. McNulty, public Governor, Durham
Z. Sherry, public Governor, Hartlepool
S. Thomas, public Governor, Durham
J. Webster, public Governor, North Yorkshire
J. Williams, public Governor, Stockton-on-Tees

R. Barker, Non-Executive Director
P. Bellas, Company Secretary
D. Butcher, Associate Non-Executive Director
H. Crawford, Executive Director of Therapies
S. Dexter-Smith, Executive Director for People and Culture
K. Ellis, Executive Director for Strategy and Transformation
A. Grant, Corporate Governance Officer (CoG and Membership) (minutes)
E. Gorringe, Associate Non-Executive Director
N. Lonergan, Interim Managing Director
J. Maddison, Non-Executive Director
J. Preston, Senior Independent Director
L. Romaniak, Executive Director for Finance, Estates and Facilities
A. Smith, Chief Executive

Reasons for Use of Standing order 5.1 – Emergency Powers

- A further special meeting before the next ordinary meeting on 15 July 2026 would be difficult to arrange, particularly during the summer holiday period.
- The matter was urgent, as the Trust needed to maintain a full Board of Directors to support effective governance and business continuity.
- Delaying the appointments could leave the Trust at a disadvantage, with insufficient Non-Executive Director capacity and some individuals continuing to undertake dual committee chairing roles.
- The preferred candidates were strong, and in a competitive market a delay could increase the risk of them accepting roles elsewhere.

Declaration of Interest

The Chair declared that she had previously met both candidates in a professional capacity when working in previous NHS roles.

Appointment of two New Non-Executive Directors

P. Bellas confirmed that:

- The consultation was held under the relevant provision of the Constitution to consult Governors on the appointment of two new Non-Executive Directors.
- Governors had received papers setting out the recruitment process and the recommended appointments.
- The recruitment process was supported by Gatenby Sanderson and included stakeholder groups and interview panel members.
- Thanks were noted to all participants, including Non-Executive Director Nini Adetuberu, who chaired the two stakeholder groups.
- The appointments panels recommended Philomena Corrigan for the clinical role and Len Richards for the digital transformation role; Governors had also received biographical information on both candidates.
- Governors were asked to agree both appointments, subject to the Fit and Proper Persons Test and other required clearances.

Agreed – That Governors present support the appointment of two new Non-Executive Directors, Philomena Corrigan and Len Richards:

- ***for initial terms of office of 1 July 2026 to 30 June 2029;***
- ***on the Trust's usual terms and conditions of services; and***
- ***subject to the receipt of satisfactory assurances under the Fit and Proper Persons Test.***

The Chair and Chief Executive confirmed the appointments under Standing Order 5.1.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Council of Governors'**
Date:	**15 July 2026**
Title:	**Governor questions submitted for Council of Governors' meetings**
Executive Sponsor(s):	**A Smith, Chief Executive**
Report Author(s):	**A Pridmore, Interim Company Secretary and Corporate Governance Director**

Report for:				
	Assurance		***Decision***	X
	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*
N/a	**N/a**	**N/a**

EXECUTIVE SUMMARY:

Purpose:

This report seeks the ratification of the process for submission, consideration and response to Governor questions that are submitted for Council of Governors' meetings. The process aims to provide a clear, transparent and consistent approach that Governors' and Trust staff can follow, to ensure that questions are managed efficiently.

Proposal:

Council of Governors are asked to support the process by which Governors' will submit questions to the Trust. The process introduces agreed timescales for submission, sets out how questions will be reviewed, and clarifies the arrangements for providing responses for facilitating a discussion at Council of Governors' meetings.

Overview:

The proposed process has been developed to support effective engagement between Governors and the Trust, while ensuring that questions are considered in a fair, consistent

and timely manner. It establishes clear arrangements for submitting question, identifying appropriate responses and dealing with matters that fall outside of the Council of Governors remit or involve confidential content. The process is underpinned by the Trust's values and the Nolan Principles of Public Life, promoting openness, accountability and respectful dialogue.

Prior Consideration and Feedback:

The proposal follows on from discussion at the Council of Governors in May 2026, where it was agreed that it would be helpful to clearly set out the process for the submission and response to Governor questions.

The proposal has been considered by the Trust Chair and Chief Executive.

Implications:

There are no financial implications arising from the proposal.

The process will support the Trust's governance arrangements and will provide a clear framework for managing requests that may involve confidential, exempt or otherwise inappropriate information.

The process promotes transparency, fairness and inclusive engagement with Governors. It will ensure that all Governors are treated consistently and respectfully, in line with Trust values and the principles of equality and non-discrimination.

Recommendations:

Council of Governors is invited to:

i. Ratify the proposed process for Governor questions.
ii. Support implementation of the process with immediate effect.
iii. Note that the process will be incorporated into relevant Governor guidance and governance documentation.

Process (for Governors) for submitting questions:

1. Questions must be submitted in writing at least 15 clear working days before the council meeting by emailing tewv.governors@nhs.net. Questions received after the deadline will not be included for discussions at the meeting.

2. The name of the governor asking the question (and the constituency they represent) must be provided. If the question is being asked on behalf of an organisation, then the name of the organisation must also be stated.

3. The Chair will review all questions received prior to the Council of Governors' meeting to determine how they should be addressed. Questions considered suitable for consideration by the Council will be included on the meeting agenda. Copies of the questions received, and responses (if available), will be circulated to Governors prior to Council meetings. Late responses will be circulated to Governors as soon as possible following the meeting.

4. Where a question is not considered suitable for discussion at the meeting, the Governor will be provided with an explanation and, where appropriate, an alternative route to respond to the question will be agreed.

Subject matter and scope of Governor questions:

We ask that you submit questions, rather than statements. Questions may be rejected if the Chair considers that they:

- are not related to matters within the powers and duties of the Trust.
- are substantially the same as a question that has previously been answered at a meeting of the Council of Governors.
- would require the disclosure of confidential or exempt information.
- are about an individual patient's care (where appropriate, the patient will be redirected to the Trust's Complaints Team).
- include names of, or clearly identify, a member of staff, patient or any other individual (where appropriate the patient will be redirected to the Trust's Complaints Team)
- are defamatory, offensive, discriminatory, abusive, repetitive, already addressed, or outside the Trust's statutory responsibilities.

Underpinning principles

Governor questions will be managed in accordance with the Trust's values, the Nolan Principles and NHS values:

- Respect – Listening, inclusive and working in partnership
- Compassion – Kind, supportive, recognising and celebrating
- Responsibility – Honest, learning and ambitious

- Selflessness – The Trust will act in the best interests of patients, service users and the public
- Integrity - Questions and responses will be handled honestly and without improper influence
- Objectivity - Responses will be evidence-based and proportionate
- Accountability - Our board are accountable to the public for its decisions and performance
- Openness - Information will be shared transparently, subject to legal and confidentiality requirements
- Honesty - Responses will be accurate and clear
- Leadership – Our board will promote high standards of conduct and respectful engagement

How questions will be answered in the Council of Governors' meeting:

- Governor questions will be included as an item on every Council agenda.
- Council will have the opportunity to review the questions and responses to raise any concerns or identify any matters that require further discussion. Questions and responses will not normally be considered individually during the meeting unless the Council or Chair determines that further discussion is required.
- Questions that are not addressed in the Council meeting will be followed up with a written response.

