



Hartlepool
Borough Council

Audit and Governance Committee Agenda

17 March 2026

Time: 5pm

Location: Council Chamber

Members: Audit and Governance Committee

Councillors Moss Boddy, Fiona Cook, Rob Darby, Gerard Hall, Phillip Holbrook, Michael Jorgeson, Corinne Male, Shane Moore (C), Scott Reeve and Aaron Roy.

Standards Co-opted Independent Members: -

Mr Martin Slimings and Mr David Whitmore

Standards Co-opted Parish Council Representatives:

Parish Councillor Kane Forrester (Wynyard) and Parish Councillor Patricia Andrews (Headland)

Local Police Representative

1. Apologies for absence

2. To receive any declarations by members

3. Minutes

3.1. To confirm the minutes of the meeting held on 24th February 2026.



4. Audit items

4.1. Internal Audit Plan 2025/26 Update – *Head of Audit and Governance*

4.2. Internal Audit Charter, Strategy and Plan 2026/27 – *Head of Audit and Governance*

5. Standards items

5.1. None.

6. Statutory Scrutiny items

Crime and Disorder issues

6.1. None.

Health scrutiny issues

6.2. Tees Esk and Wear Valleys NHS Foundation Trust – Quality Account and Quality Priorities Progress - *Associate Director of Quality Governance, Compliance and Quality Data*

6.3. Armed Forces Veterans: GP support and signposting – draft final report – *Scrutiny and Legal Support Officer*

6.4. Scrutiny investigations – progress report – *Scrutiny and Legal Support Officer*

7. Other items

7.1. Regulation of Investigatory Powers Act 2000 (RIPA) – Quarter 4 update - *Director of Legal, Governance and HR*

8. Minute from recent meetings for receipt by the committee

- 8.1 Health and Wellbeing Board – 8th December 2025.
- 8.2 Finance and Policy Committee relating to Public Health issues – None
- 8.3 Tees Valley Health Scrutiny Joint Committee – None
- 8.4 Safer Hartlepool Partnership – None
- 8.5 Tees Valley Area Integrated Care Partnership – None
- 8.6 Regional Health Scrutiny – None



8.7 Durham, Darlington and Teesside, Hambleton, Richmondshire and Whitby STP Joint Health Scrutiny Committee - None

9. Any other business which the chairman considers urgent

For information

Date of next meeting –

To be confirmed





Audit and Governance Committee

Minutes and Decision Record

24 February 2026

Meeting commenced

Time: 4pm

Location: Chamber, Civic Centre, Hartlepool

Present:

Councillor: Rob Darby (VC) (In the Chair)

Councillors: Moss Boddy, Gerard Hall, Michael Jorgeson, Corrine Male

Standards Co-opted Members:

Martin Slimings – Independent Member

David Whitmore - Independent Member

Local Police representative:

Also present: Councillor Christopher Wallace as substitute for Councillor Aaron Roy in accordance with Council Procedure Rule 4.2.

Councillor Amanda Napper

Naser Alkobir, Forvis Mazars

James Collins, Forvis Mazars

Andrea McLoughlin, Preventing Suicide (Tees) Public Health Practitioner

Officers: James Magog, Director of Finance, IT and Digital
Sandra Shears, Head of Finance – Corporate and Schools
Sylvia Pinkney, Assistant Director (Regulatory Services)
Claire Robinson, Public Health Principal
Joan Stevens, Democratic Services and Statutory Scrutiny Manager
Gemma Jones, Scrutiny and Legal Support Officer

63. Apologies for Absence

Councillors Fiona Cook, Phillip Holbrook, Shane Moore and Aaron Roy.

Parish Councillor Kane Forrester

64. Declarations of Interest

None.

65. Minutes

Minutes from 27th January 2026 – received.

66. Forvis Mazars report – Audit completion report 2024/25 – *Director of Finance, IT and Digital*

Representatives from the external auditors, Forvis Mazars, were in attendance to present to the Committee the content of the Audit Completion Report (ACR) in relation to the 2024/2025 statement of accounts.

Representatives advised that the audit work was substantially complete and that there were no matters which would require the audit opinion to be modified, subject to the resolution of matters that were outstanding on page 8 of the report. Notably the status of the Pension Fund Audit from the Teesside Pension Fund auditor. It was anticipated that the auditors would be issuing an unqualified opinion, without modification.

In terms of value for money, it was anticipated that there would be no significant weaknesses in the arrangements to report. This was in relation to the arrangements that the Council has in place to secure economy, efficiency and effectiveness in its use of resources.

Findings from the audit included conclusions regarding the significant risks identified. It was noted that these risks had been satisfactorily addressed and there were no significant issues to report.

Representatives also provided an overview of the internal control conclusion and adjustment areas, as detailed within the report. It was noted there were no significant adjustment areas that would cause concern. The annual auditors report would be finalised and published once the audit had concluded. Representatives thanked the Director of Finance, IT and Digital and the finance team for their co-operation in facilitating the audit work.

A Member thanked representatives for the clarity of their report.

Recommended

- i) That the Audit and Governance Committee note the ACR.

67. The 2024/2025 Financial Report (including the 2024/25 statement of accounts) - *Director of Finance, IT and Digital*

The Director of Finance, IT and Digital presented to the Committee an update on the 2024/25 Financial report. The Financial Report had been updated to reflect the adjustments that had been highlighted and had been agreed with external auditors. This was appended to the report.

Members were asked to approve the final report. It was also requested that should a material error be identified in the outstanding issues, that results in amendments to the financial report, these are actioned and delegated authority be given to the Director of Finance, IT and Digital in consultation with the Chairman of Audit and Governance Committee.

A Member noted that the Chairman was not in attendance to sign off the accounts, and it was confirmed the Chairman would be contacted regarding this matter.

Members thanked the finance team for providing the accounts.

Recommended

That Members :-

- i) Note the report;
- ii) Approve the Financial Report, as shown in **Appendix A**; and
- iii) Note and agree, should a material error be identified in the outstanding issues, that results in amendments to the Financial Report, these amendments are actioned and delegated authority be given to the Director of Finance, IT and Digital in consultation with the Chair of the Audit and Governance Committee to approve the updated Statement of Accounts 2024/25

68. Safer Hartlepool Partnership Action Plan 2025-2026 - *Assistant Director (Regulatory Services)*

The Assistant Director (Regulatory Services) provided an overview of the Safer Hartlepool Partnership (SHP) performance linked to the priorities outlined in the Community Safety Plan 2024/2027. Copies of the updated SHP Action Plan were provided during the meeting and the Assistant Director detailed work that had taken place to date in the following priority areas:-

- Antisocial behaviour
- Domestic Abuse
- Drug and alcohol misuse
- Serious violence
- Re-offending

- Prevent
- Acquisitive crime
- Protect

The plan noted the progress on actions made against each priority area. It was also highlighted that recommendations from the Audit and Governance Committee investigation into retail crime would be aligned to the SHP action plan and combined in this document.

In the discussion that followed it was confirmed that ongoing work was taking place to improve the picture quality of CCTV cameras in the town and to make the cameras more sustainable. Work had also taken place within the CCTV control room. A Member raised the issue of Artificial Intelligence in relation to CCTV use and it was confirmed that a license would be required for this. The quality of images was also discussed.

The Assistant Director confirmed that funding had been made available by the UK Shared Prosperity Fund to carry out the work to the CCTV cameras. This would help to ensure that all cameras were in operation. In relation to further questions on this matter the Assistant Director advised that information regarding individual cameras would not be provided for security reasons.

Recommended

- i) Members are asked to consider and comment on the SHP Action Plan 2024/2025

69. Preventing Suicide (Tees) – Presentation – *Preventing Suicide (Tees) Public Health Practitioner*

The Committee received an update on the progress made to date on the subject of preventing suicide in the Tees Valley. An overview was provided of how data is collected and monitored and how real time surveillance data is used. For some deaths the term suspected suicide is used until, following an inquest, a coroner would determine if this was a suicide. Therefore, it was highlighted that data is subject to change. A flow chart was provided of how data is received from Cleveland Police and shared with external partners and organisations.

Statistics were provided in relation to deaths by suicide in Hartlepool and Members noted that there had been a reduction in deaths by suspected suicide in 2025 compared to 2024. This was also the case for Teesside as a whole. Information was also given in relation to age and gender.

The presentation also focussed on the Tees Suicide Prevention Plan 2024-2029 and the key areas for action. These key areas were specific to the

Teesside area and tailored to the needs of each community. Key priority groups and specific factors linked to increased risk were also discussed with Members.

A comprehensive overview of the work taking place in Hartlepool was detailed in the presentation and included areas such as:-

- Supporting practice through local data collection, research and intelligence
- Provide tailored, targeted support to key priority groups
- Identifying and addressing common risk factors linked to suicide
- Promoting online safety and responsible media content

The priorities for year 2 of the plan were also discussed. These included areas of focus for underrepresented groups and targeted work with groups known to be at increased risk.

In the discussion that followed Members posed questions relating to the data presented and the specific factors linked to increased risk. It was noted that there was one branch of the Samaritans covering the Teesside area.

Returning to the data in Hartlepool, a Member queried why some groups were more at risk than others. The representative confirmed that suicide was a very complex issue with lots of factors involved, noting societal changes as also contributing factors. The role of social media was also discussed.

Reflecting on the information provided it was identified that data from across the Tees Valley was used to inform the work carried out and that data was anonymised to prevent identification of a person.

Members thanked the representative for their presentation.

Recommended

- i) That the Committee notes the content of the presentation and seeks clarification on any matters where necessary.

70. Veteran health investigation – GP survey results – *Scrutiny and Legal Support Officer*

The Scrutiny and Legal Support Officer provided Members with the results of the GP survey that was circulated in relation to the veteran health investigation. The survey was launched to gather the views and experiences of GP practices in supporting veterans and signposting to other services.

Members were advised that the survey had been sent to all 11 GP practices in the town, with 4 out of a possible 11 responses received. A correction was

made to the report in that 11 GP practices were contacted not 12 as noted in the report. It was highlighted that a GP practice can include multiple branch locations.

All GP practices that responded highlighted that they asked patients at the registration stage if they were a veteran. Two practices also indicated they displayed posters in waiting rooms to encourage existing patients to advise if they were a veteran.

The GP practices provided an overview of both health and non-health related challenges that veterans may face, with the survey also asking about potential barriers veterans may face in accessing support. Examples of good practice were also shared.

In relation to the veteran friendly GP accreditation scheme, one practice commented that they felt that it had helped their surgery to become more veteran aware. All practices welcomed further information on what support was available to veterans. A full summary would be included in the Committee's final report.

In the discussion that followed Members commented on the low responses to the survey. A recommendation was suggested that a letter be sent to the Armed Forces Minister. This letter would lobby the compulsory sign up of the veteran friendly GP accreditation scheme and to enhance the wrap around support and monitoring of this scheme.

A Member also highlighted that some GP practices had been very proactive in support of veterans and in their contribution to this investigation, Havelock Grange Practice was praised for their engagement.

The Democratic Services and Statutory Scrutiny Manager emphasised that the veteran friendly GP accreditation scheme was voluntary and GP practices were not obliged to sign up for the scheme. It was noted that GP practices do not have to apply for reaccreditation once this had been awarded.

The planned work of the North East North Cumbria Integrated Care Board Armed Forces Lead was also discussed, it was noted that there would be increased activity taking place in the area.

Recommended

- i) That the Committee receives the information provided as part of the evidence gathering stage of the investigation and notes the results of the GP survey.

71. Minutes from recent meetings for receipt by the Committee

Noted.

72. Any other business which the Chairman considers urgent

The meeting concluded at: 17.40pm

CHAIRMAN

DRAFT



Audit and Governance Committee

17 March 2026

Report of: Head of Audit and Governance

Subject: INTERNAL AUDIT PLAN 2025/26 UPDATE

1. COUNCIL PLAN PRIORITY

Hartlepool will be a place:
where people live healthier, safe and independent lives. (People)
that is connected, sustainable, clean and green. (Place)
that is welcoming with an inclusive and growing economy providing opportunities for all. (Potential)
with a Council that is ambitious, fit for purpose and reflects the diversity of its community. (Organisation)

2. PURPOSE OF REPORT

2.1 To inform Members of the progress made to date completing the internal audit plan for 2025/26

3. BACKGROUND

3.1 In order to ensure that the Audit and Governance Committee meets its remit, it is important that it is kept up to date with the ongoing progress of the Internal Audit section in completing its plan. Regular updates allow the Committee to form an opinion on the controls in operation within the Council. This in turn allows the Committee to fully review the Annual Governance Statement, which will be presented at this meeting of the Committee, and after review, will form part of the statement of accounts of the Council.

4. PROPOSALS

- 4.1 That members consider the issues within the report in relation to their role in respect of the Councils governance arrangements. In terms of reporting internally at HBC, Internal Audit produces a draft report which includes a list of risks currently faced by the client in the area audited. It is the responsibility of the client to complete an action plan that details the actions proposed to mitigate those risks identified. Once the action plan has been provided to Internal Audit, it is the responsibility of the client to provide Internal Audit with evidence that any action has been implemented by an agreed date. The level of outstanding risk in each area audited is then reported to the Audit and Governance Committee.
- 4.2 The benefits of this reporting arrangement are that ownership of both the internal audit report, and any resulting actions lie with the client. This reflects the fact that it is the responsibility of management to ensure adequate procedures are in place to manage risk within their areas of operation, making managers more risk aware in the performance of their duties. Greater assurance is gained that actions necessary to mitigate risk are implemented and less time is spent by both Internal Audit and management in ensuring audit reports are agreed. A greater breadth of assurance is given to management with the same Internal Audit resource and the approach to risk assessment mirrors the corporate approach to risk classification as recorded corporately. Internal Audit can also demonstrate the benefit of the work it carries out in terms of the reduction of the risk faced by the Council.
- 4.3 Table 1 of the report summarises the assurance placed on those audits completed with more detail regarding each audit and the risks identified and action plans agreed provided in **Appendix A**.

Table 1

Audit	Assurance Level
Trade Refuse and Special Collections	Satisfactory
Debtors	Satisfactory
VAT	Satisfactory
Firmstep IT Application	Satisfactory
NEC Document Management IT Application	Satisfactory
IT Strategic Risks	Satisfactory
Controcc IT Application	Satisfactory
Care First IT Application	Satisfactory
Integra IT Application	Satisfactory
Recycling and Landfill	Satisfactory
Artificial Intelligence IT Application	Satisfactory
Housing Benefits	Satisfactory
National Driver Offender Rehabilitation Scheme (NDORS)	Satisfactory
Officers Expenses	Satisfactory
Budgetary Control	Satisfactory
Main Accounting System	Satisfactory

Creditors	Satisfactory
Employee Protection/Violence Register	Limited
Deferred Payments Scheme	Satisfactory
HUUME IT Application	Satisfactory
System One IT Application	Satisfactory

4.4 For Members information, Table 2 below defines what the levels of assurance Internal Audit places on the audits they complete and what they mean in practice:

Table 2

Assurance Level	Meaning
Satisfactory Assurance	Controls are operating satisfactorily, and risk is adequately mitigated.
Limited Assurance	Several key controls are not operating as intended and need immediate action.
No Assurance	A complete breakdown in control has occurred needing immediate action.

4.5 As members will have noted Employee Protection/Violence Register (EPR) has been assessed as limited assurance. I have outlined the reasons for this assessment below.

- Policies and procedures have not been reviewed and communicated to staff in recent years.
- Terms of Reference for the Staff Working Group was not provided to the auditor.
- There is no forced separation of duties between officers who can approve/reject and delete incidents.
- Incidents added to the Employee Protection Register were not always approved/rejected in a timely manner, several cases being over 1 year old when approving/rejecting.
- There is no escalation process when incidents are not reviewed and either updated and a revised due date is added to the register.

4.6 In order to mitigate the risks identified, comprehensive actions have been agreed with the Assistant Director (Assistant Director for Regulatory Services). The agreed actions are detailed in **Appendix A** and cover the following areas:

- The 2022 EPR document will be reviewed by April 1st, 2026. With all EPR policies and procedures condensed into a single document. Staff Safety Policy will be reviewed with an intention to withdraw and fold into a procedural document and the zero-tolerance aspect folded into the Corporate H&S policy. This is to streamline the approval process and reduce crossover policies. Violence and aggression policy has been reviewed but not published. Scheduled to be published on the

intranet. Incident report procedure has been reviewed but not published. Scheduled to be published on the intranet.

- A task and finish group has been established and is working through the policy procedural reviews and will attempt to establish a EPR working group with nominated appointed persons. Terms Of Reference will be written as part of the EPR working group.
 - A New EPR interface with drop down categories with key phrases and risk categories to make staff aware of the potential issues.
 - A new EPR interface and review of sign of and approval and review periods written into the system with alerts to key Reps and officers.
 - The new EPR interface will have set review and automatic dates for review and retention.
 - New EPR interface will firm up the audit review process. Only EPR reps, Digital service admins or the H&S manager can delete entries. Submissions are sent to manager and EPR rep for approval with final AD approval.
- 4.7 At December's meeting of the committee, members requested that a representative from Housing, Growth and Communities attend committee to give an update on Museums Collection management. This audit was assessed as limited assurance for the following reasons:
- Lack of a fully documented inventory.
 - Safe and secure locations for collection on display or in storage.
- This exposes the service to the risk of potential loss of collections valuable both financially and to the community.
- 4.8 Actions agreed with the Director (Housing, Growth and Communities), to mitigate the risks identified were as follows:
- An updated Service Plan will be produced to bring together the current work programme and link into the Council Plan, agreed in April.
 - Staff will continue to work with Arts Council England National Security Accreditation advisor on exhibitions within the public facing venues at the Gallery and Museum developing tailor made assessments to individual exhibitions. Officers continue to engage with National Security advisors on the redevelopment of the Museum of Hartlepool to ensure the new building is fit for purpose. Officers will develop up to date risk assessments of security arrangements for Sir William Gray House and Hartlepool Art Gallery.
 - Officers will review and update the plans with support provided from HBC Building Maintenance and Building Consultancy Services to feed in support on specific roles and responsibilities for gallery and museum venues in an emergency event. Documents will be dated and reviewed annually once completed.
 - A review of the information regarding civic regalia held on the collection's spreadsheet will be completed and updates made as necessary. Input to Modes IT system will be prioritised when resource permits.

- The decant of the fine art collection into storage is planned for February 2026. The decant and cataloguing would take approximately 3 months.
- Staff will develop a long-term plan to address the inventory backlog for the whole of the collection.
- An independent security audit of Sir William Gray House would be required to understand the full scale of the issue and advise on required improvements to infrastructure and similar. Funding is not available for this currently therefore to address this action, support would need to be provided to proceed with this. Meeting with Insurances has taken place and it has been agreed to develop a plan to review the high value and other small items from collections to verify values for insurance purposes with a view to seeing if additional items need adding to the insurance cover. Response needed from Insurances to help prepare plan. Services may need to be procured to action the plan.

4.9 The ongoing progress of completing the agreed audit plan is detailed in Table 3 below:

Table 3

Number of Audits Started	77
Audits at planning stage	10
Audits at fieldwork stage	9
Audits at draft report	2
Audits finalised	56
Actions agreed	76
Actions past agreed date and not implemented	0

5. OTHER CONSIDERATIONS/IMPLICATIONS

RISK IMPLICATIONS	There is a risk that Members of the Audit and Governance Committee do not receive the information needed to enable a full and comprehensive review of governance arrangements at the Council, leading to the Committee being unable to fulfil its remit.
FINANCIAL CONSIDERATIONS	No relevant issues.
SUBSIDY CONTROL	No relevant issues.
LEGAL CONSIDERATIONS	No relevant issues.
CHILD AND FAMILY POVERTY CONSIDERATIONS	No relevant issues.
EQUALITY AND DIVERSITY CONSIDERATIONS	No relevant issues.
STAFF CONSIDERATIONS	No relevant issues.
ASSET MANAGEMENT CONSIDERATIONS	No relevant issues.

ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	No relevant issues.
CONSULTATION	No consultation required.

6. RECOMMENDATIONS

6.1 It is recommended that Members note the contents of the report.

7. REASON FOR RECOMMENDATIONS

7.1 To ensure that the Audit and Governance Committee meets its remit, it is important that it is kept up to date with the ongoing progress of the Internal Audit section in completing its plan.