Tees, Esk and Wear Valleys NHS Foundation Trust

People, Culture and Diversity Committee: Key Issues Report		
Report Date: 11 June 2026	**Report of: People, Culture and Diversity Committee**	
Date of last meeting: 6 May 2026	The meeting was quorate.	

1	**Agenda: The following agenda items were considered during the meeting:**
	• Colleague Story
	• Key Issue Reports
	  o Board Report - 12 January 2026 PCDC meeting
	  o 'Time Out' Report – 4 March 2026 meeting
	• Corporate Risk Register – Risks to PCD
	• Board Assurance Framework
	• Workforce Strategy Delivery Report
	• Workforce Data
	• Inclusive Cultures Progress Update Report
	• Health and Wellbeing Update
	• Freedom to Speak Up Guardian Update Report
	• Partnership Agreement with Staff-side
	• Annual Review of Committee Performance/Committee Evaluation
	• Committee Terms of Reference
	• Workplan - noted the potential changes to the dates of future meetings	

2a	**Alert: The Committee wishes to alert the Board on the following matters:** **-**	
2b	**Assurance: The Committee can confirm assurance on the following matters:** **Corporate Risk Register – Risks to PCD** The Committee confirms good assurance in respect of the risk management processes in place, the consideration of risks for inclusion in the Corporate Risk Register and the ongoing management of these risks. The Committee notes there are 14 risks on the Corporate Risk Register, with no change in the total number from the previous period. Among these, 2 risks have had their current risk ratings reduced during March 2026, reflecting successful mitigation efforts. All risks show evidence of review, ensuring ongoing monitoring and control effectiveness. With regard to Risk 909 (Consultant Recruitment Difficulties in NYY) the score remains below 15 at a rating of 12. Further discussions to take place with a view to reducing the risk. Risk 1137 (Supervision Compliance and Assurance) remains at 15 with an extended target date to the end of August 2026. Actions are ongoing, and reasonable assurance is reported, with internal audit highlighting areas for improvement. The Committee notes that in future, Risk Register reports will be specifically Committee focussed rather than generic. **Board Assurance Framework (BAF)** The Committee confirms it has good assurance on the management of BAF risk 1 (safe staffing) as at Quarter 4, 2025/26 and agrees that the risk score should be reduced from 20 to 15 following the delivery of the key action to develop a "specific workforce plan for each clinical and corporate service". The Committee notes that in future the BAF will be presented in a new format following the transfer of all data to the 'InPhase' system. The Committee recognises that the context for the organisation has changed and that the wording of the BAF Safe Staffing risk requires altering to reflect this. This would be addressed in forthcoming reports to the Committee. **Workforce Strategy Delivery Report** The Committee confirms that ongoing work offers good assurance that the correct activities are being carried out which effectively impacts on the Performance Metrics and the progress of the BAF, with key exception to this being sickness levels across the Trust. This would be the subject of further reports. There was strong and growing assurance that workforce risks such as safe staffing, training, supply, and governance are effectively managed with improved controls and oversight. Other positive performance indicators included: average time to hire, local induction compliance, staff leaver rate,	

mandatory and statutory training compliance (over 90% compliance), and appraisal completion rates. However, alongside sickness absence, Immediate Life Support (ILS) training also requires monitoring compliance with standards and clear actions.

The Trust demonstrates strong assurance in medical education governance, supported by high participation in national surveys and positive GMC survey outcomes validating a robust training environment. Consultant and SAS job planning targets have been met with 95% sign-off, positioning the Trust well for national expectations on service planning and workforce sustainability. Recruitment processes have improved with enhanced reporting and remain within key performance indicators despite pressures. A new approach to recruitment beyond interviews is being developed. The second MARS scheme approved 29 staff departures with notice periods extending to June 2026. The Trust manages 389 apprenticeships with good assurance and is adapting to the national changes in apprenticeship funding and mitigating risks.

The Committee acknowledges that the absence of a Workforce Strategy/Strategy Refresh report as a 'formal' successor to the People Journey Delivery Report has implications for the development of the leadership and cultural focus of a refreshed 'Safe Staffing' risk for the Board Assurance Framework. No further updates were available at the current time on the National NHS Leadership Programme or the regulation of managers.

Workforce Data
The Committee notes the overall workforce position as at March 2026 and takes reasonable assurance on the monitoring of the Trust's workforce data. The Trust's workforce headcount is 8,290 with 7,478.96 WTE, a reduction due to fewer starters and the MARS scheme. Recruitment KPIs for 'Time to Hire' are met consistently, though pre-employment checks need improvement. Internal transfers continue to aid workforce mobility. Disciplinary cases numbered 30 from December 2025 to February 2026, with low grievance activity. The Committee notes that whilst the Trust was benchmarking 'high' for disciplinaries, recent benchmarking information indicated that the Trust was not an outlier in respect of Tribunals. Freedom to Speak Up cases total 52 since November 2025, showing strong engagement. The Committee notes that the Trust would be hosting a Regional Reasonable Adjustments Team in the future.

Inclusive Cultures Update Report
The Committee confirms good assurance of the link between the indicators and the interventions, and the data provided, but only reasonable assurance that the impact is as expected. Staff participation in leadership initiatives remains strong, with improvements noted in leadership development and staff mood, though achieving management consistency remains as a concern. Accordingly, the Trust is implementing a Management and Leadership Framework, ongoing leadership programs, and team development modules to address this and promote good practice.

Staff survey data shows improvements in experiences of ethnic minority staff and those with disabilities, with reductions in harassment and bullying and increased confidence in reporting. Despite progress, disparities persist for staff with long-term health conditions and ethnic minorities regarding career progression, discrimination, and feeling valued, requiring targeted interventions. Accordingly, the Trust is undertaking surveys, developing action plans, analysing workforce data, and has committed to regional anti-racism pledges and policy reviews to address discrimination and increase support for affected staff, for example, the Reasonable Adjustments Team facilitates access to funding and promotes inclusivity. The Committee notes the good oversight of the Anti-Racist Steering Group and the positive work with Cleveland Police in relation to reporting processes and restorative practices.

While appraisal completion rates are high, audits reveal inconsistent appraisal quality, documentation, and alignment with staff development needs. This is being addressed through workshops, additional guidance, and integration of information into management training to improve appraisal quality and staff experience.