8. BACKGROUND PAPERS

8.1 Internal Audit Reports.

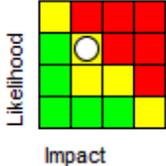
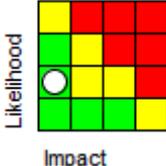
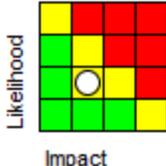
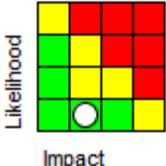
9. CONTACT OFFICER

9.1 Noel Adamson
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 TS24 8AY

Tel: 01429 523173

Email: noel.adamson@hartlepool.gov.uk

Appendix A

Audit	Objective			Assurance Level
Trade Refuse and Special Collections	Review controls in relation to Procedures & Performance; Charges; Agreements/Contracts; Income; Recovery; Performance; Data Security.			Satisfactory
Risk Identified		Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
Trade Waste Agreements are not signed by customers leading to potential non-compliance with agreement resulting in loss of income and reputational damage.			Team will write to all customers affected and amend this in the next financial year, requesting missing documents. However, as HBC does not tie customers in for extended periods like some of its competitors (and we are proud to use this as a unique selling point), there is minimal/no impact.	
Incorrect quotes are issued leading to the Authority not covering it costs for collection and disposal, resulting in loss of income.			Team to produce proforma for collection of data relating to quote-based service and use this form for all quote-based jobs.	

Audit	Objective			Assurance Level
Debtors	Assess and provide assurance on the controls in place to mitigate the risks in the following areas: Policies and procedures, Debtor Accounts, Invoicing, Scale of Charges, Credit Notes, Payments, Recovery of Debt, Write Offs, Data Security'			Satisfactory
Risk Identified	Risk Level prior to action implemented	Action Agreed		Risk Level after action implemented
No unmitigated risk identified.				

Audit	Objective			Assurance Level
VAT	Assess and provide assurance on the controls in place to mitigate risks in the following areas: Legislative requirements, Accounting for VAT, Record keeping, VAT returns, Errors and adjustments, Partial exemption.			Satisfactory
Risk Identified	Risk Level prior to action implemented	Action Agreed		Risk Level after action implemented
No unmitigated risk identified.				

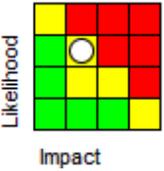
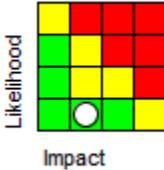
Audit	Objective			Assurance Level
Firmstep IT Application	Ensure IT application/administration controls in place.			Satisfactory
Risk Identified	Risk Level prior to action implemented	Action Agreed		Risk Level after action implemented
No unmitigated risk identified.				

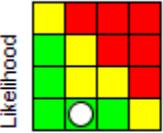
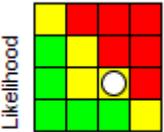
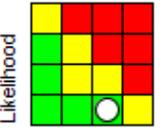
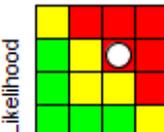
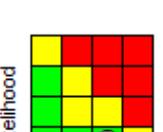
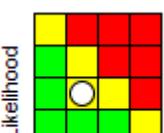
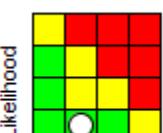
Audit	Objective			Assurance Level
NEC Document Management IT Application	Ensure IT application/administration controls in place.			Satisfactory
Risk Identified	Risk Level prior to action implemented	Action Agreed		Risk Level after action implemented
No unmitigated risk identified.				

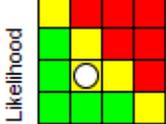
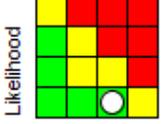
Audit	Objective			Assurance Level
IT Strategic Risks	Review IT related Strategic Risks and evaluate how assurance is obtained.			Satisfactory
Risk Identified	Risk Level prior to action implemented	Action Agreed		Risk Level after action implemented
No unmitigated risk identified				

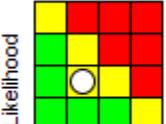
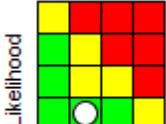
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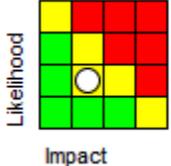
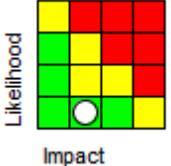
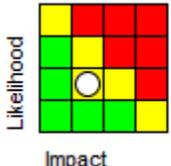
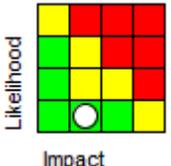
Audit	Objective			Assurance Level
Care First IT Application	Ensure IT application/administration controls in place.			Satisfactory
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented	
No unmitigated risk identified				

Audit	Objective			Assurance Level
Integra IT Application	Ensure IT application/administration controls in place.			Satisfactory
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented	
The Corporate Retention Policy is not complied with leading to data being retained which no longer should be, data could be available to users which is incorrect or which breaches compliance with GDPR/Data Protection legislation, all of which could result in reputational damage and fines/sanctions if there is a data breach.		Once the deletion process for DM has been proven, arrangements will be scheduled to cleanse the Integra related data held.		

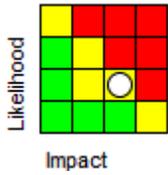
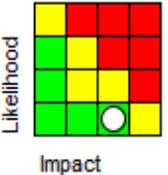
Audit	Objective	Assurance Level	
Recycling and Landfill	Assess and provide assurance on the controls in place to mitigate risks in the following areas: Legislation and Compliance; Contracts; Permits; Charges; Waste Returns; Waste Re-Use; Security.	Satisfactory	
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
The Authority does not receive updates for legislation and guidance leading to procedures and processes not being reflected resulting in financial penalties. The Authority does not receive updates for legislation and guidance leading to procedures and processes not being reflected resulting in financial penalties.		Plan has been reviewed several times by officers completing their WAMITAB waste qualifications, but this has not been formally logged. Formal review to be undertaken.	
Contracts are not in place for waste removal leading to waste not disposed with as per regulations, resulting in non-compliance with legislation and potential loss of income.		Implement contract for disposal of wood waste. We have been attempting to do this for some time, but current issues in wood disposal/recycling industry have impeded us. As things improve, we will recommence work to put contract in place.	
Contracts are not in place for waste removal leading to waste not disposed with as per regulations, resulting in non-compliance with legislation and potential loss of income.		Work currently underway to extend the contract beyond the current arrangement. This will be for 3 years initially, plus an additional three 12-month extensions.	
Payments are not taken for chargeable waste leading to non-compliance with HBC policy resulting in loss of income.		Review charges and make changes if necessary, following approval from members.	
The council does not have a re-use scheme for waste leading to blocking/preventing of recycling resulting in non-compliance with re-		Develop and implement policy for re-use.	

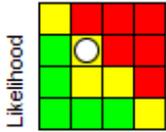
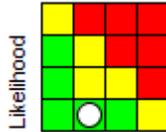
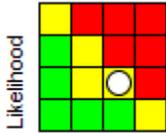
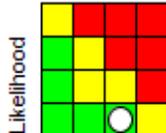
use legislation and additional costs of waste disposal.			
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Audit	Objective		Assurance Level
Artificial Intelligence IT Application	Ensure IT application/administration controls in place.		Satisfactory
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
There is either: no AI Strategy in place, the AI Strategy is unclear, not fit for purpose and/or regularly reviewed, the AI Strategy has not been fed into by departments identifying future usage and/or by HBC's IT Provider identifying potential issues or solutions, the AI Strategy is not linked to the organisation's goals and objectives, the AI Strategy is not supported by senior leadership or Members, roles and responsibilities have not been determined and/or effectively communicated to the relevant officers/Members, the AI Strategy is not monitored to ensure the correct action is taken at the most appropriate time, the AI Strategy is not reflected in the IT Contract, All of which may lead to AI technology being applied ineffectively and inconsistently across the organisation, poor value for money of the IT		Review current policy and split into separate Policy and Strategy documents from May/June review period.	

<p>solutions developed, under/overfunding for IT based on actual need/requirements/ technologies available, IT not being seen as a managerial issue, appearance that IT is not supported by management, staff unclear about the direction of IT for their service area when evaluating service changes resulting in conflicting activities or misalignment with organisational objectives/IT Contract.</p>			
<p>The AI Compliance Group has either: not been set up, or membership of the group has not yet been determined, or is not appropriate, responsibilities or Terms of Reference have not been set up, or they are not appropriate, meetings are not scheduled, or not scheduled regularly, meetings are not recorded, or not recorded in a way that does not demonstrate how the group meets its responsibilities or terms of Reference</p>		<p>First AI Compliance group to determine Terms of Reference and meeting schedule. Will also determine if any representation from other areas is required on the group.</p>	
<p>There is no definitive list of AI systems/applications in use in the organisation, leading to the ineffective, inconsistent and uncontrolled/ungoverned use of AI across the organisation, which could potentially result in the misuse of data and the possibility of fines or other sanctions and reputational damage.</p>		<p>Compliance group to consider the appropriate method for collecting and storing this information. To be discussed at first meeting.</p>	

Audit	Objective	Assurance Level	
Housing Benefits	Assess and provide assurance on the controls in place to mitigate the risks in the following areas: Performance Management, Payments, Data & Quality Control, Backdated Claims, Disputes & Appeals, Overpayments & Write Offs, Data Protection/GDPR, Compliance with legislation, Procedures, processes and training, Claim processing – New Claims, Changes in Circumstances.	Satisfactory	
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
No unmitigated risk identified			

Audit	Objective	Assurance Level	
National Driver Offender Rehabilitation Scheme (NDORS)	Ensure service provided in line with licence.	Satisfactory	
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
Breach of legal / contractual obligations leading to failure to provide an appropriate service or achieved desired performance resulting in termination of the contract.	 <p>Likelihood</p> <p>Impact</p>	All clients complete the course within the specified time limit, as those who don't are referred back to the police and are no longer clients. Survey Monkey response facility to be set up for clients.	 <p>Likelihood</p> <p>Impact</p>

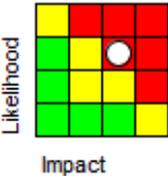
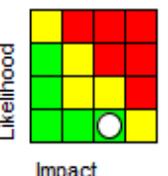
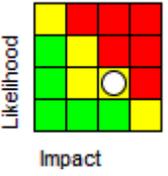
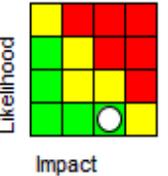
Audit	Objective	Assurance Level	
Officers Expenses	Assess and provide assurance on the controls in place to mitigate risks in the following areas: Policies & procedures, Employee Expenses, Car mileage, System data, Data processing, Insurance, GDPR/Data Protection.	Satisfactory	
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
Payment of claim-based pay may not be accurate, complete and authorised due to input processing errors leading to inaccurate payment of expenses resulting in financial loss.		Compliance report being developed by the Shared Services Manager which will be issued to Managers.	
Payment of car mileage may not be accurate, complete and authorised due to input processing errors leading to inaccurate payment of expenses resulting in financial loss.		Employees do not have business use or evidence a vehicle is fit to drive, leading to a claim against the council or individual resulting in financial loss to the council.	

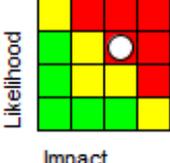
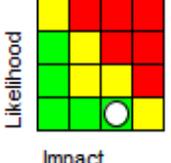
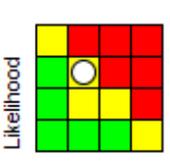
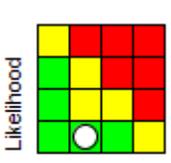
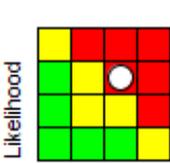
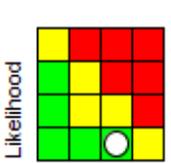
Audit	Objective	Assurance Level	
Budgetary Control	Provide assurance on the following: Roles and responsibilities in financial planning and budget monitoring are clearly defined, financial planning arrangements ensure that budgets are prepared within defined time frames to ensure timely approval of the annual budget and statutory timescales are met. An approved, medium term financial planning strategy is in place that has considered all relevant factors. The budget is promptly and accurately uploaded onto the financial ledger before the 31 March deadline. Budget transfers are authorised in accordance with Financial Procedure Rules. Accurate and timely information is provided to budget holders, Senior Management and Members to enable them to make key decisions about services. The level of reserves and planned usage is determined by the Authority's approved Reserves Strategy.	Satisfactory	
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
No unmitigated risk identified			

Audit	Objective			Assurance Level
Main Accounting System	Assess and provide assurance on the controls in place to mitigate risks in the following areas: Legislative/Regulatory requirements; Reporting; Financial Ledger; Feeder Systems; Coding Structure; Journals & Internal Transfers; Suspense & Holding Accounts.			Satisfactory
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented	
No unmitigated risk identified.				

Audit	Objective			Assurance Level
Creditors	Provide assurance that risk is being managed at an acceptable level in the following areas: Supplier accounts, Orders, Receipt of goods, Performance Management, Transparency Code requirements, GDPR.			Satisfactory
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented	
Integra purchase orders are not raised leading to payment for incorrect goods / quantities ordered / received and unplanned expenditure resulting in financial loss to the Council and / or unplanned budget spend.		Ongoing area of challenge with departments regarding compliance with recommended practice. New systems (In-stream) and new procedures (Oxygen) are to be introduced in quarters 1 and 2 of 2026. This will coincide with the issue of new procedures and compliance reporting. Non-compliant areas will be targeted via monthly provision of performance figures.		
Appropriate checks are not made to ensure new and amended supplier details are valid, correct and not duplicated, leading to incorrect / fraudulent payments being made which the organisation may be unable to recover resulting in financial loss to the Council.		Monitoring report to be produced to identify occasions where repeat transactions occur. Some of these will be valid (e.g. annual scholarship awards) however other areas will be referred to departments.		
Appropriate checks are not made and / or procedures in place are not followed leading to invalid or fraudulent payments made resulting in financial loss and inability to effectively monitor budgets and overall financial position.		Current payment performance is circa 96% within 30 days. The sampled invoices appear inconsistent with this measure, which may be due to the inclusion of disputed items or other invoices that fall outside of scope (e.g. NEC). Notwithstanding this the introduction of both In-stream and Oxygen will change the end-to-end process and		

		should lead to improved compliance with payment performance targets.	
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Audit	Objective			Assurance Level
Employee Protection/Violence Register	Assess and provide assurance on the controls in place to mitigate risks in the following areas: EPR policy, EP Working Group, Training, Incidents (entry and review), Performance Management.			Limited
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented	
Formal procedures are not in place or adequately documented and approved with officers not advised of their responsibilities leading to the EPR register not being updated or reviewed resulting in staff at risk.		<p>EPR policy on the EPR Intranet Portal was reviewed in 2022. Not sure where the 2007 document has been downloaded from. HR did have old documents, and they have now been removed. The 2022 document will be reviewed by April 1st, 2026. With all EPR policies and procedures condensed into a single document.</p> <p>Staff Safety Policy will be reviewed with an intention to withdraw and fold into a procedural document and the zero-tolerance aspect folded into the Corporate H&S policy. This is to streamline the approval process and reduce crossover policies.</p> <p>Violence and aggression policy has been reviewed but not published. Scheduled to be published on the intranet.</p> <p>Incident report procedure has been reviewed but not published. Scheduled to be published on the intranet.</p>		
There is no Employee Protection Working Group established with governance arrangements, leading to policies and procedures not being regularly reviewed resulting in departments/staff unaware of the register or updates to the register/procures.		<p>A task and finish group has been established and is working through the policy procedural reviews and will attempt to establish a EPR working group with nominated appointed persons. TOR will be written as part of the EPR working group.</p>		
Incidents are not entered at all or are entered incorrectly into the EPR leading to staff/managers unaware of potential threat to		<p>A New EPR interface with drop down categories with key phrases and risk categories to make staff aware of the potential issues.</p>		

<p>employees resulting in possible harm to employees.</p>		<p>A new EPR interface and review of sign of and approval and review periods written into the system with alerts to key Reps and officers.</p>	
<p>Incidents are not reviewed and remain on the EPR longer than needed/expected, leading to incorrect information on the register resulting in non-compliance with legislation.</p>		<p>The new EPR interface will have set review and automatic dates for review and retention.</p>	
<p>Staff access EPR information and use it with malicious intent leading to potential purposeful deletion or addition to the register resulting in potential staff at risk.</p>		<p>New EPR interface will firm up the audit review process. Only reps. Digital service admins or the H&S manager can delete entries. Submissions are sent to manager and rep for approval with final AD approval.</p>	

Audit	Objective		Assurance Level
<p>Deferred Payment Scheme</p>	<p>Assess and provide assurance on the controls in place to mitigate risks in the following areas: Legislation & Procedures, Terms & Conditions of a Deferred Payment Agreement, Agreement Criteria, Deferred Payment & Interest Calculations, Ending a Deferred Payment Agreement, Annual Return, GDPR/Data Protection.</p>		<p>Satisfactory</p>
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
<p>No unmitigated risk identified.</p>			

Audit	Objective			Assurance Level
HUUME IT Application	Ensure IT application/administration controls in place.			Satisfactory
Risk Identified		Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
No unmitigated risk identified.				

Audit	Objective			Assurance Level
System One IT Application	Ensure IT application/administration controls in place.			Satisfactory
Risk Identified		Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
No unmitigated risk identified.				



Audit and Governance Committee

17 March 2026

Report of: Head of Audit and Governance
Subject: INTERNAL AUDIT CHARTER, STRATEGY AND PLAN 2026/27

1. COUNCIL PLAN PRIORITY

Hartlepool will be a place:
where people live healthier, safe and independent lives. (People)
that is connected, sustainable, clean and green. (Place)
that is welcoming with an inclusive and growing economy providing opportunities for all. (Potential)
with a Council that is ambitious, fit for purpose and reflects the diversity of its community. (Organisation)

2. PURPOSE OF REPORT

2.1 To inform Members of the direction of internal audit activity. To seek approval of the Internal Audit Charter (**Appendix A**), and the Internal Audit Strategy and annual operational Internal Audit Plan 2026/2027 (**Appendix B**).

3. INTERNAL AUDIT CHARTER AND STRATEGY

3.1 In order to ensure compliance with Global Internal Audit Standards (GIAS) Internal Audit must regularly update its procedures and strategies. The Internal Audit Charter outlines the mission, purpose and authority Internal Audit must perform its duties in compliance with.

3.2 The mission of Internal Audit is to strengthen the Councils ability to meet its People, Place, Potential and Organisation vision. We will achieve this by creating, protecting, and sustaining value by providing the Audit and Governance Committee and management with independent, risk-based, and objective assurance, advice, insight, and foresight, enhance and protect organisational value by providing risk-based and objective assurance, advice and insight to our clients. The charter sets out how this is achieved by providing an independent, objective assurance and consulting activity.

3.3 The strategic objectives of Internal Audit are:

Objective 1	to sustain a high-quality internal audit service which is responsive, flexible and consistent with best professional practice within the constraints of the budget available
Objective 2	to maintain an experienced and knowledgeable Internal Audit Team, who are independent and objective, with professional courage
Objective 3	to keep digital, technological and AI opportunities under review and to utilise them as effectively and efficiently as possible
Objective 4	to focus on areas that matter to our stakeholders, adding value, providing valuable advice, insights and foresights

4. INTERNAL AUDIT ANNUAL PLAN

4.1 Under the Accounts and Audit Regulations 2015, the Council must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, in compliance with GIAS. At Hartlepool, the authority for ensuring this responsibility is met has been delegated to the Director of Finance IT and Digital.

4.2 To accord with GIAS and to assist in ensuring the objectives of Internal Audit are achieved, audit activity must be effectively planned to establish audit priorities and ensure the effective use of audit resources.

4.3 Given available audit resources, all aspects of the Council’s systems and arrangements cannot be audited in one year. In recognition of this an Annual Audit Plan has been prepared using a risk model based on the model accredited by the Chartered Institute of Public Finance and Accountancy, which factors include:

- System Factors
- Managerial and Control environment
- Value of transactions
- Volume of transactions

- Opinion critical
- May incur legal penalties

4.4 The Annual Audit Plan is produced in a way that ensures all relevant risk areas are covered. This allows the most relevant and comprehensive annual opinion on the Councils control environment to be given to the Audit and Governance Committee. Additionally, the audit plan has been tailored to add value to the Council following a process of discussion and consideration by all Assistant Directors and Executive Leadership Team (ELT), of their current operational issues.

5. INTERNAL AUDIT RESOURCES 2026/2027

5.1 Internal Audit currently has five FTE within the section. Staffing levels are comparable to other authorities of our size, but this will be kept under review to ensure there is enough capacity to complete audit coverage. When considering operational costs of providing the service and income generated, the net budget for the provision of Internal Audit is £229,976.

5.2 A total of 69 planned areas of audit coverage will form the basis of the mainstream Internal Audit work for 2026/27. The plan includes fundamental systems such as salaries, debtors, creditors, risk management etc., which are identified, for the purpose of the plan, as single audits. However, these will include system and probity audits in each or some of the departments, in support of the main system reviews.

5.3 In addition to the planned audit work, advice and support will be provided on an ad hoc basis throughout the financial year together with unplanned reactive work wherever necessary and appropriate.

5.4 For 2026/27, we are contracted to provide 100 days of audit work to the Cleveland Fire Authority.

6. DELIVERING THE AUDIT

6.1 Regular liaison is an essential feature of an effective and responsive audit function. In this context, Internal Audit will:

- Have frequent meetings with departments to discuss the short-term audit program, any current departmental issues which may benefit from an audit review and provide the opportunity to raise any concerns with the audit services provided.
- Following audit reviews agree action plans, identifying responsibilities and timescales for action.
- Monitor management implementing the agreed actions plans and reporting any non-implementations to Senior Management.
- Ensure action plans are focused on improving controls and delivering benefits to the Council.

- Provide feedback to the Director of Finance, IT and Digital and Members on progress on the audit plan and the outcomes of audit work.

7. INTEGRATION

7.1 Although Internal Audit and Mazars carry out their work with different objectives, it is good professional practice that both parties should work closely together, which is a principle that the Council has always been committed to. Meetings are held with Mazars to ensure overall audit resources are most effectively focussed.

7.2 Internal Audit will also seek to gain assurance from the work of the Internal Audit Section of the Councils I.T. provider NEC, where possible.

8. OTHER CONSIDERATIONS/IMPLICATIONS

RISK IMPLICATIONS	There is a risk that Members of the Audit and Governance Committee do not receive the information needed to enable a full and comprehensive review of governance arrangements at the Council, leading to the Committee being unable to fulfil its remit.
FINANCIAL CONSIDERATIONS	No relevant issues.
SUBSIDY CONTROL	No relevant issues.
LEGAL CONSIDERATIONS	No relevant issues.
CHILD AND FAMILY POVERTY CONSIDERATIONS	No relevant issues.
EQUALITY AND DIVERSITY CONSIDERATIONS	No relevant issues.
STAFF CONSIDERATIONS	No relevant issues.
ASSET MANAGEMENT CONSIDERATIONS	No relevant issues.
ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	No relevant issues.

CONSULTATION	No consultation required.
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9. RECOMMENDATIONS

9.1 It is recommended that Members:

- Review and approve Internal Audits Charter and Strategy.
- Review and approve the 2026/27 Internal Audit Plan and note the Internal Audit budget for 2026/27 of £229,976.

10. REASON FOR RECOMMENDATIONS

10.1 To ensure that the Audit and Governance Committee meet its remit, it is important that it satisfies itself that Internal Audit coverage is adequate and effective.

11. BACKGROUND PAPERS

- 11.1 - Accounts and Audit Regulations 2015
- Global Internal Audit Standards (GIAS).

12. CONTACT OFFICER

12.1 Noel Adamson
Head of Audit and Governance
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Appendix A

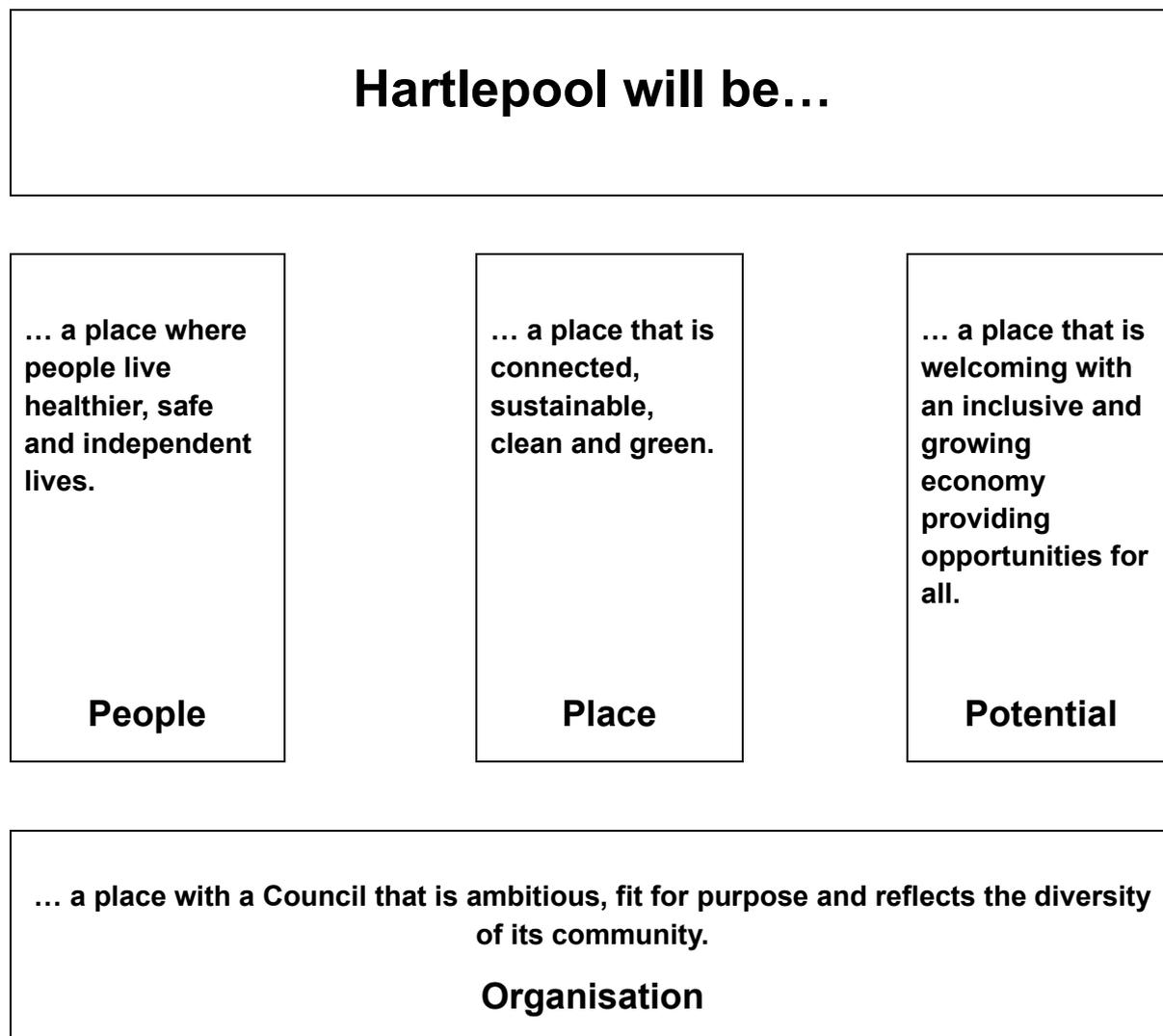


Hartlepool
Borough Council

Internal Audit Service

CHARTER

The Councils Vision for the future of Hartlepool in 2030



Our mission

Our mission is to strengthen the Councils ability to meet its People, Place, Potential and Organisation vision. We will achieve this by creating, protecting, and sustaining value by providing the Audit and Governance Committee and management with independent, risk-based, and objective assurance, advice, insight, and foresight. We will achieve the mission statement through our overall delivery arrangements. This charter sets out how this is done.

Internal Audit Mandate

Authority

The council is required by law, under the Accounts and Audit Regulations 2015, to have an internal audit of its governance, risk and control processes.

The Internal Audit Service will consider the following in undertaking its lawful duty:

- Global Internal Audit Standards (GIAS)

- The Chartered IIA Code of Practice
- CIPFA UK Public Sector Application Note (note to the GIAS)
- Chartered Institute of Public Finance (CIPFA) Code of Practice for the Governance of Internal Audit in UK Local Government
- Any additional mandatory guidance, for example Topical Requirements (part of the GIAS)

The documents referred to above are standards which:

- set the basic principles for carrying out internal audit in the public sector
- provide criteria against which quality and performance can be evaluated

GIAS, UK Public Sector Application Note, Topical Requirements can be found on the IIA website.

CIPFA Code of Practice for the Governance of Internal Audit in UK Local Government is available on the CIPFA website. The code sets out the proper practice for internal audit in local government.

For the purposes of compliance with GIAS, in this Charter the “Board” is defined as the Audit and Governance Committee. “Senior Management” is defined as the Executive Leadership Team (ELT).

We derive our authority from:

- the standards
- this charter
- the council’s constitution, specifically the financial procedure rules

The head of internal audit and governance (HIAG) is the chief audit executive. The HIAG and internal audit staff are authorised to:

- have unrestricted access to all the councils:
 - records
 - property
 - personnel
 - management
 - elected members
 - partnership services
 - services under contract with external organisations
- Receive information and explanations because of audit work.
- Obtain the assistance of council staff in relevant engagements. This includes other specialised services from within or outside the council.

We have no authority or management responsibility for any of our engagement subjects.

We (and our auditors) will not make any management decisions or engage in any activity which could reasonably be construed to compromise our independence. Auditors are free from operational system involvement or influence.

Role

Support the delivery of the authority's People, Place, Potential and Organisation vision by providing risk-based and objective assurance on the adequacy and effectiveness of governance, risk management and internal control processes.

Serving the public interest by championing and advising on good practice in Governance, risk management, and internal control processes.

We provide:

- An independent, objective assurance and consulting activity. It is designed to:
 - add value and improve the council's operations
 - help the council to meet its objectives
 - brings a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes
 - The audit and governance committee with information necessary for it to fulfil its own responsibilities and duties.
 - Support to management to fulfil its own risk, control and compliance responsibilities.

Responsibility

The head of internal audit and governance (HIAG) is responsible for all aspects of internal audit activity, including:

- strategy
- planning
- performance
- quality
- reporting

The HIAG will:

Strategy

- Develop and maintain an internal audit strategy.
- Review the internal audit strategy annually with management and the Audit and Governance Committee.

Planning

- Develop and maintain a risk based internal audit plan aligned with the council's corporate objectives.
- Engage with management and consider the councils:
 - strategic and operational objectives.
 - related risks in the development of the internal audit plan.
- Review the internal audit plan periodically with management. The review will reflect changes in the risk environment. These changes must be approved when significant.
- Present the internal audit plan, including updates, to the Audit and Governance Committee for periodic review and approval.
- In conjunction with ongoing work around workforce planning and resilience, ensure Internal Audit service is suitably staffed.
- Agree an internal audit budget sufficient to fulfil the requirements of:

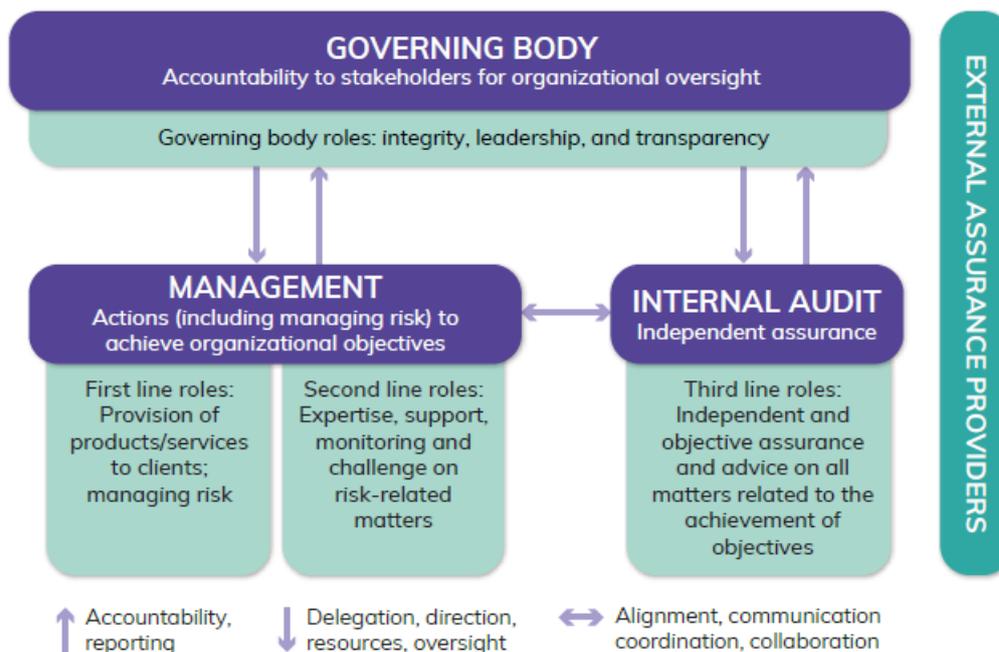
- this charter,
 - the internal audit strategy,
 - the internal audit plan.
- The internal audit budget is reported annually to the Finance and Corporate Affairs Committee and full council. This is for approval as part of the council's overall budget. The HIAG will draw any resourcing issues that potentially impact on the effectiveness of the internal audit function to the attention of:
 - the managing director
 - section 151 officer
 - the audit and governance committee
 - Coordinate with and (where relevant) provide oversight of other control, monitoring and assurance functions, including risk management and external audit.
 - Consider the scope of work of the external auditors (and other assurance providers) for the purpose of providing optimal audit coverage to the organisation.

The HIAG should be consulted about:

- Significant proposed changes to the internal control system
- Implementation of new systems

Advice can then be provided on the standards of controls to be applied. This need not prejudice the audit objectivity when reviewing systems later.

In developing the internal audit plan, we also take account of the council's assurance framework. We use the three lines of assurance model in compliance with CIPFA "Developing an effective assurance framework in a local authority guidance". These are detailed in the diagram below and are obtained through our combined assurance work.



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We achieve this through:

- Speaking to senior and operational managers who have the day-to-day responsibility for managing and controlling their service activities
- Working with corporate functions and using other third-party inspections to provide information on:
 - performance
 - successful delivery
 - organisational learning
- Using the outcome of internal audit work to provide independent insight and assurance opinions
- Considering other information and business intelligence that feed into and has potential to impact on assurance

Performance

- Implement and deliver the risk based internal audit plan
- Maintain professional resources with sufficient knowledge, skills and experience to meet the requirements of:
 - this charter
 - the internal audit strategy
 - the internal audit plan
- Allocate and manage resources to accomplish internal audit engagement objectives
- Establish and maintain appropriate internal auditing procedures incorporating best practice approaches and techniques
- Monitor delivery of the internal audit plan using appropriate performance indicators

- Hold regular senior management and statutory officer (golden triangle) liaison meetings

Quality

- Establish a quality assurance framework to:
 - provide a system for monitoring and evaluating our effectiveness and conformance with the standards
 - ensure continuous improvement within the internal audit service
 - ensure compliance with professional standards, code of ethics and council codes of conduct
 - meet client expectations and demonstrate our importance to the business
 - facilitate the HIAG statement on conformance with the international standards for the professional practice of internal auditing
- Undertake an annual assessment of the service and its compliance with the standards. Every five years the assessment is undertaken externally by a suitably qualified, independent assessor, next due 2029
- Obtain regular feedback on the quality and impact of our work (added value)

The GIAS consist of the basic requirements for the professional practice of internal auditing and for evaluating the effectiveness of performance. The five domains and fifteen standards set out what we must do to be considered effective.



To ensure compliance with GIAS, work is ongoing in the following areas to adapt and update Internal Audit procedures, as reflected in the section’s development plan:

- Formalise discussions with the Audit and Governance Committee in relation to the essential condition needed for internal audit to carry out its functions (Domain III)
- Develop assurance maps to communicate how internal audit coordinate and make use of assurance from other sources (Domain IV)

It is also incumbent upon internal audit to report where it doesn't comply with GIAS because of either statutory or professional standards of the sector in which it operates, and what it does instead.

The Audit and Governance Committee does not approve the budget and staffing levels of internal audit as per GIAS requirements. It does, however, note its budget and staffing levels as part of agreeing the annual audit plan, and if not satisfied this would fulfil its responsibilities, can make recourse to full Council.

Reporting

The following table illustrates to who and where Internal Audit reports and documents are reported to:

Report/Reporting to	Audit Project Client	Assistant Director	Directors/ELT	Audit & Governance Committee	External Audit
IA Charter			✓	✓	
IA Strategy			✓	✓	
IA Annual Plan			✓	✓	
IA Strategy and Annual Plan Update			✓	✓	
IA Strategy and Annual Plan Outturn			✓	✓	
IA Annual Opinion & Effectiveness of Internal Control			✓	✓	
Draft/Final Planning Document	✓	✓			
Draft/Final Report	✓	✓			✓
Follow Up Report	✓	✓	✓	✓	

Power BI dash boards provide a summary of all work completed over the last 2 years for ELT/Directors/AD's. This will move to 3 years at the beginning of 2026/27.

Follow Up Reporting

To ensure all actions are implemented within agreed timescales, the following process is in place:

- Business Contacts and the relevant Assistant Director reminded 5 working days before actions are due for implementation, and again 5 working days after the implementation due date:
- No response to either of these reminders, escalate to Director:
- No response from Director (or AD/BC) within 5 working days report to ELT and Audit and Governance Committee.
- Deadlines for the implementation of actions in relation to findings with a risk assessment of red rating will not be extended beyond the agreed due date without approval from ELT.

Scope

The scope of internal audit activities includes all council activities including services which are:

- provided in partnership
- under contract with external organisations
-

There are no restrictions.

Activities which have specific internal audit engagements are identified in the internal audit plan.

Assurance engagements involve the objective assessment of evidence. This provides an independent opinion or conclusions regarding the effect control of risk. The nature and scope of the assurance engagement are determined by internal audit.

Consulting engagements are advisory in nature. They are generally performed at the specific request of management.

The nature and scope of consulting engagements are subject to agreement with management. They should assist management in meeting the objectives of the organisation without undermining the key principles of independence and objectivity. Internal audit should not assume management responsibility.

The HIAG will assist with the:

- implementation of the council's counter fraud policy and strategy
- investigation of fraud and irregularities in line with policy, strategy, and the constitution
- implementation of whistleblowing arrangements including reporting and investigation

- implementation of money laundering arrangements including reporting and investigation

The HIAG must be notified of all suspected or detected fraud, corruption or impropriety.

Consultancy engagements should only be performed where resources and skills exist. They should focus on governance, risk and control – supporting the head of internal audit's annual opinion. They should not replace assurance engagements.

The HIAG cannot give total assurance that control weaknesses or irregularities do not exist. Managers are fully responsible for the quality of internal control within their area of accountability.

Managers should ensure that appropriate and adequate arrangements exist for:

- risk management
- control systems
- accounting records
- financial processes
- governance (the control environment)

Managers should not depend on internal audit activity to identify weaknesses or control failures.

Independence and Objectivity

To provide for internal audit's independence and objectivity, the HIAG reports directly to the:

- Audit and Governance Committee (the board)
- executive leadership team
- section 151 officer

We support the discharge of statutory responsibilities, and those responsibilities set out in the constitution for the:

- section 151 officer
- monitoring officer
- head of paid service

The HIAG:

- has free and full access to the chair of the Audit and Governance Committee
- is employed by Hartlepool Borough Council

The appointment, removal and performance of the HIAG will be in accordance with established procedures, with the involvement of the Chair of the Audit and Governance Committee.