Health and Wellbeing Update
The Committee confirms reasonable assurance acknowledging that assurance varies across the themes. There is good assurance for the impact of health and well-being staff support services and an

	overall score of 'improving' for staff health and safety as there is a good understanding of staff sickness absence and several related interventions are in place or due to be piloted. Reasonable assurance is proposed in respect of work concerning violence and aggression, impact of burnout, and health and safety climate. Staff survey results show a steady improvement in the overall health and safety climate score, now slightly above the NHS similar organisation average, though burnout and health and safety climate remain areas of concern. A new dashboard and audit of sexual safety incidents provide oversight of violence and aggression towards staff, with training compliance near targets and plans for an operational group to oversee actions. Gaps include incomplete understanding of incident prevalence and outcomes, and inconsistent responses. Both short and long-term sickness absence rates have decreased since January 2026, with detailed reporting and completed actions such as policy reviews and planned coaching training for managers to support absence management. The Employee Psychology Service shows effectiveness while the Employee Support Service maintains stable referral levels and positive user feedback. The Mindfulness programme courses report positive feedback and referrals to the regional Wellbeing Hub are increasing, though outcome effectiveness data is lacking at the current time. The Committee notes that the Staff Experience Group have identified flexible working as a priority area for further consideration. **Freedom to Speak Up (FTSU) Guardian Update Report** The Committee takes substantial assurance in respect of the implementation and impact of the FTSU service. Since mid-November, the FTSU Guardian Service has engaged with approximately 2,000 staff members, maintaining and even increasing contact levels, particularly in previously underrepresented areas. Visits to services by the FTSU Guardian are well targeted based on emerging concerns and intelligence, supported by robust oversight including monthly updates and immediate escalation of urgent issues to relevant Directors. The Committee notes that the FTSU Guardian has been attending Leadership events and suggests that a formal workplan could be developed to build on this approach. The strengthening and expanded reach of the FTSU service contributes positively to service safety and cultural change within the Trust, supporting the Committee's responsibilities. The Committee notes that NHS England (NHSE) plan to close the National Guardian office and the future reporting lines will be direct to NHSE. As a contracted service, the Trust's Guardian will continue to receive support from the organisation's national team.
2c	**Advise: The Committee would like to advise the Board on the following matters:** **Colleague Story** A member of staff who is the parent of a 16 year-old trans son provided a presentation to the meeting, with the consent of her son, to share her reflections on her experience whilst working as a Psychologist in the NHS. Her aims were to influence training provision, highlight the lack of local services to meet her son's needs and to draw attention to the issues in relation to the quality of Trust services. In 2021 he had presented with increased anxiety and became withdrawn, developing patterns of excessive exercise and eating difficulties. In 2022, he began receiving support from CAMHS Eating Disorder Service and CAMHS. In February 2023, he started transitioning from female to male, changing his name in June 2023. Whilst on the waiting list for the Gender Identity Service, he had periods of suicidal ideation and required considerable emotional support. Local CAMHS services were responsive, helpful and kind but did not provide the specialist Trans focused support which was needed for the family. Whilst the CAMHS support focused on the anxiety, low mood or eating difficulties there was a clear message that being Trans could not be a focus of the work. Whilst the family was not in the catchment for Hart Gables, they had some contact with the charity, although the offer of a peer support group did not meet the need for specialist support. The Rainbow Staff Network, Trans Reference Group and Abigail Holder, Inclusive Community Engagement Lead have provided support and a point of contact for the member of staff and this has been valuable. The Committee notes the challenges in respect of accessing appropriate services and the gaps in care. It suggests that the presentation be considered by the Quality Assurance Committee. **'Time Out' Report – 4 March 2026 meeting** The Committee notes the report from the 'Time Out' highlighting key workforce, culture and organisational development issues. Staff Survey results show improvement in overall engagement, with response rates increasing from 44% to 52% and the Trust identified as the second most improved Mental Health/Learning Disability Trust, alongside above national average access to

supervision and improved scores for advocacy, work–life balance and morale; however, areas of concern remain, including experiences of racial discrimination, support for staff with long-term conditions, access to reasonable adjustments, and a lack of improvement in violence at work and post-incident feedback. A 'Deep Dive' is planned into violence and aggression reporting to assess potential underreporting. The Committee notes that a Trust-wide three-year workforce plan is in development, focused on reducing agency and bank usage, supporting new staffing models aligned to clinical transformation to enable the hospital to community shift and the delivery of evidence-based care, and embedding a service-led approach to workforce planning, supported by training and lived experience input. There is also a need for further consideration to be given to future changes to corporate roles and the requirement for additional commissioning/contract management expertise/skills.

The Committee also notes the position regarding the transformation of People Services through a national programme, including development of a digital-first Target Operating Model with automated processes and 24/7 access, alongside regional 'Scaling Up' workforce initiatives. The Committee highlights the need to consider organisational culture more broadly within the Board Assurance Framework, strengthen triangulation of workforce and quality risks, and confirms actions including further analysis of workforce challenges and to hold future 'Time Out' sessions on a face-to-face basis

Partnership Agreement with Staff-side
The Committee notes that the Partnership Agreement is under review at the current time. This sets out the framework for effective joint working, consultation and information sharing between the Trust and Staff-side, with the aim of supporting positive employee relations, meaningful staff involvement and constructive engagement on matters affecting the workforce and service delivery. It establishes shared principles of openness, early consultation and mutual respect, and defines the respective roles of the Trust, managers and staff-side representatives, alongside the operation of Joint Consultative Committee (JCC) and Local Consultative Committee (LCC) arrangements. As part of the current review, a number of practical and governance-related areas have been identified for discussion with staff-side. The outcome of these discussions will inform any proposed amendments, which will be considered through partnership governance arrangements, in line with the agreement.

Annual Review of Committee Performance/Committee Evaluation
The Committee notes that the frequency of meetings is likely to change in future, perhaps with the introduction of shorter meetings which have a more themed approach. Some concerns were expressed in respect of the limited attendance from some members which was to be discussed with the Chief Executive out with the meeting, along with clarification in respect of links with other Committees.

Committee Terms of Reference
The Committee approves a minor change of wording to the Terms of Reference and notes that decisions in respect of membership are within the remit of the Board of Directors.

2d	**Risks**	• No new risks • Potential risk to 'Well-led' from the lack of a successor 'People Journey' strategy

Recommendation: The Board is asked to note the contents of the report.

3	**Any Items to be escalated to another Board Sub-Committee/Board of Directors**	• BAF risk 1 (safe staffing) risk reduction (score reduced from 20 to 15) at Quarter 4, 2025/26 following the delivery of the key action to develop a specific workforce plan for each clinical and corporate service • Sickness Absence levels, not reducing as expected • Attendance of members at meetings • Colleague Story as a potential Quality item for Quality Assurance Committee
4	**Report compiled by:** Deborah Miller, Corporate Governance Manager, Roberta Barker, Non-Executive Director (Committee Chair), Sarah Dexter-Smith, Executive Director of People and Culture	

DM/28/05/2026

Tees, Esk and Wear Valleys NHS Foundation Trust

Mental Health Legislation Committee (MHLC): Key Issues Report to the Board of Directors	
Report Date:	**11 June 2026**
Date of last meeting:	**6 May 2026** – Committee was quorate

1 Agenda: The Committee considered the following agenda items during the meeting

- Mental Health Legislation Combined Assurance Report, including Mental Health Capacity Act/DoLS
- Multi-Agency and Internal Mental Health Legislation Operational Group Update (DTVF)
- Multi-Agency and Internal Mental Health Legislation Operational Group Update (NYY)
- Data publication – Patient Carer Race Equality Framework (PCREF) including Mental Health Act Detention Rates Report
- Section 17 Leave and Time Away from the Ward
- Positive and Safe: Quarter 3 Update
- Progress of CQC MHA Monitoring Activity – 1 January 2026 to 30 April December 2026
- Individual Case Study
- Patient Advocacy – Assurance Update Report and Presentation
- Policies and Procedures for approval
- Scheme of Delegation
- Committee Evaluation
- MHLC Workplan – noted
- Any Other Business - Feedback from the Development meeting on 13 April 2026

2a Alert: The Committee alerts members of the Board to the following:

Patient Advocacy - Assurance Update Report

The Committee confirms a limited assurance rating for an initial assurance report on how services are engaging with statutory advocacy provision, including Independent Mental Health Act, Independent Mental Capacity Act and Care Act advocacy, drawing on the first round of service-level returns submitted in response to the February 2026 assurance request. The report identifies variation in the quality and completeness of returns, while also highlighting examples of good practice, particularly where services built on the work of the Mental Health Legislation Team and shared learning across teams. The approaches within Adult Mental Health had been strengthened. Members note ongoing work with Wards to improve equity of access, including recognition of postcode variation in informal advocacy provision, with Durham and Middlesbrough having established services while gaps remain in York, North Yorkshire and Darlington. It also recognises that detention-specific information currently available to patients is too generic and is under review by services.