We have an impartial, unbiased, objective attitude and will avoid conflicts of interest. If our independence or objectivity is impaired, details of the impairment should be disclosed to either:

- the section 151 officer
- the Chair of the Audit and Governance Committee
- or both dependent upon the nature of the impairment

We are not authorised to:

- perform any operational duties for the organisation
- initiate or approve accounting transactions external to the internal audit service
- direct the activities of any council employee not employed by the internal auditing service (unless they have been assigned to the service or to assist the internal auditor)

Constructive working relationships make it more likely that our work will be accepted and acted upon.

The internal auditor does not allow our objectivity or impartiality to be impaired.

The HIAG currently provides advice as Clerk to the Staff Lottery, undertakes complaint investigations as part of the Councils Corporate Complaints process and provides administrative cover for the Councils main bank accounts.

Governance

Audit and Governance Committee

The Audit and Governance Committee is a key component of the council's governance framework. They underpin good governance and financial standards by providing an independent and high-level focus on:

- the audit
- assurance
- reporting arrangements

The committee provides independent assurance to the council members of the adequacy of the:

- risk management framework
- internal control environment
- integrity of the financial reporting and annual governance processes

It oversees internal audit and external audit. This helps to ensure efficient and effective assurance arrangements are in place.

For the purposes of the GIAS the Audit and Governance Committee performs the role of the 'board'. The Audit and Governance Committee complies with CIPFA best practice standards through their terms of reference and work programme. An annual review of self-assessment of the effectiveness of the Audit and Governance Committee, as required by the CIPFA guidance on audit committees will be facilitated.

The Audit and Governance Committee will:

- approve the internal audit charter
- approve the risk-based internal audit plan and strategy
- receive reports from the head of internal audit and governance on internal audit activity's performance relative to its plan and other matters

Standards of internal audit practice

- We work in accordance with the International Professional Practices' Framework (IPPF) which comprises the Global Internal Audit Standards, Topical Requirements and Global Guidance.

We are further guided by interpretation provided by the:

- Chartered Institute of Public Finance (CIPFA) Code of Practice for the Governance of Internal Audit in UK Local Government
- The Chartered IIA Code of Practice
- CIPFA UK Public Sector Application Note (note to the GIAS)
- CIPFA publication on the "role of the head of internal audit"
- CIPFA "Developing an effective assurance framework in a local authority guidance"

Internal auditors are aware of their responsibilities for protecting information and demonstrate respect for the confidentiality, privacy, and ownership of information acquired when performing internal audit services or as the result of professional relationships.

Internal auditors understand and abide by the laws, regulations, policies, and procedures related to confidentiality, information privacy, and information security that apply to the organisation and internal audit function.

This is achieved through compliance with the HBC Policies and Procedures along with annual mandatory training on information governance in relation to:

- Custody, retention, and disposal of engagement records.
- Release of engagement records to internal and external parties.
- Handling of, access to, or copies of confidential information when it is no longer needed.

External work and charter validity

External work

The internal audit section provides internal audit services to public sector external clients.

The nature and extent of work for external clients is kept under review to ensure:

- it does not impinge on the audit work carried out for the council
- there is no conflict of interest or impairment of independence arising from this work

Approval and validity of this charter

This charter shall be reviewed and resubmitted annually. It will be also reviewed should there be any changes to:

- internal audit arrangements
- public sector internal audit standards

Approval will be sought from:

- senior management
- the Audit and Governance Committee as the board of the organisation and council.

Appendix B



Hartlepool
Borough Council

INTERNAL AUDIT SERVICE

STRATEGY

1 Purpose of Internal Audit

- 1.1 To support the delivery of the authority’s People, Place, Potential and Organisation vision by providing risk-based and objective assurance on the adequacy and effectiveness of governance, risk management and internal control processes.
- 1.2 Serving the public interest by championing and advising on good practice in Governance, risk management, and internal control processes.

2 Vision of Internal Audit

- 2.1 Use technology and training to empower the team to achieve their full potential in delivering an annual plan of added value, risk-based assurance assignments in compliance with Global Internal Audit Standards (GIAS), contributing to the governance and control environment that will enable the Council to meet its People, Place, Potential and Organisation vision.

3 Mission of Internal Audit

- 3.1 To strengthen the Councils ability to meet its People, Place, Potential and Organisation vision. We will achieve this by creating, protecting, and sustaining value by providing the Audit and Governance Committee and management with independent, risk-based, and objective assurance, advice, insight, and foresight.

4 Strategic Internal Audit Objectives

- 4.1 The Internal Audit environment is evolving rapidly, and the Internal Audit Team will need to be aware of these changes and have the skills to consider them in relation to the activities planned, and the skills to adapt those plans where necessary to continue to provide valued assurance in the most efficient and effective ways.

Our strategic objectives are:

Objective 1	to sustain a high-quality internal audit service which is responsive, flexible and consistent with best professional practice within the constraints of the budget available
Objective 2	to maintain an experienced and knowledgeable Internal Audit Team, who are independent and objective, with professional courage
Objective 3	to keep digital, technological and AI opportunities under review and to utilise them as effectively and efficiently as possible
Objective 4	to focus on areas that matter to our stakeholders, adding value, providing valuable advice, insights and foresights

4.2 We will do this by:

- delivering a range of assurance assignments each annual plan year, which focus on the Council's core governance processes, strategic priorities, corporate risks and key financial systems. We will perform these assignments in line with GIAS as set out in our suite of Internal Audit documents
- identifying areas for improvement in the Council's risk management, internal control, governance and service delivery arrangements to make a positive contribution to the overall management and operation of the authority. We will do this by examining and reporting on the adequacy and effectiveness of the control environment for each audit in the Annual Plan.
- continually improving the knowledge base and skills of the Internal Audit Team across relevant areas to support the Council's objectives. We will achieve this through our Training Plan
- reviewing and updating the Internal Audit suite of documents to ensure that all process and procedures comply as far as possible with the GIAS. We will do this through our Development Plan.
- engaging with our stakeholders to ensure that we are meeting their expectations. We will do this through our Development Plan.
- promoting the Internal Audit Team as a valuable resource who can be engaged in relevant emerging issues, projects and programmes at an early stage to provide advice and guidance to prevent control weaknesses from arising. We will do this through our Development Plan.

4.3 The table below identifies how Internal Audit policy documents fit together in complying with GIAS and where policy documents are reported to and approved.



- 4.4 The Head of Internal Audit and Governance is accountable for the delivery of this Internal Audit Strategy. Progress reports on the delivery of the Annual Plan, (attached as **Appendix A**), and the relevant parts of the Development and Training Plans (attached as **Appendix B**), for that year will be presented to both ELT and the Audit and Governance Committee.
- 4.5 A suite of performance indicators will be developed and reported to both ELT and the Audit and Governance Committee. These indicators will measure progress against the Annual Audit Plan, Training Plan and Development Plan.

Indicator/Target	Target Set
Annual Report to Members by 30 th July following year-end demonstrating accomplishment of the Strategy, showing: - - Completion of the Training Plan 2026/27 - Completion of the Development Plan 2026/27 - Completion of the Annual Self-Assessment of compliance with GIAS and report to ELT and Audit & Governance Committee	2026/27

26/27 Internal Audit Plan

Department	Director/Assistant Director	Auditable Area
Adult Services and Public Health	John Lovatt	Controcc
Adult Services and Public Health	John Lovatt	CareFirst
Adult Services and Public Health	John Lovatt	Better Care Fund
Adult Services and Public Health	John Lovatt	Commissioning
Adult Services and Public Health	John Lovatt	Emergency Duty Team - credit cards
Public Health	Chris Woodcock	Domestic Abuse
Public Health	Chris Woodcock	Drug and Alcohol Contract
Public Health	Chris Woodcock	GP provided Health Checks
Public Health	Chris Woodcock	Smoking Cessation
Public Health	Chris Woodcock	Commissioning
Children's & Joint Commissioning	Rebecca Stephenson	Commissioning
Children's & Joint Commissioning	Emma Rutherford	Education other than at School (EOTAS)
Children's & Joint Commissioning	Rebecca Stephenson	Commissioning of Children in Care Placements
Children's & Joint Commissioning	Fiona Stubbs	High Tunstall
Children's & Joint Commissioning	Amanda Whitehead	DSG (continuation of 2526 audit)
Children's & Joint Commissioning	Laura Gough	ICS Application
Children's & Joint Commissioning	Laura Gough	Statutory Requirements - Qualifications, Registration and Training - Social Workers
Children's & Joint Commissioning	Laura Gough	Children's Safeguarding Board - Governance Review
Children's & Joint Commissioning	Rebecca Stephenson	Performance Management
Children's & Joint Commissioning	Laura Gough	Desegregation of CHUB
Neighbourhood & Regulatory	Scott Parkes	Highways Grant
Neighbourhood & Regulatory	Scott Parkes	Highways Pothole Grant
Neighbourhood & Regulatory	Scott Parkes	Levelling Up Fund
Neighbourhood & Regulatory	Scott Parkes	Building Maintenance
Neighbourhood & Regulatory	Scott Parkes	Capital Programme- Highlight contract closure on build
Neighbourhood & Regulatory	Scott Parkes	Planning and Building Control
Neighbourhood & Regulatory	Sylvia Pinkney	Emergency Planning - Governance
Neighbourhood & Regulatory	Sylvia Pinkney	Business Continuity/Disaster Recovery
Neighbourhood & Regulatory	Sylvia Pinkney	Warm Homes Grant
Neighbourhood & Regulatory	Sylvia Pinkney	Health and Safety
Neighbourhood & Regulatory	Sylvia Pinkney	Employee Protection Register
Housing Growth and Communities	Housing and Communities	Connect to Work Grant
Housing Growth and Communities	Housing and Communities	Core Learning Skills Grant - Adult Education
Housing Growth and Communities	Housing and Communities	UK Shared Prosperity Fund
Housing Growth and Communities	Inclusive Growth	Museums

Housing Growth and Communities	Inclusive Growth	Highlight
Housing Growth and Communities	Housing and Communities	Statutory Renters Rights (Legislation)
Housing Growth and Communities	Housing and Communities	Crisis Resilience Fund
Housing Growth and Communities	Housing and Communities	Pride In Place Grant - Governance Review
Housing Growth and Communities	Housing and Communities	Housing Advice and Homelessness (c/f 2526 plan as deferral requested by client)
Finance IT and Digital Services	Laura Griffiths	Computer Audit
Finance IT and Digital Services	Paul Dixon	DFG Sign off
Finance IT and Digital Services	Paul Dixon	Iworld Application
Finance IT and Digital Services	Paul Dixon	NFI
Finance IT and Digital Services	Paul Dixon	Benefits - Housing
Finance IT and Digital Services	Paul Dixon	SPD Fraud
Finance IT and Digital Services	Paul Dixon	Budgetary Control
Finance IT and Digital Services	Paul Dixon	Cash/Bank
Finance IT and Digital Services	Paul Dixon	Council Tax
Finance IT and Digital Services	Paul Dixon	Creditors
Finance IT and Digital Services	Paul Dixon	Debtors
Finance IT and Digital Services	Paul Dixon	Insurances
Finance IT and Digital Services	Paul Dixon	Loans & Investments
Finance IT and Digital Services	Paul Dixon	Local Council Tax Support Scheme
Finance IT and Digital Services	Paul Dixon	Main Accounting System
Finance IT and Digital Services	Paul Dixon	NNDR
Finance IT and Digital Services	Paul Dixon	Officers Expenses
Finance IT and Digital Services	Paul Dixon	Procurement
Finance IT and Digital Services	Paul Dixon	Salaries and Wages
Finance IT and Digital Services	Paul Dixon	V.A.T.
Finance IT and Digital Services	Paul Dixon	Integra
Finance IT and Digital Services	Paul Dixon	ResourceLink/MyView
Finance IT and Digital Services	Paul Dixon	Fraud Awareness
Managing Director	Denise McGuckin	Risk Management
Managing Director	Denise McGuckin	Performance Management Framework
Legal Governance and HR	Neil Wilson	Members Allowances/Travel/Subsistence
Legal Governance and HR	Hayley Martin	Workforce Strategy 23-26 - governance review
Legal Governance and HR	Hayley Martin	Training (legislation changes)
Legal Governance and HR	Hayley Martin	Recruitment, Retention and Selection

Internal Audit Development Plan 26/27

TEAMMATE+ RELEASES	ACTION	STRATEGIC OBJECTIVE
Maintain an effective process for recording, managing and reporting internal audit work.	Move to Teammate cloud hosting. Review procedures accordingly.	1, 3
BRANDING OF IA DOCUMENTS	ACTION	STRATEGIC OBJECTIVE
New corporate branding to be used.	Add new corporate logo to all documents Add new corporate version of logo with Internal Audit service written on to all documents. Re-colour all documents in new corporate colours – green for corporate functions – need to check the shade.	1
TEAMMATE	ACTION	STRATEGIC OBJECTIVE
Develop procedure to deal with the admin of Stores including deletion archiving.	Include annual routine in IA calendar.	3
TEAMMATE	ACTION	STRATEGIC OBJECTIVE
Develop procedure to deal with the close down and archiving or deletion of projects.	Include annual routine in IA calendar.	3
TEAMMATE	ACTION	STRATEGIC OBJECTIVE
Update Audit Manual and Procedures to note requirements for data retention of sensitive or personal data in projects once they are complete and final report issued.	To review GIAS and check whether the EQA will need to see these pieces of data to confirm audit opinion or whether HoAG having done sample check of this plus existing PA review procedures is enough to prove any auditor could have come to same opinion based on evidence Will need to factor in time to action the deletion or redaction, if necessary, on remaining files once those that need deleting have been.	3
TRAINING	ACTION	STRATEGIC OBJECTIVE
Provide a robust training plan for Internal Audit staff.	Training to be delivered over Q1, 2, 3 & 4 on mandatory items as listed in the GIAS and new fraud act, Topical requirements, New TM hosting, corporate policies and new procurement act.	1, 2
TRAINING	ACTION	STRATEGIC OBJECTIVE
Develop training plan for clients, managers and AD's. Agree and facilitate Audit awareness training.	Deliver training in areas stakeholders have identified as needing information on such as the audit process, risk and control, etc. Once Hosting in place key personnel will need training in new procedures and screens.	2

ESSENTIAL CONDITIONS	ACTION	STRATEGIC OBJECTIVE
Formalise discussion of essential conditions with ELT, senior management and audit and governance committee.	Develop/Agree formalised reporting structure to ensure all relevant parties are aware of their responsibilities in the delivery of an effective internal audit.	1, 4
REPORTING	ACTION	STRATEGIC OBJECTIVE
Improve reporting to AD's and Directors.	Continue PowerBI dashboard roll out to all ADs, IGG, HoF, Directors, MD and Chair of A&G. Review whether Directors should receive copy of all final reports.	1, 4
QUESTIONNAIRES/FEEDBACK	ACTION	STRATEGIC OBJECTIVE
Assess if we are obtaining feedback from all relevant stakeholders, including feedback from auditors.	Develop as part of QAIP. Decide on program of themes for questionnaires at the end of audits and link to IA strategy. Decide if additional questionnaires to go to AD's and/or Directors, or ELT, or Audit Committee to ask specific questions. Audit Committee as part of annual self-assessment. ELT with report for new strategy and plan. Look at feedback questionnaire for audits – review questions. 1-2-1 feedback from auditors re audits that went well or that didn't.	1, 2, 4

Internal Audit Development Plan 2027/28

ASSURANCE MAP	ACTION	STRATEGIC OBJECTIVE
Develop assurance maps to communicate how internal audit coordinate and make use of assurance from other sources.	Liaise with departments to identify areas of assurance. Design internal audit approach to coordinate effort and maximise assurance.	1, 4
REPORTING	ACTION	STRATEGIC OBJECTIVE
Internal Audit staff produce own data reports from IT application systems for testing purposes.	Liaise with IT application system owners to provide internal audit staff with a method of producing system data reports via training or guidance.	1, 2
RISK ASSESSMENT	ACTION	STRATEGIC OBJECTIVE
Promote Risk Management and controls throughout the audit process.	Add departmental risks and controls and assignments to dimension entities so pulls into RA for assessment. Add in evidence to support RA scores such as analysis (whole team could have responsibilities for this), add in legislation or other regulation, guidance, policies, info	4

	to help – this should also then feed into the projects if selected for plan (more support for the scope and planning?). To make sure above is accurate may need to add in another scoring mechanism to account for inclusion in strategic risk register and other things. Once departmental risk registers set up, will be able to pull risks onto audits.	
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Internal Audit Development Plan 2028/29

CONSULTANCY PROCEDURE	ACTION	STRATEGIC OBJECTIVE
Develop procedure to identify process for undertaking potential consultancy exercises.	Develop procedure outlining our expectations and limitations.	1
INTRANET	ACTION	STRATEGIC OBJECTIVE
Review documents/information on intranet.	Update the pages with correct information. Consider whether we could present any of the information in a different way e.g. Teams video recording. Introduce the team, photos? Use teams mate users' channel in the future. Include charter and strategy on teammate channel.	1
DATA ANALYTICS STRATEGY	ACTION	STRATEGIC OBJECTIVE
Develop a data analytics strategy for the audit team. Continue review of Data Analytic tools and use of benchmarking as part of 25/26 Internal Audit Development Plan.	Develop a strategy showing where we want to get to and how we will get there, including improving the use of IT data analytics within the audit process. Include assessment of data available, work being undertaken within the authority already, training of staff, keeping up to date with IT developments within the authority, Complete audit training in this area and then review/develop strategy.	1, 3
COMMUNICATION STRATEGY	ACTION	STRATEGIC OBJECTIVE
Develop a communication strategy to ensure all parties receive timely and relevant information	Document internal audit function's plan for managing stakeholder relationships. Update web pages and other outlets through which the internal audit communicates with stakeholders.	1, 4



Audit and Governance Committee

17 March 2026

Report of: Scrutiny and Legal Support Officer

Subject: TEES ESK AND WEAR VALLEYS NHS FOUNDATION TRUST – QUALITY ACCOUNT AND QUALITY PRIORITIES PROGRESS

1. Council Plan Priority

Hartlepool will be a place:

where people live healthier, safe and independent lives. (People)

2. Purpose of Report

2.1. Representatives of Tees Esk and Wear Valleys (TEWV) will be in attendance to provide the Committee with information regarding their current position and performance against the Trust’s quality priorities. The Committee will also be informed of the emerging priorities for next year.

3. Background

3.1. Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum.

3.2. Healthcare providers must provide a detailed statement about the quality of their services with a requirement to send the Quality Account to the local Overview and Scrutiny Committee.

- 3.3. The presentation attached at **Appendix 1** will be provide the Committee with an opportunity to engage in the process for the production of their Quality Account.

4. Recommendations

- 4.1. The Committee should consider and comment on the update on performance and the priorities for quality improvement.
- 4.2. That a statement of assurance be prepared and submitted to the Trust, with final approval delegated to the Committee Chair and Vice-Chair.

5. Background Papers

- 5.1. No background papers were used in the preparation of this report.

6. Contact Officers

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Gemma Jones – Scrutiny and Legal Support Officer
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Tees, Esk and Wear Valleys
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust

Quality Account and Quality Priorities Progress

Hartlepool Audit and Governance Committee
17 March 2026



Tewv.cqc@nhs.net

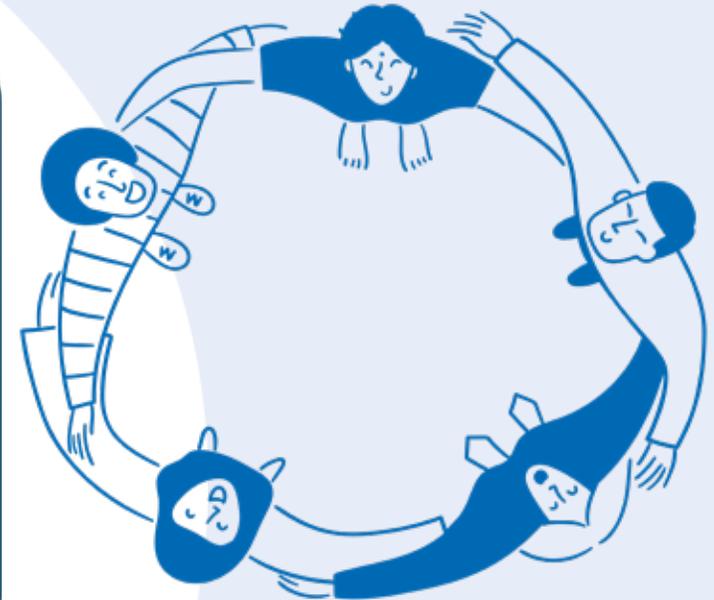
Leanne McCrindle, Associate Director of Quality Governance, Compliance and Quality Data
Chris Morton, Lived Experience Care Group Director DTV&F



TEWV Quality Account

All NHS Providers have a Statutory Duty to develop and publish an annual Quality Account by the 30 of June each year.