In discussion, the Committee explored the need for culturally appropriate advocacy, including support for asylum seekers and refugees, and learned that commissioned advocacy provision is more developed in some areas than others, particularly in Teesside and the City of York compared with rural parts of North Yorkshire. Overall, the Committee concludes that the advocacy landscape across the Trust is complex and that further data, provider mapping and continued focus on embedding advocacy are needed to improve oversight, promote advocacy rights and strengthen assurance. Proposals for corrective actions include: chasing outstanding returns; escalating non-responses where needed; continuing provider mapping; progressing strategic advocacy work through Integrated Care Governance Group (ICGG); and submitting further assurance on service-level learning at the next reporting cycle.

2b Assurance: The Committee confirms assurance to the Board on the following:

Mental Health Legislation (MHL) Combined Assurance Report, including Mental Capacity Act/Deprivation of Liberty (DOLS)

The Committee approves a good level of assurance in respect of the robustness of data provided and confirms that the legislation, Mental Health Act and Mental Capacity Act/DoLS, has been applied correctly, noting evidence of overall compliance and improvement across key measures. It is

reported that 5 patients were discharged without being read their rights (July–October 2025), showing improvement, alongside a reduction in escalations to 88 (from 95 previously). There were 4 lapsed Section 5 episodes across four wards, and approximately 35% of Section 5s are applied within 24 hours of admission, with a delayed deep-dive review planned. AWOL episodes total 93 for the reporting period (November 2025–February 2026), including 2 requiring CQC notification, while 8 discharges from 182 Tribunal hearings and 3 from 151 Hospital Managers' hearings are recorded. Of 202 Section 136 cases, 2 are extended and 2 reach 24 hours, with all discharged to the community. The Committee notes one failure of administrative scrutiny and none for medical scrutiny, alongside strong demand for training across clinical staff groups. A significant reduction in DoLS activity is observed, from 63 to 5 authorisations for residents in 365 Thornaby Road and 1 for MHSOP at Foss Park, reflecting changes in service provision and continued application of least restrictive principles.

Multi-Agency and Internal Mental Health Legislation Operational Group Updates (DTVF)
The Committee notes that the DTVF Multi-Agency and Internal Mental Health Legislation Operational Groups are established with a good level of assurance and provide oversight of the application of the Mental Health Act and Mental Capacity Act, supporting both internal practice and partnership working. It recognises good partner engagement, although attendance from some agencies remains inconsistent, and notes that a Behavioural Disturbance workstream is being established with multi-agency involvement. It highlights the need to strengthen partnership working, particularly with ambulance services, where mental health-related demand is increasing and agreed actions to improve engagement and contact arrangements. Demand for Mental Health Legislation training is high, with approximately 200 staff requesting sessions, and commissioning of targeted training is underway. The Committee also notes ongoing work to improve recording of Section 17 leave through an external audit, alongside identified issues in patient feedback mechanisms.

Multi-Agency and Internal Mental Health Legislation Operational Group Updates (NYY)
The Committee notes that the NYY Multi-Agency and Internal Mental Health Legislation Operational Groups are established and provide oversight of the application of the Mental Health Act and Mental Capacity Act, supporting both internal practice and partnership working. It notes good engagement with partners, including plans for a joint Away Day, and confirms that the Right Care Right Person approach is embedded, supported by local guidance. The Committee recognises ongoing work to improve secure transport arrangements and identifies variation in practice regarding the use and transfer of sections when patients attend Acute Trusts, with a lack of a consistent pathway. It is noted that a working group is being established to develop a clear Trust-wide approach, alongside emerging learning from patient safety investigations relating to transfers and environmental risks. The Committee agrees actions to progress pathway development and standardised reporting and concludes that there is a good level of assurance that the groups are identifying key issues and supporting coordinated improvement activity across services.

Section 17 Leave and Time Away from the Ward
The Committee confirms good assurance in respect of oversight and monitoring of Section 17 Leave and Time Away from the Ward, supported by continued quality assurance activity and monthly performance review. The Committee notes that the report has been considered by the Quality Assurance Committee and that the policy is due for renewal with a review event scheduled for June 2026. Whilst no Regulation 28 order had been issued and Coroners have acknowledged improvement; it had been recognised that informing carers of Section 17 leave arrangements was not explicitly mentioned in Trust Policy. This was to be considered as part of the day event and policy review.

Overall improvement in compliance is recognised, although variation persists, with February performance in one service (DTVF MHSOP) declining to 69.57% due to a lack of audit returns following three months above 85%. The Committee notes areas of strong compliance, including 100% achievement regarding Informal Time Away From the Ward (TAFW), in ensuring patients and carers receive relevant contact information, and in accompanied leave standards. Compliance with discussing the TAFW plan at the last use was 0%, indicating a clear area for improvement. Accompanied leave measures, standards related to accompanied leave achieved 100% compliance, with the exception of the requirement to offer a copy of the Section 17 form to the accompanying