At the time of reporting, TEWV continues to collaborate with relevant senior leaders and subject matter experts to enable all contributions to be collated covering the period April 2025 to March 2026. The Quality Account will include completion of mandated statements regarding quality, an update of progress made with the Trust's Quality Priorities, and details of those priorities where milestones/ measures will continue to be embedded into the following financial year. This presentation includes progress on TEWV Quality Priorities, and the full Quality Account will be shared during the stakeholder consultation period. The timeline for stakeholder consultation, internal review/ approval and publication is detailed as follows:



**30/04/2026 -
31/05/2026**
Stakeholder
Consultation

04/06/2026
Quality Assurance
Committee

June 2026
Board of Directors

22/06/2026
Audit and Risk
Committee

By 30/06/2026
Publication

TEWV Quality Priorities Progress

Background:



In April 2024, the Trust's Quality Assurance Committee endorsed a new co-creation approach to developing Quality Priorities, with each priority co-led by people with lived experience. This ensures that the voice of service users, carers and families is at the heart of quality improvement.

The quality priorities will be sustained and carried forward over a three-year timeline to ensure sustained continuous improvement and a steadfast commitment to delivering of high-quality care. These are some of the most important priorities for people who use our services, and we are therefore committed to supporting a strategic approach that aims to embed these priorities over the next 3 years, within our operational framework.

Quality Priority 1
Patient Experience:
Promoting education
using lived experience



Quality Priority 2
Patient Safety:
Relapse Prevention



Quality Priority 3
Clinical Effectiveness:
Improving Personalisation
in Urgent Care



Why is this important?

This priority is focused on improving accessibility of services and early intervention. Through the identification and review of themes of patient feedback regarding access to services; the use of the Recovery College and patient stories, we will establish a cycle of learning, which will be shared with key Partners.



Quality Priority 1

Patient Experience: Promoting education using lived experience



Tees, Esk and Wear Valleys
NHS Foundation Trust

Measures already delivered to support this Quality Priority:

- ü A Training Lead was recruited to the Involvement and Engagement Team and commenced in post October 2024. Their role is focused on consolidating existing training packages that the Trust currently use about lived experience and coproduction. This review will incorporate training on personalised care planning. Another function of the Training Lead role will be supporting the training roll out across the Trust.
- ü The Trust Safeguarding and Public Protection Team have been working with groups of young people via Participation Groups and schools to look at what young people think about feeling safe. The voice of the young people will be collated and used in Safeguarding Training and other key work in relation to the impact of parental mental health on children to increase awareness and support early identification of needs for families.
- ü Training and development sessions have been co-created on the new 'Co-creation Framework' and are available to all teams.
- ü The induction and training programme for Involvement and Engagement members has been re-designed and rolled out. Work continues into the new year to co-create a development programme for Involvement and Engagement members.
- ü Partnerships with local acute Trusts have been strengthened and a range of training opportunities have been made available to enhance care for patients. Health and Justice also continue to deliver training to HMPs and Partner organisations.

Further areas in progress to support delivery of this Quality Priority:

Strategic Carer Involvement

- During Quarter 3 25/26, conversations across Patient Experience and Patient Safety.
- The Working Carers Network, Peer Support, Nursing, and Care Group leadership identified that significant carer-focused work is already taking place, but that it is fragmented and insufficiently connected at a strategic level.
- As a direct response, an introductory Trust-wide workshop on carer involvement was convened on the Thursday 27 November with Carers from the Trust involvement register, external carer organisations and Internal teams spanning patient experience, patient safety, involvement & engagement, peer support, nursing, and care groups
- The purpose of this session was to begin a collaborative conversation about how carers' voices can more meaningfully inform strategic decision-making, and how existing work can be better aligned and strengthened.
- This approach reflects a shared decision-making (SDM) perspective, recognising carers as partners in shaping improvement rather than consultees at the end of the process.

Clear Mapping of Existing Carer-Related Activity

- In preparation for this work, a comprehensive overview of **current carer involvement across the Trust** has been developed and shared, drawing together:
- Patient Experience activity (including carer awareness training, Triangle of Care accreditation, metrics and reporting)
- Patient Safety work (PSIRF, family involvement in After Action Reviews, bereavement support and language guidance)
- Involvement & Engagement structures (Co-Creation Boards, locality involvement groups, Trustwide forums)
- Care Group delivery (Triangle of Care self-assessments, carer champions, local initiatives across DTVF and NYYS)
- Workforce support through the **Working Carers Network**
- This mapping exercise has been critical in **making visible both the scale of existing effort and the inconsistency of strategic oversight**, which was a key concern raised in earlier assurance discussions.

Strengthening Assurance Through Strategic Dialogue

- Rather than treating carer awareness as solely a training issue, Quarter 3 has reframed this as a governance and assurance challenge:
 - Ø How carers are involved in decisions about care, safety, and service change
 - Ø How learning from carers is captured, shared and acted upon
 - Ø How assurance moves beyond accreditation or attendance metrics to consider quality and influence
- The November workshop is therefore positioned as the first step in a longer-term strategic approach, enabling clearer next steps around governance routes, leadership ownership, and alignment with Quality Priorities.

Co-Creation Group Quarter 3 25/26 assurance review:

Assurance for this priority remains **reasonable**, with improved confidence that the gap around carers has been explicitly recognised rather than minimised, action being taken is **system-wide and collaborative** and not isolated, and carers are being engaged as contributors to strategy, not only service-level feedback. However, assurance is **not yet full**, as this work is at an early stage and will require follow-through to demonstrate impact on experience and decision-making.

Why is this important?

This priority is focused on timely and proactive access to support, for patients who experience relapse, in order to minimise harm, particularly through the effective use of well-being plans.



Quality Priority 2

Patient Safety: Relapse Prevention



Tees, Esk and Wear Valleys
NHS Foundation Trust

Measures already delivered to support this Quality Priority:

- ü A review of Wellbeing Plans has been progressed, and further work continues on best practice examples for people using community services. Relapse prevention will be further supported through the implementation of the new Personalising Care Planning Policy, which will be live from February 2025. A communication and engagement campaign is currently in development and will last 6 months to embed the new policy. Practice guidance, best practice approaches and documentation to support clinicians and staff is also being developed to help embed the policy.
- ü Outline guidance for wellbeing plan content is also now available to all staff via the 'Ask Cito' robot.
- ü The Quality Assurance and Improvement Programme tools include regular review of patient's safety plan and its co-production with the patient (or significant person involved in their care where they are unable to). This is where wellbeing and relapse prevention needs are documented on the electronic patient record.

Further areas in progress to support delivery of this Quality Priority:

During Quarter 3, work under this priority has focused on **embedding the foundations for improved relapse prevention**, strengthening governance challenge, and preparing for more detailed assurance work in Quarter 4.

Key areas of progress include:

Coproduced training resources and animations on relapse prevention and safety planning have been launched, aligned to the Personalising Care Planning and Safety & Risk Management policies.

Ongoing use of the **Quality Assurance & Improvement Programme** continues to demonstrate improving compliance with safety planning requirements, while also surfacing variability in quality and consistency.

Co-Creation Board discussions have provided clear and constructive challenge, highlighting:

The risk of over-reliance on tick-box safety plans

Inconsistent post-discharge follow-up

The need to strengthen meaningful involvement of carers and support networks

These discussions have supported a deliberate shift in focus from *whether plans exist* to *whether plans are personalised, accessible and effective in preventing relapse*.

National Alignment and Governance Development

During Quarter 3, exploratory work has also begun to align local practice with the emerging **NHS England Personalised Care Framework (Modern CPA)**, which places personalised safety assessment, formulation and management at the centre of care delivery.

Key developments include:

- Ø Initial discussions with senior clinical leaders and business case development regarding the **transition of the Personalised Care Framework into business as usual**, with proposed future oversight through the **Executive Clinical Triumvirate**.
- Ø Agreement that further work is required to clarify governance, accountability and assurance arrangements, ensuring this does not recreate process-heavy CPA practices.
- Ø Planned Care Group Director and Executive Development sessions to inform formal consideration by in Quarter 4.

This provides a strong strategic foundation for addressing the quality and consistency issues already identified through local assurance and co-creation.

Co-Creation Group Quarter 3 25/26 assurance review:

Assurance for this priority remains **reasonable**, with clear caveats:

- Policy, training and strategic alignment are in place.
- Evidence of consistent, high-quality practice is still emerging.
- Post-discharge support, plan usability and carer involvement remain key areas for improvement.

Importantly, these gaps are now **explicitly recognised and informing next steps**, rather than being obscured by aggregate compliance measures.

Why is this important?

This priority is focused on improving the effective use of the 'my story once' approach. The priority will be linked with the community transformation work and also aims to improve patient experience when accessing urgent care services.



Quality Priority 3

Clinical Effectiveness: Improving Personalisation in Urgent Care



Tees, Esk and Wear Valleys
NHS Foundation Trust

Further areas in progress to support delivery of this Quality Priority:

Measures already delivered to support this Quality Priority:

- ü The 'My Story Once' principles have been incorporated into the Personalising Care Planning Policy and the approach is modelled in the training that has been developed.
- ü The Policy was circulated for Trust wide and external consultation and is due for approval and launch (supported by communication and training campaigns).
- ü The training package has been reviewed and updated.
- ü Planning of the training programme has commenced including a face-to-face training day. This is instead of the online training module on personalising Care Planning previously delivered. The new face-to-face training will reflect the interdependency of the policies mentioned previously and will include training on the new Safety and Risk Management Policy, Personalising Care Planning Policy and Working with People being in distress. Roll out of the training programme will continue into 2026 for all applicable staff.
- ü Personalised Care Planning webinars have been held to provide staff with valuable insights and all the tools, approaches and skills required to develop meaningful and personalised care plans for those we care for.

During Quarter 3, activity under this priority has focused on **targeted workforce development, system enablers for information sharing, and strengthening clinical leadership oversight.**

Key areas of progress include:

- Ø **Targeted training for urgent care teams** has been accelerated, with a specific focus on validating existing care plans and patient narratives rather than re-assessing by default.
- Ø **Digital prompts within the Electronic Patient Record (EPR)** have been introduced to remind staff to check for existing care plans, safety plans and patient narratives before initiating further assessment.
- Ø **Culture of Care sessions for medical staff and delivery to leadership** have been launched, focusing on compassionate, person-centred practice in urgent and inpatient settings. These sessions explicitly reinforce the principles of personalisation, shared understanding and appropriate information use. Early feedback indicates increased awareness among clinicians of the impact of repeated questioning and the importance of validating what patients have already shared.

Information Sharing and "One Person, One Assessment"

During Quarter 3, progress has been made in developing **Trust-wide Information Sharing Guidance**, co-produced with VCSE partners facilitated by Teesside Mind and people with lived experience, to support more personalised and effective urgent care.

The guidance responds to persistent challenges that undermine personalisation, including variable information sharing between organisations, unnecessary repeat assessments and referrals, and limited feedback to individuals about referral outcomes.

It promotes a **"One Person, One Assessment"** approach, grounded in shared principles of common language, proportionate and purposeful information sharing, trauma-informed conversations, and professional confidence in information gathered by partner services.

Work is now underway to seek **organisation-wide agreement and adoption through combined governance structures**, supporting consistent implementation across urgent, community and inpatient pathways.

Culture of Care and Urgent Care Interfaces

Culture of Care work in inpatient services continues to make an important contribution to this priority, particularly at the **interface between urgent, inpatient and discharge pathways.**

This work reinforces:

The importance of **relational continuity**, especially when people move rapidly between services.

Practices that reduce distress and harm caused by fragmented communication and repeated questioning.

The role of compassionate, trauma-informed care in improving both patient experience and clinical effectiveness at moments of crisis.

The integration of Culture of Care principles into medical and leadership development strengthens the conditions for more consistent personalisation in urgent care settings.

Co-Creation Group Quarter 3 25/26 assurance review:

Assurance for this priority remains **reasonable**, with clear evidence of action and early impact.

The combination of **Information Sharing Guidance** and **Culture of Care workstreams** provides a strong and coherent foundation for improvement. Further work is required to achieve consistent personalisation in urgent care, particularly in embedding information sharing practices and ensuring all staff reliably validate what has already been shared by patients.



Audit and Governance Committee

17 March 2026

Report of: Scrutiny and Legal Support Officer

Subject: ARMED FORCES VETERANS: GP SUPPORT AND SIGNPOSTING – DRAFT FINAL REPORT

1. Council Plan Priority

Hartlepool will be a place:
where people live healthier, safe and independent lives. (People)
with a Council that is ambitious, fit for purpose and reflects the diversity of its community. (Organisation)

2. Purpose of Report

- 2.1 To present the Committee’s report on ‘Armed Forces Veterans: GP Support and Signposting’ and to provide an opportunity for Members to –
- i) discuss and agree a set of recommendations to be included in the final report.
 - ii) express any views, or comments, they may wish to be relayed to the Adult Services and Public Health Committee for consideration, alongside the report’s conclusions and recommendations.

3. Background

3.1. The Audit and Governance Committee completed its investigation in 2025/26 and, based on the evidence provided, the report, attached at **Appendix A**, has now been produced.

4. Recommendations

4.1. That the Committee:

- i) Identifies recommendations to be included in the final report.
- ii) Considers approval of the report for submission to Adult Services and Public Health Committee; and
- ii) Identifies any additional views or comments it would like to be brought to the attention of the Adult Services and Public Health Committee, during consideration of the report's conclusions / recommendations.

5. Reasons for Recommendations

- 5.1. To allow the final report to be submitted to Adult Services and Public Health Committee.

6. Background Papers

- 6.1. [Agenda, reports and minutes from Audit and Governance Committee meetings for 2025/26.](#)

7. Contact Officers

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Hartlepool
Borough Council

Audit and Governance Committee

FINAL REPORT - DRAFT

ARMED FORCES VETERANS: GP SUPPORT AND
SIGNPOSTING

MARCH 2026

DRAFT

Executive summary

Introduction

Veteran health remains a key area of focus and priority and ensuring timely access to health services is essential in supporting those that have served in the armed forces. This issue was selected as a topic of investigation by Audit and Governance committee members for this municipal year. The Committee recognises that veterans often face unique health challenges because of serving in the armed forces and at times require specialist support and treatment for their health. GP services play a pivotal role in the diagnosis and treatment of health conditions for veterans. This report aims to explore veteran access to GP services and the signposting to health and wellbeing services.

In response to concerns raised regarding veteran experiences of accessing GP services in Hartlepool, a piece of work had been undertaken by Hartlepool Borough Council's Armed Forces Champion¹, and the local MP². Building on this initial piece of work, the Armed Forces Champion had been supportive of a further piece of scrutiny work by the Audit and Governance Committee under its statutory health scrutiny responsibilities. Conducting an investigation into this matter also supports the Council's commitment to the delivery of the principles of the covenant duty and in support of our covenant partners.

This report examines the experiences and views of veterans and explores their access to GP services within Hartlepool, all of whom have signed up to the Veteran Friendly GP accreditation scheme. It aims to highlight areas of improvement and best practice and proposes recommendations to strengthen support for veterans in GP practices. Through improved understanding and collaboration, health services can better meet the unique needs of those who have served.

¹ Hartlepool Borough Council's Armed Forces Champion – Councillor Chris Wallace

² Jonathan Brash, MP for Hartlepool

Conclusions

1. There is a clear commitment from GP practices in meeting the health and wellbeing needs of Hartlepool's veterans, as demonstrated by voluntary Veteran Friendly GP accreditation across all 11 GP practices. Veteran experiences do, however, appear to differ and there are clear examples of best practice that it would be beneficial to share across the wider GP network.
2. Whilst there is support and training as part of the accreditation process, ensuring adequate resources and institutional leadership buy-in is central to the ongoing success of delivering healthcare personalised to the needs of specific veteran groups. So too is the need for the coproduction of services with those who have lived experience.
3. Training and awareness raising of veteran-specific health problems, tailored support services and referral pathways, across all GP staff, is essential to the health of the patient and the effective implementation of Veteran Friendly GP accreditation scheme (VFAS). An increased awareness amongst staff of the VFAS and promotion of this scheme within individual practices would also be beneficial. This, alongside effective succession planning, would ensure that when designated clinical leads change, implementation of the requirements of the accreditation continues.
4. Ease of access to GP services remains a significant priority for veterans, however, this is also an issue for the wider population. The management of expectations is essential. The legal duty, and principles of the Armed Forces Covenant, require that veterans are not disadvantaged and receive the same access to services as the wider population. The exception to this being additional services that can be available in response to service-related conditions / injuries.
5. GP services need to be proactive in identifying / coding veteran status on a patients record and advertising that veterans can volunteer this information, especially if have they been registered as a patient at the practice for a long time.
6. Social prescribers play a key role in supporting veterans and their families with non-health related issues.
7. Levels of satisfaction with consultations differ depending on the nature of the consultation. Consultations about general health issues were generally perceived as good or very good, whilst interactions regarding service-related issues were less positive.

Conclusions (continued)

8. Listening to the lived experience of veterans, including the involvement of veteran representatives in Patient Participation Groups would be beneficial.

9. The potential location of a Valour Centre in Hartlepool would be instrumental to improving the health and wellbeing of veterans across Hartlepool, and the surrounding area.

Recommendations

To be discussed at Audit and Governance Committee on 17th March 2026.

DRAFT

1. Purpose of report

1.1. The purpose of this report is to summarise the work undertaken in reviewing how veterans are supported by Hartlepool GP practices and signposted to health and wellbeing services. This report provides an overview of the engagement and consultation process and evidence base relating to this topic. These findings have shaped the conclusions and recommendations noted at the beginning of this report.

2. Membership (for part or whole of investigation)

2.1. The membership of the Audit and Governance Committee was as detailed below:-

Councillors Boddy, Cook, Darby, Hall, Holbrook, Jorgeson, Male, Moore, Reeve and Roy.

3. Aim, terms of reference and methods of investigation

3.1. Key to the success of the investigation was clarity in terms of the Committee's aim for the outcome of this piece of work, a defined terms of reference and agreed methods of investigation. All of these were agreed by the Committee on the 4th November 2025 and are detailed below:-

Investigation aim – To explore how veterans are supported by GP practices and signposted to health and wellbeing services.

Terms of reference:-

i) To gain an overarching understanding of:

- the requirements of the Armed Forces Covenant in relation to access to services, including health related services.
- what veteran-specific health services are available and how veterans are signposted to these services.
- the views and experiences of veterans in the accessing of healthcare provision, and being signposted to support, via GPs.
- why it may be challenging for veterans to access healthcare services.
- the availability of local veteran health data, including levels of GP registration. How is it collected / managed / used in the development and delivery of health services? How does Hartlepool data compare to neighbouring local authorities.
- the impact of the extension of the Covenant Duty and what, if any, challenges there could be in terms of the provision of health services for Hartlepool's serving forces / veteran community (health partners and Local Authority health services).

- ii) To examine the Veteran Friendly GP accreditation scheme (VFAS) as a scheme to support veteran access to health care and its effectiveness for residents of Hartlepool. In particular:-
- what are the overall aims / requirements / benefits of the VFAS and how is its implementation monitored?
 - what is the level of accreditation in Hartlepool, how is it implemented by Hartlepool GP practices?
 - how effective is the operation of the scheme in Hartlepool from a veteran and GP perspective? How could it be improved?
 - how are GPs supported to fulfil the requirements of their accreditation and what challenges do they face in delivery of the scheme? What funding packages / support are available?
 - How are veterans supported to access health services by GP practices in Hartlepool.
- iii) Consider examples of best practice in the provision of healthcare for veterans and identify how veterans and GP practices can be supported to improve access to this.

Methods of investigation - Members of the Audit and Governance Committee met on multiple occasions to discuss and receive evidence relating to this investigation. The methods of investigation were chosen to ensure a balanced understanding of the evidence and are summarised below:-

a) Consultation via a survey

- Survey circulated and promoted to veteran groups and all GP practices in the town to gather views, experiences and feedback.

b) Expert Consultations

- Speaking with subject matter experts
- Sharing examples of best practice

c) Member evidence gathering sessions

- Obtaining Stakeholder and partner views to allow for exploration of the issue.

d) Document reviews

- Reports, veteran data and statistics, journal articles and policies and procedures were examined.

4. Setting the scene

4.1 As a starting point for its investigation, the Committee noted that a military veteran is anyone who has served in the regular or reserve UK Armed Forces for a minimum of one day. The veteran population is very diverse in terms of gender, age, ethnicity, length of service and socioeconomic group. It is estimated there are around 2 million veterans living in the UK³, of which 3844⁴ live in Hartlepool. Further data on the composition of Hartlepool's veteran population is outlined in section 5 of this report.

Armed Forces Covenant

4.2 The Armed Forces Covenant was enshrined in law in the UK through the Armed Forces Act 2011, as a formal voluntary statement of moral obligation that the armed forces community would be treated fairly and face no disadvantage when accessing public and commercial services. Special provision being made in appropriate cases for those who have sacrificed the most.



4.3 Examples of how armed forces personnel and their families may face disadvantage can include losing their place on hospital waiting lists due to moving often, having their care interrupted or needing to re-register/register with GP services⁵. It was, however, emphasised that under the covenant, and legal duty, the requirement not to disadvantage veterans does not mean that they should receive better service / treatment compared to other citizens, except where there is a service-related injury / condition.

4.4 Key principles of the Armed Forces Covenant:

- Those who serve in the armed forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services.
- Special consideration is appropriate in some cases, especially for those who have given the most such as the injured and the bereaved.

Covenant Duty

4.5 The first 'legal' duty came into force in 2022⁶ requiring that 'due regard' be given to the needs of the armed forces community. The duty applied to local authorities, governing bodies of state-funded schools, and various NHS bodies in some specific policy areas within housing, education, and healthcare.

³ [Gov.UK](https://www.gov.uk)

⁴ Office of National Statistics (ONS) Census 2021

⁵ [Care Quality Commission](https://www.carequalitycommission.org.uk)

⁶ The Armed Forces Act 2021

4.6 Due regard meaning that active consideration needs to be given to the Covenant when developing, delivering and reviewing policies and decisions that may impact the armed forces community. It means placing appropriate weight on the Covenant principles, when all relevant factors are considered, but does not mean that any particular conclusions have to be reached, or specific public service delivery outcomes achieved.

4.7 The Covenant Legal Duty is, however, to be further increased in scope and depth in 2026 to cover more policy areas, listed below: -

- Housing
- Education
- **Healthcare**
- Social care
- Childcare
- Employment and service in the armed forces
- Personal taxation
- Welfare benefits
- Criminal justice
- Immigration
- Citizenship
- Pensions
- Service-related compensation
- Transport

4.8 Whilst the extension into wider healthcare policy was particularly relevant to this investigation, the need for GPs to make every contact count and the signposting of veterans to support across all of the areas identified above is essential. This ensures the needs of veterans are to be effectively met. Veterans being a potentially vulnerable patient group, reports indicate that 52% have a long-term disability or illness, which is higher than the general population (32%). Veterans may also have complex needs that may go unrecognised or unmet⁷.

Veteran Friendly GP accreditation scheme

4.9 Building on the legal covenant duty, GPs can also choose to gain voluntary accreditation under the Veteran Friendly GP accreditation Scheme, launched in 2019, with the aim of improving medical care for veterans. Meaning that GP practices have a better understanding of military specific health issues and can provide tailored care⁸. The scheme, run by the Royal College of General Practitioners



⁷ [British Journal of General Practice](#)

⁸ [Royal College of GP Practitioners](#)

(RCGP) in collaboration with NHS England, is not a contractual obligation and GP practices voluntarily sign up for this scheme.

4.10 From a local perspective Members were advised that the North East and North Cumbria Integrated Care Board (NENC ICB) had in the past supported GP practices in Hartlepool, that were seeking the voluntary accreditation, with funding to allow staff to have protected learning time. This was, however, one off support with no ongoing provision (financial, training or otherwise) to support changes in lead officers or monitoring.

4.11 Members were pleased to find that all GP practices in Hartlepool have this accreditation (a full list can be found at **Appendix A**) and noted with interest how GP practices can become accredited and what this means in practice for them (as detailed in **Appendix B**).

4.12 An evaluation into the effectiveness of the accreditation programme was carried out in 2022⁹. The evaluation focused on the benefits of the scheme for both veterans and the GP practices, it concluded that:

- The programme has increased signposting to veteran-specific services.
- There was a greater understanding of the NHS priority referral criteria for veterans.
- Recording of veteran status had improved.
- Findings demonstrated how accreditation results in better treatment and identification of veterans.

4.13 It is noted that the Care Quality Commission (CQC)¹⁰ is responsible for ensuring that GP practices are meeting the needs of their patient population during inspections. This includes regulations to review person-centred care, dignity and respect, safe care and treatment and good governance. The CQC would also ask that providers understand the diverse health and care needs of people in their local community, so that care is joined up and supports choice and continuity.

5. Armed forces veteran data and intelligence

5.1 Data relating to the number of veterans living in Hartlepool and in England is available via the 2021 census and displayed in **Table 1**¹¹. There are 3844 veterans living in Hartlepool, representing 5.15% of the overall population, slightly higher than the rate across England and Wales (3.8%).

⁹ [British Journal of General Practice](#)

¹⁰ [Care Quality Commission](#)

¹¹ [Office of veteran affairs](#)

Area	Number of veterans
Darlington	5387
Hartlepool	3844
Middlesbrough	4624
Redcar and Cleveland	6992
Stockton	8237
Northeast	109,361
England	1,737,781

Table 1. Veterans living in England

5.2 Of the 3844 veterans living in Hartlepool:

- 3031 served in the UK regular armed forces
- 654 served in UK reserve armed forces
- 159 served in both regular and reserve UK armed forces
- More than 50% of veterans in Hartlepool are over the age of 60¹²

5.3 Whilst recruitment data is readily available, the availability of post discharge data on a local / regional perspective continues to be more challenging. The results of the 2021 Census have gone some way to providing the data required to support the development of support / focusing of resources to meet the needs of veterans from a local perspective. The recording of data, and identification of veterans by GPs needs to continue to improve going forward if their needs are to be effectively met.

6. Challenges and barriers to accessing healthcare

6.1 The Committee noted that military life was by its very nature, structured and supported in every aspect. Whilst many veterans do settle well into civilian life, for some it can be difficult to adapt. Despite the provision of transitional support by the MOD, for some veterans there can be a lack of knowledge or awareness of where to access services / support and this includes healthcare.

6.2 During service, health needs are predominantly met by the Armed Forces¹³ and veterans may struggle with the availability of services such as GP and dentistry appointments, when compared to the speed and ease of access when serving. There could also be a reluctance to seek help and support, with barriers including stigma and military cultural attitudes (stoicism)¹⁴. Mental health issues such as PTSD, depression or anxiety may also contribute to a veteran feeling unable to seek help.

¹² Office of National Statistics (ONS) Census 2021

¹³ [nhs.uk](https://www.nhs.uk)

¹⁴ [Combat Stress](#)

6.3 Veterans can be medically discharged from the Armed Forces, with the most common reasons being for health issues relating to back, knees, mental health or hearing¹⁵. Healthcare professional's military or veteran-specific knowledge is essential to understanding the specific and unique needs and experiences of veterans.

7. How can GP practices support veterans

7.1 The Committee recognised that whilst GP services are pivotal to veteran healthcare, support can also be provided from a range of government, NHS and charity services specifically designed to support their health and wellbeing.

Examples of how GP practices can support veterans are as follows:

- i) An effective first point of contact - Veterans should be asked to register with a GP as soon as possible as they are often the first point of contact for managing physical and mental health.
- ii) Identifying veterans – Veterans are advised to inform their GP that they have served in the armed forces, regardless of the length of service or how long ago they have left. The GP practice should also encourage the veteran to identify themselves to ensure clinicians are made aware of the veteran status. This ensures that veterans can be signposted to appropriate services. Including those that may be specifically available for service-related injuries / conditions.
- iii) Coding of veteran on patient records - Veteran status can be recorded on a patient record. The recording of this information is essential to ensure appropriate care and referrals can be made to dedicated health services¹⁶. This can be done at the point of registration or when it becomes apparent during consultation or from any other documentation to indicate this. Further information on this process is noted in section 9.1 of this report. Paperwork or medical records from the military medical Centre can also be transferred to the GP practice.
- iv) Signposting to specialised care - Veterans can be referred to specialised services, such as Op COURAGE, a mental health specialist service or Op RESTORE, which provides dedicated care for physical health issues related to military service.
- v) Priority Access - Veterans are entitled to priority access to NHS care for conditions related to military service, although this is always subject to clinical need and does not entitle the veteran to jump the queue ahead of someone with a higher clinical need¹⁷.
- vi) Consider military context – this can be during diagnosis and treatment.
- vii) Social Prescribers in supporting veterans - Veterans may present with issues that are not solely related to physical and mental health. These can be -

The logo for OpRESTORE, featuring the text 'OpRESTORE' in a bold, sans-serif font. The 'Op' is in red and 'RESTORE' is in blue. Below the text is a horizontal bar with a red section on the left and a blue section on the right.The NHS logo, consisting of the letters 'NHS' in a blue, sans-serif font. Below the letters is a horizontal bar with a red section on the left and a blue section on the right. Underneath the bar is the text 'The Veterans Mental Health and Wellbeing Service' in a smaller, black, sans-serif font.The logo for OpCOURAGE, featuring the text 'OpCOURAGE' in a bold, sans-serif font. The 'Op' is in red and 'COURAGE' is in blue. Below the text is a horizontal bar with a red section on the left and a blue section on the right.

¹⁵ [Care Quality Commission](#)

¹⁶ [Gov.uk](#)

¹⁷ [Armed Forces Covenant](#)

homelessness, isolation, debt and employment. Early outcomes data from a project funded by the NHS Armed Forces Health Team suggested that the role of social prescribers can play a key role in supporting veterans to be signposted to appropriate veteran friendly services, access training and employment services and help with housing¹⁸.

8. Consultation and engagement

8.1 As part of the investigation, evidence was sought from a variety of key sources including veterans, GP practices, stakeholders and partner organisations (as listed in **Table 2**). The information provided is essential in obtaining a firsthand understanding of experiences and issues.

Table 2. Key sources of evidence

Evidence source	Type of evidence	How it informed the investigation
Veterans living in Hartlepool	Survey	Provided the views and experiences of veterans.
GP practices in Hartlepool	Survey	Provided the views and experiences of GP practices.
Director of Delivery for North East and North Cumbria Integrated Care Board (NENC ICB)	Presentation at Member evidence gathering session.	Clarified the responsibilities of the NENC ICB in relation to veteran healthcare.
Head of Primary Care – Tees Valley (NENC ICB)	Data / research	Clarified how GP practices in Hartlepool were coding veterans on healthcare systems.
Armed Forces Lead (NENC ICB)	Presentation at Member evidence gathering session.	Provided information relating to ongoing work by the NENC ICB into veteran health in a neighbouring authority.
Hartlepool Borough Council (HBC) Public Health Team	Data / research	Provided data relating to the veteran population in Hartlepool.
HBC Armed Forces Champion and Armed Forces Veterans Champion	Presentation at Member evidence gathering session.	Sharing experiences and representing veterans during this investigation.
MP for Hartlepool	Letter of support	Sharing examples of casework relating to veteran access to healthcare.
Royal College of GPs Veterans Champion	Interview with Officers	Provided an overview of the VFAS and how this is monitored.
Havelock Grange Medical Practice	Presentation at Member evidence	Informed the Committee as to how veterans are supported and how the

¹⁸ [Armed Forces SP End of Year Report Final](#)

	gathering session.	VFAS is implemented within their practice.
Armed Forces Covenant Team	Interview with Officers	Provided an overview of the Armed Forces Covenant Duty and the responsibilities of signatories.
Office of Veteran Affairs	Interview with Officers	Provided an overview of the operation of the VFAS.

8.2 A variety of mechanisms were used to compile this information, including surveys, interviews and presentations, and a summary of the evidence considered is summarised below.

Armed forces veteran survey

8.3 The Committee agreed that a survey be conducted to seek the views of veterans in relation to their experiences of accessing GP services and being signposted to further support, including veteran-specific support. Participants were also asked to share their views on how veteran aware they felt their practice was.

8.4 This survey builds on the work that was previously undertaken by the Armed Forces Champion into this matter and was launched on the 1st November 2025 and closed on the 31st December 2025. The survey was circulated and promoted to organisations in the town that support veterans and via the Hartlepool Armed Forces Liaison Group.

8.5 A summary of results from the veterans' survey can be found in **Appendix C** of this report. However, Members were asked to note the low number of survey responses. Despite an increase in responses since the relaunch of the survey, 41 were received in total, of which 38 participants identified as veterans. Therefore, the statistical significance of the data needed to be taken into consideration.

8.6 Results from the survey indicated that:-

- i) 37 of the veterans who responded to the survey had not been asked by their GP if they were a veteran (either at registration or during the course of appointments). Participants also had little awareness of the Veteran Friendly GP accreditation Scheme or what this accreditation meant for them as a veteran or for the practice. This highlighted the need for improved communication / awareness raising of the scheme, and what can be expected in terms of access to treatment from additional services for service-related conditions.
- ii) Over half of participants surveyed had visited the GP practice for a service-related health condition, 1 had been offered support from a service-related organisation.

- iii) When asked for general comments and feedback, most comments related to difficulties in accessing appointments. It should be noted this is an issue experienced by the wider population in Hartlepool, as noted in the 'Big Conversation' findings report¹⁹. Comments were also made about the lack of veteran awareness in GP practices, something that is the cornerstone of the accreditation scheme.
- iv) Interactions with GPs were on the whole positive, however, there were differing levels of satisfaction in relation to consultations about general health and service-related issues. Consultations in relation to general health issues were generally perceived as good or very good, whilst interactions regarding service-related issues were less positive.
- v) The increased promotion of the Veteran Friendly GP accreditation scheme and the increased awareness of veteran-specific issues may be of benefit to veteran patients.

GP practice survey

8.7 In order to obtain a balanced view of the situation, a GP practice survey was circulated to all GP practices in Hartlepool (detailed in **Appendix A**), via email, to gather feedback / experiences in supporting veterans. The survey asked a series of questions relating to:

- The identification of veterans
- Health and non-health related challenges that veterans may face
- Barriers and challenges for veterans accessing healthcare
- Examples of good practice
- Promotion of veteran-specific services
- Additional training/further information

8.8 This survey was launched on the 24th November 2025 and closed 31st January 2026. The closing date had been extended to allow more time for the practices to respond. Practices were contacted on 3 separate occasions and invited to respond to the survey, a representative from NENC ICB also circulated the survey and encouraged GP practices to take part. Despite these efforts, 4 responses out of a possible 11 were received, however, it was recognised that the timing of the survey may have been an influencing factor (i.e. being launched during winter where GP practices face more pressure and demand on services).

8.9 Details of the findings of the survey are outlined in **Appendix D**. Although a small sample size, it was noted that all GP practices that responded were proactive in asking if patients were veterans at the registration stage. It was recognised that

¹⁹ [Your Say Hartlepool](#)

veterans at times presented with non-health related issues and emphasised the roll of social prescribers in the support they can offer with non-health related conditions.

8.10 In addition to the GP survey, the Committee welcomed input from the Havelock Grange GP practice regarding how they implement the VFAS scheme. The practice representatives informed Members that at the point of sign up, new patients are asked if they are a veteran. Once coded as a veteran on the system, the clinical lead for armed forces contacts the veteran and discusses their medical records. If needed records are transferred from the military. Services that are veteran/armed forces specific are promoted in the practice alongside raising awareness of the needs of veterans. Signposting to other services was also taking place. Existing patients are also encouraged to identify themselves as a veteran if not done so already. It was reported that veteran-specific campaigns were taking place in the practice and that the number of patients identified as veterans was growing.

9. Evidence from the NENC ICB

9.1 Further evidence was provided for the Committee's attention by the NENC ICB Head of Primary Care – Tees Valley. It was confirmed that GP practices in Hartlepool code patients as veterans at the point of registration or when it becomes apparent during consultation or from any other documentation to indicate this. Once coded as a military veteran, a patient status alert shows on their demographics box to indicate veteran status. This is visible at any point when the record is opened. Practices do not operate a pop up for this since they believe the patient status alert would be enough to indicate to the clinician or administrator that they are a veteran.

9.2 Members heard from the NENC ICB Armed Forces Lead regarding some of the work that was taking place in a neighbouring authority and were pleased to learn that this would be replicated in the Hartlepool area, beginning in January 2026. A summary of the work carried out by the Armed Forces Lead can be found at **Appendix E**. Work was outlined in the following areas:

- Supporting all GP practices in Sunderland to be a signatory of the Armed Forces Covenant.
- Co-wrote the Good Practice Guide for GP practices.
- Formed a Sunderland Armed Forces Partnership Board.

10. Evidence from the Royal College of General Practitioners (RCGP)

10.1 The Committee welcomed input from the Veterans Champion for the RCGP. During the course of discussions, it was highlighted that 73% of all GP practices in the country have signed up to the voluntary Veteran Friendly GP accreditation

scheme and Hartlepool was commended for having 100% coverage across all of the practices.

10.2 The RCGP Veteran Champion emphasised the importance of:

- Making sure that all members of staff are aware that their practice is accredited and what this entails. This being especially important for frontline staff, including receptionists.
- Effective coding of a patient's veteran status.
- In-house staff training in terms of the requirements of the scheme, the challenges that veterans can face and the signposting opportunities that are available.
- Succession planning, and training, to ensure that when the designated clinical lead changes, implementation of the requirements of the accreditation continues.
- The role of social prescribers in supporting veterans.
- Listening to the lived experience of veterans, including the involvement of veteran representatives in Patient Participation Groups.

11. Evidence from Hartlepool Armed Forces Champion and the MP for Hartlepool

11.1 As previously indicated, the initial work had resulted from issues raised with the Armed Forces Champion and the towns MP. The outcome of the survey originally undertaken fed into the Committee's investigation.

11.2 The MP for Hartlepool provided a written submission (attached at **Appendix F**), and this was considered by the Committee at its meeting on the 27th January 2026. The letter outlined the MP's full support of the investigation. The letter set out evidence drawn directly from casework and regular conversations with veterans about their experiences of engaging with GP services, both positive and negative.

11.3 The Armed Forces Champion, Councillor Wallace, actively contributed to the investigation, reiterating the concerns raised by veterans. A written submission is attached at **Appendix G**. Particular attention was drawn to the UK Government's VALOUR programme, a national initiative designed to improve how veterans access care, advice and coordinated support. The programme is led by the Office for Veterans' Affairs (OVA) within the Ministry of Defence.

11.4 A bid for funding for the programme was in the process of being submitted, success in which would see the delivery of a Valour Centre in Hartlepool. This would deliver a range of services and signposting mechanisms to support those already in place, including the Veteran Friendly GP accreditation scheme.

12. Acknowledgements

The Committee would like to place on record our appreciation and thanks, in particular of the willingness and co-operation we have received from all those involved in the investigation.