	person, which was met in 50% of cases. Ongoing improvement actions include a Trust-wide audit, strengthened staff awareness, targeted ward-level action plans, and future system support through the implementation of the Rio EPR. **Positive and Safe: Quarter 3 Update** The Committee confirms there is good assurance demonstrated of progress implementing the Positive and Safe Strategy. The update on the implementation of the three-year Positive and Safe Strategy and a review of restrictive practice for Quarter 3 (2025/26), reported 1,966 restrictive interventions, an increase from 1,518 in Quarter 2, primarily attributed to patient acuity, while remaining within expected parameters. It is highlighted that 239 patients experienced restrictive interventions, with 9 patients accounting for 48% of all interventions, including one patient responsible for 93% of seclusion and 12% of interventions Trust-wide, indicating areas of significant unmet clinical need. The Committee notes an increase in prone restraint to 16 confirmed episodes, alongside data quality issues, with 10% of incidents missing patient identifiers, limiting statutory reporting and analysis of equity and repeat use. Disproportionality in the use of restrictive interventions across some ethnic groups is also recognised, although completeness of ethnicity data is impacted by unknown recording. The Committee recognises the need for continued focus on data quality, culturally informed practice and embedding the Positive and Safe Strategy across services. **Progress of CQC MHA Monitoring Activity – 1 January 2026 to 30 - April 2026** The Committee confirms a good level of assurance in respect of the oversight systems and processes and notes the progress made in relation to CQC Mental Health Act inspection activity across Trust inpatient wards, including thematic learning. During the reporting period (January to April 2026), 11 inspections, including informal visits, were undertaken. No new systemic themes were identified; however, recurring issues continue to relate to environmental factors such as access to therapeutic outdoor space, nutrition, staffing pressures, and the quality and storage of Mental Health Act documentation. The Committee notes that 75 actions have been completed since April 2025, with a small number of outstanding actions subject to ongoing monitoring and receives assurance regarding the effectiveness of oversight arrangements. It also recognises that wider themes identified in the CQC's Monitoring the Mental Health Act 2024/2025 one-page summary of key points report, including demand pressures, workforce challenges and inequalities in access, are consistent with those observed within the Trust.
	Advise: The Committee advises the Board on the following: **Data publication – Patient Carer Race Equality Framework (PCREF) including Mental Health Act Detention Rates Report** The Committee notes the position regarding detention rates under the Mental Health Act which have been analysed by gender, ethnicity and age using 2024/2025 data benchmarked against national and expected rates. Significant data quality limitations are identified, including ethnicity being unknown for almost one-third of individuals and approximately 50% of restrictive intervention data missing ethnicity, which impacts the reliability of conclusions. Available data indicates that detention rates for Black/Black British people are similar to national averages and are around twice those of White people locally, with Black/Black British women disproportionately affected. The Committee also recognises a consistent pattern of under-representation of ethnically minoritised and racialised communities in services alongside higher rates of admission and detention, highlighting the need to improve access, cultural humility and workforce capability. A targeted engagement plan is also in development to address these issues through community partnership, co-design and improved learning, and the Committee supports further work to strengthen ethnicity data recording, develop a Performance Improvement Plan and enhance organisational oversight. **Individual Case Study** The Committee reviewed an individual clinical case study regarding the circumstances of a young adult woman with bipolar disorder and polysubstance misuse, focusing on the challenges encountered during the expiry and attempted extension of her Community Treatment Order (CTO). The discussion highlighted that the AMHP does not need to see the patient in person to extend a Community Treatment Order (CTO), provided the Responsible Clinician had seen them, given that a phone conversation could suffice for the Part 2 signature. The patient experienced no harm or relapse following a CTO lapse, with satisfactory clinical outcomes and minimal carer involvement.

Key actions include sharing case study learning with the AMHP Lead and supporting wider dissemination via external groups. The Committee stresses the importance of early collaboration between clinical teams and AMHPs, recognising the impact of varying statutory interpretations, and calling for clear processes to resolve or escalate disagreements to ensure effective and equitable application of the Mental Health Act for CTOs.

Policies and Procedures for approval
The Committee receives a report reviewing policies and procedures relevant to its remit to ensure ongoing compliance with regulatory and statutory requirements. It is noted that a number of policies previously approved in January 2026 have been subject to minor amendments following further review by the Equality and Diversity team and, in the case of the Section 17 Leave Policy, in response to a Regulation 28 Coroner's report. The updates include strengthening equality impact wording to emphasise time-limited and least restrictive approaches to patient rights, the introduction of gender-neutral language, minor typographical corrections, and enhancements to guidance within the Section 17 policy, including clearer expectations around contingencies, family involvement and alignment with electronic patient records. The Committee notes that these changes have been approved by the Executive Medical Director and formally approves the updated policies and associated procedures: (i) 'CLIN-0001-v5.4 - Consent to examination or treatment' and associated forms; (ii) MHA-0003-002-v2.5 – S135(2) Procedure; (iii) MHA-0003-v10.3 - Section 136 Policy; and (iv) MHA-0003-001 v3.5 S17 - Leave for detained patients' Policy.

Scheme of Delegation
The Committee approves the Scheme of Delegation which sets out the key responsibilities and functions placed on the Hospital Managers of the detaining authority.

Committee Evaluation

The Committee notes the results of the Committee Evaluation tool circulated in April 2026, which identifies key themes in relation to membership, representation and engagement. It notes that consistent nursing representation from Care Groups is to be strengthened and that a review of arrangements for lived experience representation is currently in place with proposals to enhance the patient voice being in development. The Lived Experience Director is to progress these through the appropriate governance routes prior to consideration by the Committee in September 2026.

Committee Terms of Reference
The Committee approves the revised Terms of Reference in respect of minor changes to update the reference to the Mental Health Act 1983 to state 'as amended by the Mental Health Acts 2007 and 2025'. No further changes to the Terms of Reference are proposed at this stage, pending future review of involvement and engagement proposals.

Any Other Business - Feedback from the Development meeting on 13 April 2026
The Committee notes the report which summarises the Committee Development Meeting held on 13 April 2026, focusing on the review of the Committee's work during the 2025/2026 period and plans for 2026/2027. A dashboard was scoped during 2025/2026 for use by the Committee; however, implementation is overdue and requires urgent action in 2026/2027. Whilst a review is undertaken to identify proposals for the Patient Voice/Lived Experience, the Committee will gather lived experience through multiple routes such as a Lived Experience Director, case studies, advocacy services, and patient feedback platforms, rather than an individual patient representative. In addition, there was a presentation on the implementation and implications of the Mental Health Act 2025. The Act will be introduced in phases over 8-10 years, with stricter criteria for detention and community treatment orders, new conditional discharge forms from February 2026, and increased workforce needs including approved clinicians and tribunal members. Patient rights and safeguards will change, including the introduction of nominated persons and encouragement of advanced choice documents. The following key risks were identified: limited resources for Mental Health Act implementation, training, workforce gaps, and support for minority ethnic communities. Identified actions included: progressing the dashboard, exploring patient voice methods, reviewing support for ethnic minorities and non-medical prescribers, and benchmarking against similar Mental Health Legislation Committees.

2d	**Review of Risks**	There were no new risks.
Recommendation: The Committee requests that the Board of Directors: • *Note the report and confirm the levels of assurance set out above.*		
3	**Actions to be considered by the Board:** The following matters for escalation are for the Board to note/consider: • Individual Case Study (to be considered by the Operational Groups); • Section 17 – ongoing work in progress; • Performance Improvement Plan for ethnicity recording – recommendation; and • Patient Advocacy.	
4	**Report prepared by***: Roberta Barker, Chair of Committee/Non-Executive Director, Kedar Kale, Executive Medical Director and Deborah Miller, Corporate Governance Manager*	

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report Date: 5 June 2026		**Report of: Audit and Risk Committee** Quorum was met – all members were in attendance
Date of last meeting:		21 May 2026
1	**Agenda**	The agenda included: • Counter Fraud Progress Report • Internal Audit Progress Report 2025/26 • Internal Audit Plan 2026/27, update • Internal Audit Charter and Protocol Annual Review • Briefing on the Global Internal Audit Standards • External Audit Progress • External Audit Engagement Packs • External Audit Strategy Memorandum for 2025-26 • Summary report from Executive Risk Group meeting on 2 April 2026 • Tender Waivers Approved (2025-26) • Briefing on the draft accounts and accounting treatment of significant items • Registration of interests • Draft Annual Report 2025/26 • NICE Assurance and Improvement Programme and NICE Implementation – 2025/26 Annual Report • Annual Committee Performance Evaluation 2025/26 • Annual Review of Committee Terms of Reference • Cross cutting issues from Board Committees • Committee Workplan 2025/26
2a	**Alert**	**Head of Internal Audit Opinion** AuditOne advised that, based on work completed to date, it is likely that the Head of Internal Audit Opinion (HOIAO) will be reasonable assurance. This reflects the balance overall of fewer good and substantial assurance reports proportionately, with fewer substantial assurance reports having been returned during 2025/26 and two limited assurance reports (for EPRR and clinical supervision), which the Board is already aware of. An adverse outcome from the Data Security and Protection Toolkit Assessment advisory audit, which is an independent review conducted annually prior to the national submission in June, was also considered. It is unlikely that further work before the HOIAO is finalised will change the assurance due to the reduction in 'substantial' ratings (down from 7 to 3 currently). **Executive Risk Group (ERG)** Committee was alerted to reported incidents (including RIDDOR) at Bankfields Court, relating to staff injury arising from the care of one patient. The issues and responses were briefly outlined and Committee received assurance on enhanced executive oversight, additional support in place to ensure the appropriate ongoing care of the patient and staff safety and input from the Challenging Behaviour Foundation and MerseyCare. An Ethics Committee had been stood up and had considered implications and next steps to mitigate dual workforce and patient safety risks. Q*uality of care matters will be considered by Quality Assurance Committee, workforce matters by People Culture and Diversity Committee and finance matters by Resources and Planning Committee.* ERG also considered ongoing concerns on risks related to smoking incidents on inpatient sites and a task and finish group will report to a future ERG meeting. Committee heard that, due to proactive external networking by the health and safety lead, the Trust had secured an immediate alert to action being taken by the HSE in one NHS organisation. This had led to a requirement for them to develop

		an organisation stress risk assessment. Health & Safety and People & Culture leads were responding proactively to develop a Trust stress risk assessment.
2b	**Assurance**	**Internal Audit Plan 2026/27** Committee received assurance on the structured approach to development of a prioritised 2026/27 plan shortlist and supported the proposed move to develop an indicative strategic, rolling three-year plan using the same risk-based approach. This considered an AuditOne 'audit universe' of potential organisational risks, their generic risk ratings (non Trust specific) across several domains, whether/when previously audited and the outcomes and areas of highest risk. It was agreed that executives would consider an alternative, e.g. peer review or other, as absence management, whilst only recently audited, remained a key risk area (above target). Plan proposals including audit scopes will be discussed with Committee Chairs before a final plan is approved at the next committee meeting. **Global Internal Audit Standards** Committee received a briefing on the new standards, which strengthen expectations for Audit Committee and senior management, including responsibilities relating to governance, independence, oversight and adequate resourcing of the internal audit function. Assurance was provided that no gaps have been identified in current arrangements. **External Audit Progress and Audit Strategy Memorandum for 2025/26** Committee received a report on the planned scope and timing of the 2025/26 audit. The audit approach is largely unchanged from the previous year with a focus on the financial statements and value for money. The audit will consider presumed risks in relation to fraud in revenue recognition, management override of controls and valuation of land, buildings and right-of-use assets due to the materiality and complexity of these balances. The audit will also include a review of material income and expenditure balances within the Trust's subsidiary PIPs (as completed for the first time the previous year). Committee received assurance on work underway and that there were currently no identified risks to completion by the end of June, in line with NHSE audited accounts submission deadlines. **Tender Waivers** Committee received assurance that the overall number of waivers remain low, with 25 waivers approved in 2025/26 totaling £3.7m. Assurance was provided that waivers are used appropriately, where specialist systems or expertise is required or where the continuity of suppliers is necessary. Assurance was also provided in relation to the use of national framework agreements where tenders had not been used. **Draft 2025/26 Accounts and the accounting treatment of significant items** Committee received prior assurance that the Trust had processes to ensure the accounts were prepared in line with accounting standards, accurately reflected transactions during the year and submitted on time. Members had welcomed the opportunity for Non-Executive Directors to be briefed in advance to consider the report in detail, prior to the meeting and for the detailed briefing provided. It was noted that the Lead Governor had also attended this meeting and all Governors had been offered the opportunity to be briefed on the draft accounts at an alternative, later, date. **Registration of Interests** Committee received the report with reasonable assurance that conflicts of interest were being registered in accordance with the policy, with compliance at approx.70% following the change to recording on ESR. There was increased confidence in the accuracy of the relevant senior staff cohort and the policy and processes were in place to support compliance, including the escalation of non-

		responders. Advice had been sought from People and Culture Directorate on the use of sanctions for those who continually fail to declare and the potential to report breaches to Executive Directors Group was also proposed. Committee discussed the importance of accurate and up to date information, especially for outlying medics, in the context of the Aubrey Report and members queried potential to link compliance to the appraisal process. **Quality Assurance and Improvement Programme and NICE Implementation – 2025/26 Annual Report** Committee received the report with good overall assurance regarding the operational and strategic oversight of quality assurance and clinical effectiveness activities and that no new gaps in assurance or mitigating actions had been escalated or proposed by management. Committee also received assurance that programme carry-over forms part of a planned cyclical approach, rather than being indicative of non-delivery or specific capacity shortcomings. Committee queried the impact of oversight through the Clinical Effectiveness Group and received assurance that the revised governance structure provides a more effective link to operational delivery without reducing oversight. Clarification was provided that National Clinical audits were focused on compliance with defined core national standards, with the Prescribing Observatory programmes being supported by the Pharmacy Team.
2c	**Advise**	**Counter Fraud** Committee discussed planned opportunities to strengthen the reach of counter fraud awareness across the Trust, including those working across dispersed sites and 24/7 services and supported the opportunity to explore increasing visibility through information sharing (only) at visits conducted by the Freedom to Speak up Guardian, whilst acknowledging his independence should be maintained. **Internal Audit** Committee welcomed the positive progress in management oversight, including low levels of overdue actions and no actions outstanding beyond revised agreed dates, or 12 months. Committee supported a proposed amendment to the audit plan – the removal of the Overtime Audit due to the availability of data through new processes. The audit was deemed to be of reduced priority due to significant progress made to reduce overtime and had not therefore been retained as a 2026/27 plan priority. The audit will be replaced by an advisory review of the NHS Provider Capability Self-Assessment, to strengthen assurance on governance and regulatory readiness. Committee also proposed that benchmarking information be included in audits and sought continued mutual improvement against audit KPIs. **Internal Audit Charter** Committee approved the charter, which sets out the mandate, independence, scope and responsibilities of the internal audit function. The charter is largely unchanged from the previous year, except for the inclusion of the new Chief Executive within the escalation protocol. **Executive Risk Group (ERG)** It was noted that ERG had conducted a deep dive into risk relating to ligatures, to ensure risks considered self-harm more broadly and reflected a dynamic environment where the Trust needs to remain vigilant. ERG had agreed to an extension to enable clinical engagement on proposed revisions to the supervision policy, and in response a limited assurance internal audit. It received assurance that, in the meantime, there had been a significant increase in compliance and supervision rates had doubled in the last year.