13. Background Papers:

The following background papers were consulted or referred to in the preparation of this report:-

- [Audit and Governance Committee – Reports and minutes \(23 Sep 25, 4 Nov 2025, 9 Dec 25, 27 Jan 26, 24 Feb 26\).](#)

14. Contact Officers:

Joan Stevens, Democratic Services and Statutory Scrutiny Manager
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Tel:- 01429 284142
Email:- joan.stevens@hartlepool.gov.uk

Gemma Jones, Scrutiny and Legal Support Officer
Legal Services, Hartlepool Borough Council
Tel:- 01429 284171
Email:- gemma.jones@hartlepool.gov.uk

Audit and Governance Committee (2025/26)

GP practices* in Hartlepool registered with the Veteran Friendly GP accreditation scheme

- Bankhouse Surgery
- Chadwick Practice
- Drs Koh and Trory
- Gladstone House Surgery
- Hart Medical Practice
- Havelock Grange Practice
- Headland Medical Practice
- McKenzie Group Practice
- McKenzie House Surgery (Wynyard Road)
- Seaton Surgery
- West View Millenium Surgery, West View Road

*To note some practices have more than one branch location

Veteran Friendly GP accreditation scheme

How to become accredited

GP practices are required to complete the sign-up form to become a Veteran Friendly accredited practice. This takes 20 minutes and the information pack can be consumed in less than two hours, with supplementary learning shared in a short newsletter on a quarterly basis. The form can be completed by anyone in the practice team, whether their role is clinical or non-clinical, with practice managers often taking the lead.

Role of the clinical lead

The role of the clinical lead is to:

- be the point of contact for practice staff on veteran matters
- be the point of contact for the RCGP project team to disseminate new information to the practice team, such as the contents of the quarterly newsletter
- educate and inform your practice team about the programme and how they can contribute to providing personalised care to veterans in your care
- safeguard the sustainability of accreditation by handing over the clinical lead role to a colleague should the lead leave the practice and provide the RCGP with the successor's contact details.

Expectations of the practice

Endeavour to know which patients registered at the practice are veterans and apply the 'military veteran' SNOMED* code to their notes

- commit to keeping staff up to date with NHS veteran-specific referral pathways and resources and understanding the health needs of veterans. The RCGP will help with this.

While a clinical lead must be named in the form, the learning and support can be shared across the wider practice team - with social prescribing link workers ideally placed to play a key role in running this initiative. Clinical leads don't need to be veterans either - in fact most aren't - showing you don't need military experience to make a life-changing difference for this vulnerable patient group.

Once signed up and the short accreditation pack is read the lead should:

1. Share the key information from the accreditation pack with colleagues
2. Ask patients registering with the surgery if they have ever served in the British Armed Forces and record their answer in their patient record. They recommend writing the term 'Military Veteran' (due to a number of different codes available)
3. Stay up-to-date with best practice via the Veteran Friendly accreditation newsletter, which provides easy access to the latest information and learning

The result will be better care for patients and their families and a multitude of benefits to the practice.

Once a practice has become accredited, there is no need to renew accreditation. They ask that the clinical lead maintains their knowledge via newsletters and any new training released.

In the event the veteran clinical leaves the practice, the accreditation is still valid if their responsibilities have been handed over to a new clinical lead and that person has completed the accreditation training. A new veteran clinical lead should contact the RCGP with the new name and direct email address, to receive an accreditation welcome pack with details of their training.

*A SNOMED code is a comprehensive and internationally validated system to record clinical information in the patient record.

DRAFT

Veteran Survey Results

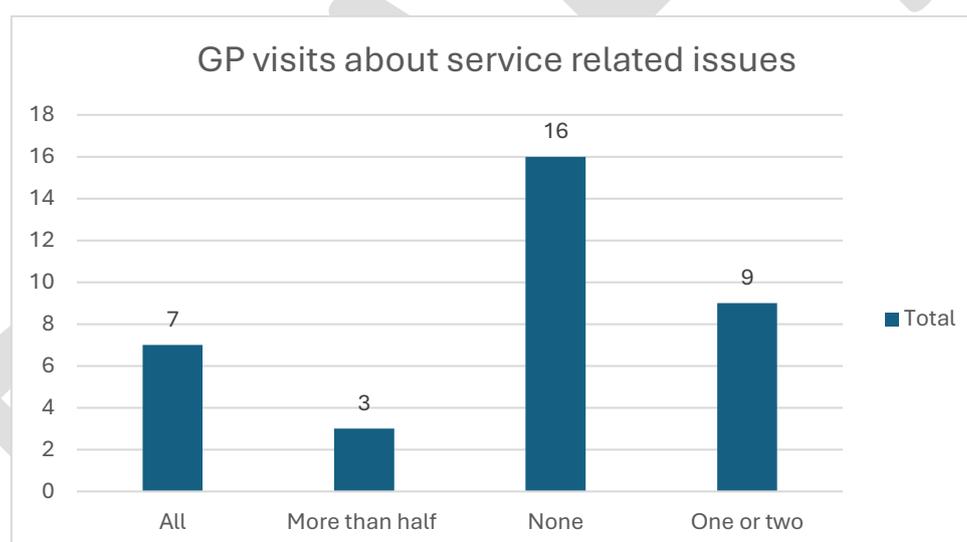
1. Demographic

A series of questions were asked to determine the demographics of all participants. It was noted that 38 participants identified as veterans and all were registered with a GP practice in Hartlepool. To note questions were not mandatory and not every participant answered all questions.

2. Service-related health conditions and support

Participants were asked 'in the last 12 months how many visits to your GP were about service-related issues?'. **Chart 1** shows that, of those that responded, 19 participants had visited their GP in the last 12 months for a service-related health condition and 16 had not.

Chart 1. GP visits about service-related issues



The survey proceeded to ask 'Have you ever been offered any veteran or armed forces specific help or support by your GP?' 34 participants said they had not, 1 answered yes, 3 indicated they were not sure (**table 1**).

Table 1. Veteran or armed forces specific help or support

Have you ever been offered any veteran or armed forces specific help or support by your GP?	No. of responses
No	34
Yes	1
Not sure	3
Total	38

3. Veteran awareness

Participants were asked 'Have you ever been asked by your GP practice if you are a veteran or a member of the Armed Forces?' 37 participants answered that they have never been asked this question, 1 answered they had been asked when joining the practice. 2 participants commented that they had offered this information but did not feel that this had an impact.

Referring to the Veteran Friendly GP accreditation scheme, results (**table 2**) showed that 11 participants knew that their GP practice had this accreditation, 21 were not sure and 6 did not know what this meant.

Table 2. Veteran Friendly GP accredited practice

<i>Do you know if your GP Practice is veteran friendly accredited?</i>	<i>No. of responses</i>
Yes, it is accredited	11
Not sure	21
I don't know what this means	6
Total	38

When asked if they thought that this accreditation had helped them, of those that responded, 4 indicated that they felt that it had, 16 did not feel it helped and 17 were not sure.

4. Feedback on health consultations

Participants were asked to rate their experiences of visiting their GP practice for consultations on general health and service-related issues in the last 12 months (results detailed in **chart 2** and **chart 3**).

Chart 2. **Consultations about general health**

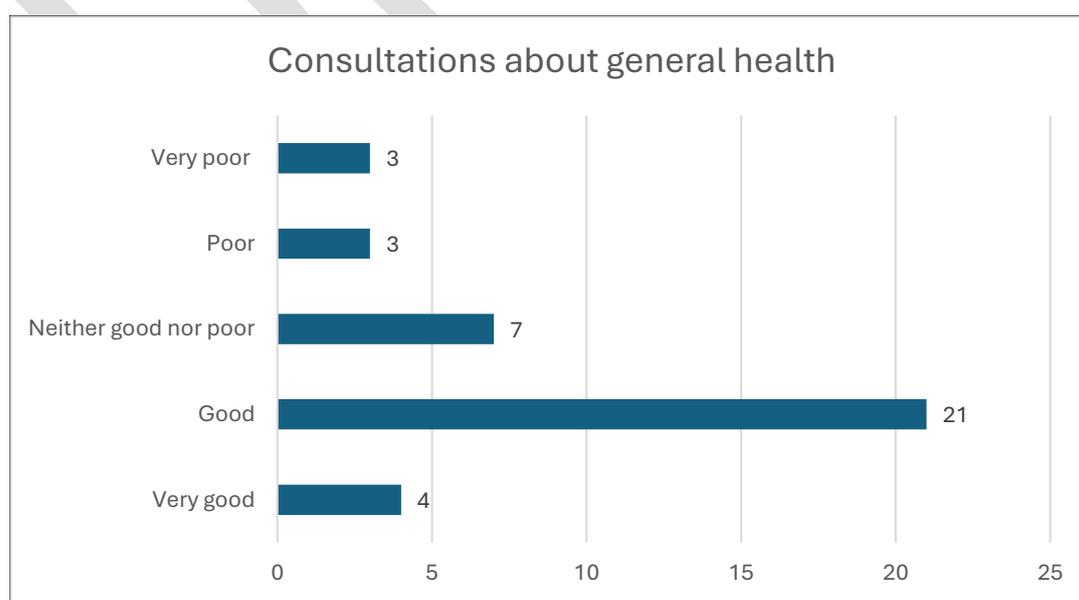
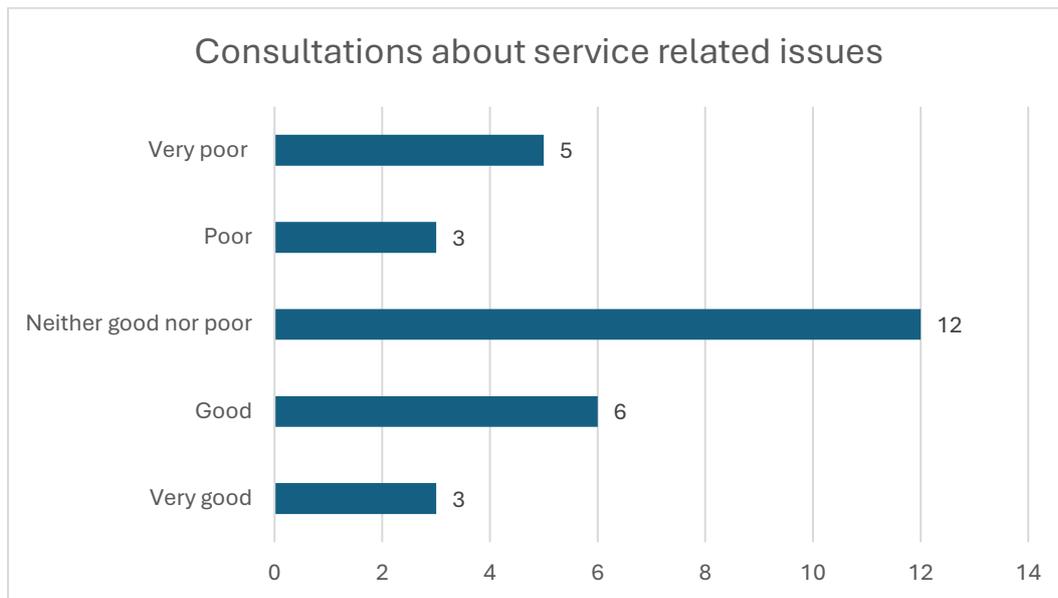


Chart 3. Consultations about service-related issues



5. General feedback on GP practices

The survey then explored if participants had any further comments on their GP practice, with 16 responding to this question. 8 indicated they wanted better access to GP services including an easier way to book appointments and shorter waiting times to see a health clinician. A selection of comments are listed below -

"I would just like to see a doctor when required."

"It needs to be easier to see a medical professional face to face."

"Appointment system - can't get a same day appointment and have to book 2/3 weeks in advance."

"Getting through on the phone is a nightmare, however doing the online consultation has been good."

"Difficult to get GP appointment, more likely to go to a walk in for most things."

"I have used the app and it is nothing short of confusing when I tried to select a location for appointments!"

6 people commented they wanted their GP practice to be more veteran aware.

"I have registered as a veteran at my practice but they didn't seem to know what it was."

"During a recent visit to a nurse she did not know what the veteran friendly GP practice was. She had never heard of it."

“I asked if it was recorded on my medical records that I was an ex-serviceman. The nurse said she didn’t know or where to find it on my records.”

“Registering was straight forward but staff seem unaware of the system.”

6. Making it easier to access support

A question was posed asking what would make accessing services for your physical and mental health easier, with 24 responses to this question: -

- 3 participants indicated they wanted their practice to be more caring
- 5 wanted the practice to be more veteran aware
- 12 commented they wanted improved access to GP services

Some of the comments are noted below -

“A specific member of staff within GP surgeries who has received training in supporting veterans. This person could provide appropriate advice, offer tailored support, and signpost veterans to relevant services or organisations that specialise in physical and mental health care for ex-forces personnel within the community.”

“Online appointment bookings.”

“More Doctor led appointments.”

“GP appointment wait times prohibitive currently, improvement essential.”

GP Survey results

A summary of the results from the GP survey is listed below

- i) Identifying veterans – when asked how veterans are identified within their practice, all four practices responded that they asked at registration. Two practices also indicated they asked during GP appointments, two advised they encouraged patients to volunteer this information via posters displayed in the practice. To note, there is no requirement for a veteran to provide this information.
- ii) Veteran specific health challenges – Some examples of veteran specific health conditions included mental health related issues such as Post Traumatic Stress Disorder and anxiety. Other issues related to joint/musculoskeletal conditions.
- iii) Non-health related challenges – the survey responses indicated that veterans can at times present at GP practices for non–health related issues such as housing, employment, social isolation, relationship issues and debt.
- iv) Barriers and challenges veterans may face in accessing support – the survey asked what the GP practices felt were potential barriers for veterans in accessing support. The answers echoed what was presented in section 6 of this report, that there may be a reluctance to seek support due to a sense of pride or stigma, feeling that services would not help or a lack of awareness of what support was available.
- v) Best practice/good examples – one practice reported that they had an excellent social prescribing team who would support veterans and their families with non-health related issues. Another advised that they made a room available at their practice to allow veterans to access specialist counselling.
- vi) Promoting veteran-specific services – ways in which they are promoted included sharing information amongst staff, leaflets, material in waiting rooms, social media, displaying posters and social prescribing teams.
- vii) Veteran Friendly GP accreditation scheme – two GP practices responded that they felt the scheme was effective. One commented that it helped the practice to become more aware of what support is available for veterans and had encouraged them to record veteran status.

viii) Additional training/further information – all GP practices who responded to the survey welcomed further information on agencies that offer support to veterans. Two practices indicated they would find it beneficial to have a directory of specific services to inform what support was available, for example charities/specialist support.

DRAFT

NENC ICB Armed Forces Lead - Summary of work in the Sunderland region

- Armed Forces Champion in every GP practice both clinical and administration
- Roll out of the NHS England e-learning module (Skills for Health) Military Veterans accreditation
- 100% of GP Practices signed the Armed Forces Covenant
- Co-wrote and Introduced The Good Practice Guide
- Made changes to the Reservists Policy
- 100% of GP Practices are Veteran Friendly GP accredited
- Formed the Sunderland Armed Forces Partnership Board
- National & Local Award winners
- Gold MOD Employers Recognition Scheme



HOUSE OF COMMONS
LONDON SW1A 0AA

Office of Jonathan Brash MP
206 York Road
Hartlepool
TS26 9EB

Thursday 15th January 2026

Councillor Shane Moore
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Dear Councillor Moore,

I am writing to you in my capacity as Member of Parliament to share evidence and observations regarding the experiences of veterans engaging with GP practices in the town, as part of the Audit and Governance Committee's work in this area.

The evidence I set out is drawn directly from my own casework and from regular conversations with veterans in the course of my day-to-day role. Over time, a consistent picture has emerged which I believe warrants careful consideration by the Committee and by local GP practices themselves.

I want to be clear at the outset that there are undoubtedly pockets of good practice. In several cases, veterans have reported positive and supportive experiences, often where staff within a practice have direct experience of service life themselves, or have close family members who have served. In these circumstances, there is frequently a greater understanding of veterans' needs and a more proactive approach to signposting and support.

However, despite these examples, too many GP practices do not currently offer a bespoke and tailored pathway for veterans when they engage with primary care. Too often, veterans are treated in exactly the same way as the general population, without due recognition of their service background or the specific challenges that can arise as a result of it.

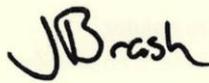
I regard the provision of a tailored approach as essential. Veterans can face unique physical and mental health challenges, as well as difficulties linked to transition, trauma, and long-term conditions connected to their service. A system that does not actively identify veterans or adapt pathways accordingly risks missing opportunities for early intervention and appropriate support.

In my view, it is therefore imperative that GP practices actively engage with the Audit and Governance Committee's investigation and, more importantly, with the veteran community itself. Meaningful engagement has the potential to drive practical changes in procedures and culture that would make a real difference to veterans' experiences of primary care.

I do not raise these issues to be overly critical of GP practices or their staff. They are hardworking professionals operating under significant pressure, and their commitment to patient care should be recognised. However, I am firmly on the side of our veterans in this matter, and I believe there is more that can and should be done to ensure they receive the understanding and tailored support they deserve.

I hope these observations are helpful to the Committee's work, and I would welcome any opportunity to support its investigation further.

Yours sincerely,



Jonathan Brash MP
Member of Parliament for Hartlepool

Statement from the Armed Forces Champion – Councillor Chris Wallace

The investigation has been necessary to gain an understanding of what is expected by veterans of the NHS, and how suitable the Veteran Friendly accreditation scheme (VFAS) is in meeting the needs of veterans in Hartlepool and wider for the treatment of injuries and illnesses sustained as a part of army service.

It is also useful to hear from GP practices on how they are able to meet these needs, and to see what is further required to meet VFAS commitment. I thank the town's veterans and the GP practices who contributed to the survey. Information will be valuable for taking the next steps.

In working with Hartlepool's veterans over the last two years. I have seen some success stories in terms of Veterans seeking help and receiving care. But it is clear that there is more work to be done in the way of education around the needs of veterans, especially around the subject of mental health.

PTSD is a cruel and complicated illness that can require varied solutions for each individual depending on circumstance and situation. At present the NHS and central government is not set up to address this comprehensively and more awareness of the various charities is needed to provide better signposting and communication.

The investigation is just the start. Recommendations will be actioned and we will continue to work with GPs, the ICB, veterans and the relevant Ministers to improve healthcare for veterans in Hartlepool.

Chris Wallace
Armed Forces Champion



Audit and Governance Committee

17 March 2026

Report of: Scrutiny and Legal Support Officer

Subject: SCRUTINY INVESTIGATIONS – PROGRESS REPORT

1. Council Plan Priority

Hartlepool will be a place:
where people live healthier, safe and independent lives. (People)
that is connected, sustainable, clean and green. (Place)
that is welcoming with an inclusive and growing economy providing opportunities for all. (Potential)
with a Council that is ambitious, fit for purpose and reflects the diversity of its community. (Organisation)

2. Purpose of Report

2.1. To provide Members with the progress made to date on the delivery of the agreed scrutiny recommendations of the Audit and Governance Committee investigations.

3. Background

3.1. In accordance with the agreed procedure, this report provides Members of the Committee with the details of progress made against investigations undertaken, as detailed below: -

- (i) The progress made in relation to the Child and Family Poverty investigation is attached at **Appendix A**. This provides an overview of the recommendations, and a detailed explanation of the progress made

against each outstanding scrutiny recommendation agreed by the Committee.

- (ii) The progress made in relation to the Accessibility of Council Services in Hartlepool investigation is attached at **Appendix B**. This provides an overview of the recommendations, and a detailed explanation of the progress made against each outstanding scrutiny recommendation agreed by the Committee.
- (iii) The progress of the Derelict Land and Buildings investigation will be provided at a later meeting. This is due to the council leadership restructure and the change of responsibility of certain roles that were allocated actions from the recommendations.

4. Recommendations

4.1. That Members: -

- a) Note the progress against the agreed recommendations of the Audit and Governance, and explore further where appropriate;
- b) Consider if any investigations can be closed.
- c) Retain **Appendix A and B** for future reference.

5. Reasons for Recommendations

5.1. To monitor the progress of the Committees scrutiny investigations.

6. Background Papers

6.1. The background papers used in the preparation of this report were the Child and Family Poverty and the Accessibility of Council Services in Hartlepool report appended to this report.