		In response to a query at a Board seminar, executives had agreed that digital risks should not be incorporated within Transformation risk, to ensure Board visibility is maintained and this had been fed back to Board. **Annual Report** Committee received an update on the compilation of the Annual Report for 2025/26 and was invited to provide comment following the meeting on whether the report presented a fair, balanced and understandable view of the Trust's position. Outstanding sections included the Annual Governance Statement, which would be completed following receipt of the Head of Internal Audit Opinion, and performance which will be rewritten to provide a more cohesive summary. Committee discussed the presentation and accessibility of the report, the final version of which would not be submitted to NHSE but was needed prior to the Annual Members Meeting. It was acknowledged that the revised internal reporting timetable and process had been a significant improvement to the previous cycle. Committee will receive a final draft report for submission to NHSE for consideration prior to Board on 25 June 2026. **Annual Committee Performance Evaluation 2025/26** Committee received the report with good assurance on the effectiveness of its governance and on internal and external audit arrangements. Feedback highlighted some gaps in understanding about several items the Committee only considered annually due to recent membership changes. Committee agreed to hold a dedicated development session following completion of the annual accounts cycle to explore the feedback in more detail and to support understanding. It was also agreed that a session for Governors would be delivered by the Committee Chair and Associate Director of Finance separately to maintain clarity of roles and responsibilities. **Annual Review of Committee Terms of Reference** Committee agreed minor changes to the terms of reference and these will be presented to a future Board meeting for approval.
2d	**Review of risks**	No additional risks identified at the meeting.
3	**Actions/ escalations**	No additional actions or matters to escalate.
4	**Report compiled by**	John Maddison, Chair of Audit and Risk Committee/Non-Executive Director, Liz Romaniak, Executive Director of Finance, Estates and Facilities and Karen Christon, Deputy Company Secretary

Tees, Esk and Wear Valleys NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 11 June 2026		
Date of last meeting: 07 May 2026		**Report from the Quality Assurance Committee (quoracy met)**
		Chaired by B Reilly, Deputy Chair of the Trust/Non-Executive Director
1	**Agenda -** The Committee considered the following matters: • Minutes of meeting held on 02 April 2026 • Board Assurance Framework • Summary of Executive Directors Group Quality and Performance meeting, 28 April 2026 • Quality Governance Triple A Report including: CQC Activity and Integrated Oversight Plan, Quality Assurance and NICE, Quality Dashboard and Quality Risks Programme • Child and Adolescent Services CQC Inspection • Local Issue Resolution and Complaints Annual Report • Patient and Carer Experience Annual Report 2025/26 • National Community Mental Health Survey 2025 • Resuscitation Six Monthly Report • Medical Devices Six Monthly Report • Rehabilitation Services Model • Harrogate and Richmond Community Team • North Yorkshire and York Mandatory Training Compliance • Involvement and Engagement Services moved into Services Requiring Additional Support (SRAS) • Managing the Quality and Delivery of Clinical Subcontracts • Committee workplan 2026/27		
2a	**Alert**	**Matters of alert (areas requiring escalation or heightened awareness)** **Hambleton and Richmond Community Team:** Committee confirms there is reasonable assurance with regards to oversight and monitoring of known issues related to quality of care, however, there is limited assurance linked to the delivery of the improvements in quality of care. The main challenges are capacity and demand. Significant work has been done to stabilise and strengthen the quality and safety of services provided. Changes to leadership roles and additional support have strengthened the processes and operational function of the team. Planned KPI recovery, however, is currently constrained by clinical workforce capacity. Further focus is being given on workforce stabilisation, recruitment, sickness absence management and temporary capacity options. Committee will continue to seek assurance of improvements. **Mandatory training compliance for North Yorkshire & York** is above the 85% target as at 31 March 2026. However, despite the overall position, compliance is not consistent across subjects. The main challenges are face to face training, DNAs, operational issues and data quality with some staff training profiles showing incorrect requirements. Weekly monitoring and escalation arrangements are in place from ward/team to Care Group Board, with enhanced reporting (including trajectories, variance, causes and actions, validation of weekly training and DNA reports) strengthened through Quality & Performance and Service Improvement and Development Groups, however, there is limited assurance as the improvement actions are not yet fully embedded.
2b	**Assurance**	**Matters of assurance (Positive Assurance and areas of strength)** **Board Assurance Framework** There is good assurance on the management of the relevant strategic risks to the Committee.

		Committee confirms from the information received from the **Executive Directors Group report** that there is reasonable assurance of the quality of care in the care groups, based on the Integrated Performance Dashboard, Quality Dashboard, reports and data provided by services and corporate colleagues. However, there is currently limited assurance of the impact of improvement actions in some services. **Resuscitation -** There is a good level of assurance regarding the management and delivery of the resuscitation service. **Medical Devices -** Good assurance is confirmed relating to the current standards, processes, and oversight in the management of medical devices and measures are in place to effectively maintain patient safety and compliance with regulatory requirements **Patient and Carer Experience Annual Report 2025/26** The Annual Report was received with good assurance evidenced from the positive patient and carer experience outcome, the recovery in feedback response rates following the transition to iWGC, and the improvements in quality and use of feedback, whilst noting the actions underway to address variation in response coverage, carer involvement and inpatient reporting of feeling safe. **Local Issue Resolution and Complaints Annual Report** Good assurance was demonstrated in the annual report evidenced by the continued improvement in complaints handling performance, governance and oversight and organisational learning, despite an increase in overall activity and complexity. **Rehabilitation Service -** Committee confirms there is good assurance relating to the care delivery in the services. Committee confirms there is good assurance that appropriate oversight and coordination arrangements are in place for the **CQC inspection of Specialist Community mental health services for children and young people**. Initial written feedback from the CQC highlighted strong staff engagement and a supportive culture, the Trust has commenced prompt action planning in response to the initial feedback letter.
2c	**Advise**	**Matters of Advice (Points for Consideration or Ongoing Development)** **Managing the Quality and Delivery of Clinical Subcontracts** Committee confirms there is good operational assurance, however limited assurance on Care Group Board clinical oversight required to meet quality framework assurance with regards to the management of subcontracts held by the Trust in its lead provider role. Work has been undertaken to focus on the safeguarding of patient care, clinical effectiveness and safety mitigations within the current subcontracted portfolio. Measures are being developed to move towards strengthening assurance controls. There are no contracts that present an immediate, unmitigated risk to patient safety. Clinical oversight of contracts within care groups and development of an established process will mitigate any current gaps in assurance and reporting will be through to Care Group Board and the Quality Assurance Committee from July 2026. **The Involvement and Engagement (I&E) Service** has gone into a service requiring additional support (SRAS) due to the need for stabilisation and to implement a safe, policy led transformation.
2d	**Review of Risks**	**Committee emphasised the importance of:** Overall, the Committee was assured that risks are being actively identified and managed, whilst recognising that further work is required to strengthen assurance on the effectiveness and sustainability of mitigating actions in several key risk areas.

3	**Actions to be considered by the Board**	**Items for Escalation to the Board** • Committee agreed no formal escalations or amendments to the BAF were required at the meeting. • However, the following items should be highlighted for awareness, not escalation: • **Services Requiring Additional Support (SRAS)** more broadly**:** Continued system pressure with services moving in/out of SRAS and limited assurance regarding overall quality of care and patient experience despite good governance oversight.
4	**Report compiled by**	Bev Reilly, Interim Chair of the Committee, Deputy Chair of Trust/Beverley Murphy, Chief Nurse/Donna Keeping, Corporate Governance Manager

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report date to Board of Directors – 11 June 2026		
Date of last meeting: 04 June 2026	**Report from the Quality Assurance Committee (quoracy met)**	
	Chaired by Marie Burnham, Chair of the Trust	
1	**Agenda -** The Committee considered the following matters: • Minutes of meeting held on 7 May 2026 – deferred to next meeting (July 2026) • Patient Story – Chris's Voice • Board Assurance Framework • Corporate Risk Register • Summary of Executive Directors Group Quality and Performance meeting, 26 May 2026 • Quality Governance Triple A Report including: CQC Improvement Plan, Quality Dashboard (Appendix 1), Quality Risks QAI Programme (Appendix 2), Quality Assurance and Improvement Programme and NICE Guidance Implementation Update (Appendix 3) • Assurance that Right Care, Right Person is being managed in a way that does not expose people to unnecessary risk* • Research and Development • Safeguarding and Public Protection Annual Report • Learning from Deaths Quarterly Report • Positive and Safe Annual Report • Compliance with Duty of Candour * • Organisational Learning Group Quarterly Report • Quality Impact of Waiting Times Quarterly Report • Trust Wide Community Transformation Six Monthly Report • Infection, Prevention and Control Six Monthly Report • Patient Flow across Trust Wide Adult Mental Health Acute Care Services • Statement of Purpose* • Proposed Committee workplan 2026/27 (* Indicates where Committee was provided information in a reading pack.)	
2a	**Alert**	**The Committee wishes to alert the Board to the following matters:** ▪ The significant staffing issues across Secure Inpatient Services (SIS) due to a combination of vacancies, sickness, workforce processes and maternity leave. Actions being taken in response were noted with the impact of mitigations being felt. ▪ Third month where use of prone restraint is reported. The incidents related to the complex care of three people in Adult Learning Disability services (ALD) and SIS. A range of approaches have been put in place to address the issue including engaging with Mersey Care NHSFT to adopt an alternative method for seclusion exit. A training plan has been agreed in principle with final sign-off awaited from both Trusts. ▪ Limited assurance on the timeliness of completion of after action reviews (AARs) and mortality reviews. It was acknowledged that AARs being used in public, for example in Coroners hearings, is leading to reports being completed in a more comprehensive / detailed way which is contributing to the delays. EDG oversight of the action plan to address the delays was being maintained.

		▪ Significant self-injurious behaviour at Bankfields Court. Executive oversight was instituted approximately 8 weeks ago and the CQC has been notified. The position has also been escalated to HNY ICB via the Chief Nursing Officer. Legal advice was being taken to carefully plan next steps. ▪ Limited assurance that community transformation is currently consistent with more focus required in North Yorkshire and York to achieve this. The Care Group was responding to this by developing more cohesive systems of care at place, especially in relation to people who have mild to moderate needs, in advance of Neighbourhood Mental Health Resource Centres coming online.

2b	**Assurance**	**The Committee received the following positive assurances:**
		
		▪ Positive assurance that 91% of clinical teams have watched Chris's story (patient story), and, although difficult to measure its direct impact, there has been an increase in patient and carers' responses and in care and family involvement via the quality assurance schedule.
		▪ Substantial assurance of the oversight of compliance with Statutory Duty of Candour through monthly audits undertaken by the Patient Safety Team.
		▪ Good assurance in relation to:
		  ▪ The effectiveness of current risk management procedures and oversight of risks listed in the Corporate Risk Register.
		  ▪ The implementation of Right Care Right Place and related controls due to clear operational guidance and thresholds, detailed escalation and dispute resolution processes and comprehensive multi-agency governance arrangements.
		  ▪ The systems and processes for oversight, monitoring and progress with the Integrated Oversight Plan.
		  ▪ Improvement activity in line with the Positive and Safe Strategy and that restrictive practice remains subject to robust governance, monitoring and continuous improvement.
		  ▪ Research activities with assurance regarding the completion of key governance tasks.
		  ▪ The Trust's arrangements to safeguard children and adults across our organisation; however, it was noted that further work was required to embed learning.
		  ▪ Reporting and learning from deaths in line with national guidance.
		  ▪ Compliance with Statutory Duty of Candour requirements during Quarter 3 and Quarter 4 based on the findings from the audits completed during this period; an improved position on previous quarters.
		  ▪ Oversight of waiting times for an assessment.
		  ▪ The management and governance of the Infection Prevention and Control Service.
		  ▪ The controls, oversight and management of patient flow across Trust-wide AMH acute inpatient services.

	Advise	**The Committee wishes to advise the Board that:** ▪ The Trust continues to work with Chris's family (patient story), and York and York St John's Universities have also agreed to present the film to third year multi-professional students. Plans were also being put in place with Teesside University. ▪ A change to the Improvement Plan 14b Supervision to provide alignment with the action plan in response to an Internal Audit review was approved. ▪ The revised Statement of Purpose, as required under Care Quality Commission (Registration) Regulations 2009 was approved following annual review. ▪ Reasonable assurance, with actions being taken to increase controls' effectiveness, was provided in relation to:

		▪ The understanding of compliance requirements with statutory duty of candour within the Care Groups. A reviewed process was being tested, initially, in AMH planned care teams across both Care Groups, with positive outcomes in Q4 demonstrating improved compliance. ▪ The quality and access for patients waiting for an assessment within the Trust. An action plan to address lengthy waits, including the trajectory, was being monitored by the Executive Director's Group. ▪ The ongoing adverse impact on quality and experience arising from patients clinically ready for discharge and long lengths of stay in hospital for some people who require inpatient care. ▪ The Committee agreed proposals in respect of its future workplan. Recognising that there might be potential changes to the meetings' calendar; that all committee workplans needed to be aligned through the accountability framework; and the plan would need provide assurance on the controls included in the revised BAF for 2026/27, it was agreed to continue to use the existing workplan until July in preparation for the introduction of the updated version in September (August being a fallow month).
2d	**Review of Risks**	Overall, the Committee was assured that risks are being actively identified and managed, whilst recognising that further work is required to strengthen assurance on the effectiveness and sustainability of mitigating actions in several key risk areas. The Committee paid particular attention to the following risks: ▪ The sustainability of current improvement activity arising from the number of people deemed clinically ready for discharge within DTVF. ▪ The significant staffing issues in SIS. ▪ The changing nature of ligature risks (being non anchored) and the mitigations put in place to protect patents from exposure to harm.
3	**Actions to be considered by the Board**	**Items for Escalation to the Board** ▪ No matters were identified for escalation to the Board. ▪ No formal escalations or amendments to the BAF risks were noted at the meeting.
4	**Report compiled by**	Marie Burnham Chair of the Committee, Deputy Chair of Trust, Beverley Murphy, Chief Nurse, Phil Bellas, Company Secretary

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