7. Contact Officers

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Scrutiny & Legal Support Officer
Legal Governance and HR
Hartlepool Borough Council
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AUDIT AND GOVERNANCE SCRUTINY ENQUIRY ACTION PLAN

NAME OF COMMITTEE: Audit and Governance Committee

NAME OF SCRUTINY ENQUIRY: Child and Family Poverty

+ please detail any risk implications, financial / legal / equality & diversity / staff / asset management considerations

* please note that for monitoring purposes a date is required rather than using phrases such as ‘on-going’

RECOMMENDATION	RESPONSE / PROPOSED ACTION ⁺	FINANCIAL / OTHER IMPLICATIONS	LEAD OFFICER	COMPLETION STATUS
1) Exceptional services are provided in Hartlepool to mitigate the effects of poverty and these are the predominant focus of Hartlepool Council poverty activities. However, going forward, strategies and services need to move towards a more hands up/prevention/route out of poverty focused model lead to deliver more impactful change. As is being planned by the Trussell Trust Foodbank and The Joseph Rowntree Foundation.	Welfare Support has been adjusted to move from a ‘hand outs’ to ‘hands up’ model of help.		PT	Complete
	The Head of Service responsible for hardship is part of the Trussell Trust working group leading on implementing their strategic change plan.		PT	Five year plan – to 2027
	Work has begun to develop a local ‘anti-poverty’ strategic group tasked with grounding any strategic actions based on lived experience and the need to support change.		DS/PT/ and others internal to HBC and external VCSE	Complete
2) The voluntary Socio Economic Duty be potentially adopted with the assistance of a working group that will look into: - What is required to facilitate	Establish task group based on recommendation.		PT	September 2023
	Research other councils/ anchor organisations who have successfully implemented the		PT	Complete

<p>the formal adopt the Socio Economic Duty; - What would be the benefits of its adoption; - How might it reduce poverty; and - What all of the above mean in practical and financial terms for the Council.</p>	<p>duty</p>			
<p>3) The establishment of a Hartlepool Poverty Truth Commission be progressed with the assistance from Thrive Teesside and the Poverty Truth Network. The purpose being to incorporate lived experience of socio economic disadvantage at all levels of decision making and policy development.</p>	<p>Meet with Poverty Truth Network to establish what is required to establish a PTC</p> <p>Work with Voices of Hartlepool, a small resident voice group that aims to become a PTC</p> <p>Identify further residents that want to be actively part of a PTC</p> <p>Engage with Thrive Teesside, local experts in PTC work</p>		<p>DS/ PT – local anti-poverty strategic group</p> <p>PT</p> <p>DS/ PT – local anti-poverty strategic group</p> <p>DS/ PT – local anti-poverty strategic group</p>	<p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p> <p><i>To note funding for the PTC ended in December 2025. No decision about future plans.</i></p>
<p>4) As and when the outcomes of ongoing national work in relation to best practice and service improvement becomes</p>	<p>Based on PTC work, adoption of SED, engagement of internal HBC colleagues, external key anchor organisations and VCSE,</p>		<p>DS/ PT – local anti-poverty strategic group</p>	<p>Complete <i>Anti-poverty strategy was approved at</i></p>

available, a further refresh of the new Child and Family Poverty Strategy be undertaken.	establish the framework for an anti-poverty strategy using local proven successful action and learning from other areas that have tried something different			<i>Finance and Corporate Affairs Committee in Sept 25.</i>
5) The implementation of the recommendations contained within the report to be monitored by the Audit and Governance Committee. Alongside an update on the poverty position in Hartlepool.	As outlined in all points above		PT	6 monthly check-ins
6) National targets have been removed for the reduction of poverty, however, national indicators have been created. It would be beneficial to set a series of Hartlepool specific indicators, against which outcomes (including the activities of the Poverty Truth Commission and adoption of the Socio Economic Duty) can be measured.	Collate a local data set that indicates need – based on e.g. Free School Meals (FSM)(financial), Local Council Tax Support (CTS), access to Foodbanks, take up on advice and debt services		PT and Hartlepool Financial Inclusion Partnership	In progress <i>Local data sets are (FSM / CTS) available and have been provided to poverty action group in the past.</i>
7) Ward based poverty data to be sent to Cllrs on an annual basis.	This would be based on national datasets (households below average income) together with FSM and LCTS data		PT	Not feasible
8) In terms of Schools, a poverty update is to be provided at a Head Teachers Briefing, as part of which schools:	PT to provide a briefing at Director’s Headteachers briefing outlining Poverty Proofing the School Day opportunities and continuing discussions around the impact of the cost of school		PT	Complete

<ul style="list-style-type: none"> - Will be reminded of the value of the 'Poverty Proofing' exercise offered by Children North East; - Be encouraged to seek guidance and advice from external source where available, such as the SHINE Trust; and - Asked to promote the second hand uniforms scheme (Hartlepool Preloved Clothing) as a means of reducing costs for parents. 	<p>uniform to households</p>			
<p>9) In terms of decision making:</p> <ul style="list-style-type: none"> - Impact assessments are a part of the 'key' decision making process and development of strategies and Child and Family Poverty Impact Assessment and Equability and Diversity Impact Assessments are to be amalgamated to simplify the process; and - Where the process for monitoring the implementation of decisions identifies a potential 'new' or 'increased' poverty impact, the Impact Assessment should be revisited to gain a full 	<p>Task group to be established to begin to address impact assessments, to merge them together and to establish processed to track impact</p>		<p>Catherine Grimwood</p>	<p>Complete</p>

<p>understanding of the position and any action that may be required.</p>				
<p>10) In terms of debt collection:</p> <ul style="list-style-type: none"> - The impact of debt collection on those experiencing poverty needs to be evaluated with a view to supporting the provision of focused assistance and support; and - Where debt is poverty related, options for changes to procedures for debt collection be explored in terms of the provision of additional support / assistance. 	<p>Task group to be established to determine how the council takes action on households for e.g. non-payment of council tax, the administration and court charges attached to this and the impact of attachment of earnings on households</p>		<p>James Magog, Penny Thompson</p>	<p>In progress</p> <p><i>Update to be provided at A&G – 17th March 2026</i></p>
<p>11) In terms of advice and support:</p> <ul style="list-style-type: none"> - Citizens Advice and other debt counselling services to be promoted to local groups and the VCS; and - Awareness rolled out to partners/voluntary sectors on initiatives such as Baby Bank/Sensory spot. 	<p>Communications strategy will be part of the anti-poverty strategy namely – Who offers what help, how and where with a variety of options of how to access the information from traditional methods (print) to digital methods (websites and social media)</p>		<p>DS/ PT – local anti-poverty strategic group</p>	<p>Complete</p>
<p>12) The Council to seek from the Joseph Rowntree Foundation (JRF) an ongoing strategic commitment to work with Hartlepool Borough Council on</p>	<p>MD has sent a letter to the new Chief Exec and senior leaders in JRF</p> <p>This is to be followed up by the</p>		<p>DM</p> <p>PT/DS</p>	<p>Commitment secured no later than December 2023</p>

Hartlepool's poverty issues.	strategic poverty group Ongoing meetings locally with JRF staff working on the ground		PT	<i>Update to be provided at A&G – 17th March 2026</i>
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AUDIT AND GOVERNANCE SCRUTINY ENQUIRY ACTION PLAN

NAME OF COMMITTEE: Audit and Governance Committee

NAME OF SCRUTINY ENQUIRY: Accessibility of Council Services in Hartlepool for Those with Disabilities and Long-Term Conditions

+ please detail any risk implications, financial / legal / equality & diversity / staff / asset management considerations

* please note that for monitoring purposes a date is required rather than using phrases such as ‘on-going’

RECOMMENDATION	RESPONSE/PROPOSED ACTION	FINANCIAL / OTHER IMPLICATIONS	LEAD OFFICER	COMPLETION STATUS
<p>1) Exploration of some adjustments would require more significant investment and be longer term actions. Other short / medium term actions would be to:-</p> <p>i) Develop a communications campaign to:</p> <ul style="list-style-type: none"> - Highlight the various support schemes and reasonable adjustments that are already have in place; - Promote ‘One-Stop-Shop’ touch points such as the Civic Centre reception and Community Hubs where people can get assistance with everything in one place. 	<p>i) Communications Plan to be developed with campaign work to begin from August 2023</p>		<p>i) To iv) Connor Kerr / Bev Bearne</p>	<p>i) In progress</p> <p><i>A brand refresh has improved branding accessibility, inc. better use of colours, easier to read fonts. Website now complies with accessibility guidelines.</i></p>

<p>Making those who find accessing the Civic Centre aware that the same service can be accessed elsewhere; and</p> <p>- Promote the role of Community Hubs and Community Navigators to increase the understanding of the services they offer.</p> <p>ii) Ensure that community buildings and touch points have posters and leaflets on display for a range of disability support groups and charities.</p> <p>iii) Circulate basic guidance to staff on font size and type, use of plain English, how to book an interpreter when one is required and put this information in an easy to find location on the intranet.</p> <p>iv) Create an “accessibility” tile on the intranet homepage so it is easy to find and collate a range of useful accessibility information for staff to be able to find quickly</p>	<p>ii) Communications Team to facilitate the distribution of posters and leaflets to community buildings</p> <p>iii) Guides to creating accessible content and booking interpreters are already available on the Equality and Diversity tile on the intranet for staff</p> <p>iv) An Equality Diversity tile is in place on the intranet homepage and links to a range of information including the above</p>			<p>Options for campaign are being explored including the development of digital newsletter.</p> <p>ii) In progress As above</p> <p>iii) Complete</p> <p>iv) Complete</p>
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<p>and easily when a disabled person makes contact.</p>				
<p>2) Equality of access to services for all is a fundamental right and residents with disabilities and long term conditions should not be restricted in terms of the times they can access services or the levels of privacy they can expect. To this end:-</p> <p>i) A Text Relay Service should be introduced;</p> <p>ii) Given the financial restrictions faced by the local authority, the feasibility and benefits, of creation of a pod facility in the Civic Centre be explored to allow residents and officers to use online signing / translation services;</p>	<p>i) The Text Relay service:</p> <ul style="list-style-type: none"> - Is now in use via customer services for all Adult Social Care Team including Adult Safeguarding / ISPA with access to the Relay UK app. - Has been introduced in the Support Hub. <p>ii) There would be a cost implication to this.</p> <p>Civic Centre - Meeting rooms within the Civic Centre reception area can be utilised as pod facilities – wider issue is access to translation services at point of contact but this is addressed further in the plan.</p>		<p>i)Laura Griffiths / Julie Howard / Leigh Keeble</p> <p>ii)Laura Griffiths / Julie Howard / Leigh Keeble</p>	<p>i)Complete</p> <p>ii)Complete</p>

<p>iii) The creation of a network of BSL trained staff, to act as first point of contact for volunteers, be explored;</p>	<p>Community Hubs - There is a pod that that could be used in the community hubs for 1:1 and a laptop or tablet could be provided to support video interpretation. This would, however, need to be booked and a pilot of block booking a few hours a week can be trialled.</p> <p>iii) Staff volunteers would be a first point of contact with any complex communication via qualified translators. There would be a resource implication in setting this up.</p> <p>Currently exploring training provision with the Council's Organisational Development team who are in contact with RNIB and RNID – it is recommended that this be mandatory training for all frontline staff.</p> <p>There is also the potential opportunity to offer BSL training to employees through the Workforce Development Programme and is currently being reviewed.</p>	<p>iii) Financial implication to be calculated before final decision on the implementation of the recommendation</p>	<p>iii) Gemma Ptak/ Leigh Keeble</p> <p>Laura Griffiths / Julie Howard</p>	<p>iii) Not feasible</p> <p><i>Deaf Awareness training that can be accessed by all staff has been added to the Workforce Development Programme from 2024-25.</i></p>
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<p>iv) Existing TV screens in the Civic Centre reception be used to promote accessibility services and the assistance that is available; and</p> <p>v) The Loop system currently used in council buildings be reviewed to ensure that it is still compatible with modern hearing aids.</p>	<p>In terms of the Community Hubs staff some level of training would be useful but this would need to be used regularly to be effective.</p> <p>iv) Easy to do with no additional resources (other than loading information.</p> <p>A sign language video could be produced that could be accessible via a range of mediums including web-site and Hartlepool Now.</p> <p>Once a clear service offer is known this can be promoted via a wide range of mediums.</p> <p>v) Indications as part of the investigation were that new hearing aids aren't compatible with the existing system. This action has be allocated to the Building Maintenance team for review.</p> <p>Specialist company have been contacted and are to visit the Civic Centre to undertake compatibility tests.</p>	<p>Financial implication to be calculated before final decision on the implementation of the recommendation</p> <p>Financial implication to be calculated before final decision on the implementation of the recommendation</p>	<p>iv)Laura Griffiths / Julie Howard</p> <p>v)Laura Griffiths / Julie Howard</p>	<p>iv) Not feasible</p> <p><i>Due to location of screens this is not deemed to be suitable.</i></p> <p>v) Complete</p> <p><i>– A company has been out to assess Civic Centre. Stated all compatible.</i></p>
<p>3) Provide access to a video / telephone translation service</p>	<p>- This was specifically requested by the BSL community so I think that this should be referenced</p>	<p>Financial implication to be calculated before</p>	<p>Laura Griffiths / Julie Howard</p>	<p>Complete</p> <p><i>The use of sign video has been</i></p>

<p>(for BSL and other languages) in the Civic Centre, and a private room for the discussion of confidential issues. This facility to be promoted (e.g. via signs on glass partitions in a similar way to how pharmacies tell customers they can use a private consultation room).</p>	<p>and linked to a facility to request a BSL interpreter at the same time – the private room is no use without the Translation service.</p> <ul style="list-style-type: none"> - The provision of a room in the Civic is possible and a standard laptop could be used to provide a video translation service (no other equipment needed and 'Big Word' system is already used for translations). This could also be provided in the central hub. <p>Rooms are in fact already available on request for all residents but this was something that Deaf users really wanted</p> <p>The question being – why are deaf residents not aware of this – do we publicise it and are staff encouraged to use it) The introduction of a process to ensure that they are taken to a separate room for private signed / translated discussions would be achievable with a refresh of accessibility awareness training</p> <ul style="list-style-type: none"> - Request for translation services and use of the text service is low (historic use of the video translation service had also been low) but it is unclear if this is 	<p>final decision on the implementation of the recommendation</p>		<p><i>established. This is now on the website and teams can access BSL interpreters via links on tablets etc.</i></p>
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	<p>because of a failure to engage or that individuals felt that their views aren't heard.</p> <p>- We do not have a person qualified to provide translation services. Having trained staff to be a first point of contact (basic translation / signposting services) would be useful but would have cost implications and demand is unclear. A suggested option, albeit with a financial implication being:</p> <ul style="list-style-type: none"> • A refresh of awareness training • Staff with basic translation services and knowledge of how to access other systems • A pilot scheme for the provision of a trained individual to be located in the Central Hub and / or Civic (drop in sessions half a day a week), demand and success of which could be monitored. This to be publicised as an option to access translators and other options provided (such as text service or video translation, etc.) • Introduction of sign video service to be scoped / considered although usage of 			
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	previous solutions has been historically moderate.			
4) A review of workforce training be undertaken to explore how disability awareness and an understanding of reasonable adjustments, could be increased, within available resources. As part of this:-	There may be some courses on Skillsgate that staff can access however we don't have enough licences for all staff so there would need to be a managed process to this.		Hayley Martin / Gillian Laight / Rachel Clark	
i) Accessibility and diversity awareness training to be rolled out as mandatory training for all HBC staff and offered as an option for Councillors as part of the induction process; and	Aug update - Deaf Awareness training that can be accessed by all staff has been added to the Workforce Development Programme from 2024-25. Feb 2024 update – money has been allocated to Adult learning train to 100 front line staff in 'communication tactics'. Neil Harrison to identify staff to inc. customer services etc.			i) Complete
ii) Options for training be explored including the use of online packages to allow ease of access and roll out across departments, without the need for an external trainer.				ii) Complete
5) The newly established Equality, Diversity and Inclusion Officer Group to be used as a mechanism to share best practice, monitor performance and identify service improvements.	A new Equality, Diversity and Inclusion Officer Group was established at the beginning of the year and this falls under their remit.		Catherine Grimwood / Bev Bearne	Complete
6) Improvements to the HBC website be explored to ensure that it is EDI compliant going			Connor Kerr / Bev Bearne	The new website has been launched

<p>forward, including but not be limited to:-</p> <p>i) Read options for documents, to allow access by blind or visually impaired residents;</p> <p>ii) Captions / signing on social media posts / videos; and</p> <p>iii) When time-critical videos are posted on social media, and there is not time to set up closed captions, the video should include a text card to say that subtitles will be added. For videos which are not time-critical subtitles should be added before they are uploaded.</p>	<p>i) Current website to be replaced and this recommendations will be covered in the specification for the new site</p> <p>ii) and iii) will be completed as recommended</p>			<p>and meets accessibility guidelines.</p> <p>i) Complete</p> <p>ii) Complete</p> <p>iii) Complete – All time critical videos will contain subtitles due to new software.</p>
<p>7) Council reports, documents and forms must be accessible (easy read / screen reader friendly) and going forward clear content guidance should to be provided, and its use promoted, including:-</p> <p>i) Where appropriate, instructions for the inclusion of links to allow the use of screen readers; and</p> <p>ii) Promotion of use of a document accessibility checker.</p>	<p>i) The brand guidelines refresh will include reference to accessible content.</p> <p>ii) MS Word has an in-built document accessibility checker.</p>		<p>Connor Kerr / Bev Bearne</p>	<p>i) Complete</p> <p>ii) Complete</p>

	Instructions on how to use it are on the intranet on the Equality and Diversity tile			
8) A consultation to be undertaken with partners (attendees to be confirmed) on the potential benefits, and level of support for, the creation of a needs passport / card system that could be used to ensure that officers quickly recognise and respond to any additional support needs.	<p>Discussion in respect of developing a passport card locally with representatives from the joint Sensory Support Plan working group on 19/10/2023. Included HI-VIS UK, Hartlepool Vision Support, Hartlepool Deaf Centre.</p> <p>There are a number of existing schemes that can support identification of a certain condition however people should be considered as individuals in their own right.</p> <p>https://www.did-card.co.uk/ https://www.disabilityid.co.uk/about</p>		Neil Harrison /John Lovatt	<p>Not feasible</p> <p>Exploration of these types of cards has shown this would not be the most appropriate way of ensuring that individual needs are easily identifiable.</p>
9) The process for creation of the Highlight on the Waterfront development is an example of good practice in terms of engagement / involvement with residents with disabilities and lifelong conditions. This good practice to be rolled out across the development of all services and strategies.	<p>Engagement itself can be delivered but it is hard to quantify as it will be relevant to each specific service/strategy.</p> <p>The financial element of strategy development is dependent on the nature of consultation and the service and so difficult to quantify.</p>	Financial implication to be calculated before final decision on the implementation of the recommendation	Directors	<p>Complete</p> <p>While this approach has been well received, any consultation and engagement is geared towards the size and</p>

	<p>There is already a commitment to:</p> <ul style="list-style-type: none"> - Engaging and involving people in service developments. - Developing the co-production process to involve people who have lived experience - Engaging and involving people at the earliest stages of service design and development. <p>Recent strategy consultations have also included everything from behavioural insights work to talking to the client group so varies significantly in terms of costs</p>			<p>complexity of the scheme.</p>
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Audit and Governance Committee

17 March 2026

Report of: Director of Legal, Governance and Human Resources
Subject: REGULATION OF INVESTIGATORY POWERS ACT 2000 – UPDATE QUARTER 4

1. Council Plan Priority

Hartlepool will be a place:

where people live healthier, safe and independent lives. (People)

2. Purpose of Report

2.1. To provide elected members with an update on activities relating to surveillance by Hartlepool Borough Council and policies under the Regulation of Investigatory Powers Act 2000 (RIPA).

3. Background

3.1. The Council has lawful powers under the Regulation of Investigatory Powers Act 2000 (RIPA) to carry out surveillance in specific circumstances. Although these powers are used only rarely, they may be necessary to support the Council’s functions—for example, in cases involving serious criminal damage, hazardous waste offences, trading standards investigations, or serious or repeated benefit fraud. Any surveillance must be both necessary and proportionate.

3.2. Any RIPA surveillance the Council seeks to authorise must be approved by an authorised officer. Covert surveillance may only be used when:

- It is required for the prevention or detection of crime; and

- The offence being investigated is one that could result in a custodial sentence of at least six months.

3.3. In addition, since the Protection of Freedoms Act 2012, any proposed covert surveillance must also be approved by a magistrate.

3.4. A confidential record of all authorised surveillance activity is maintained, including details of authorisations, reviews and cancellations. The Investigatory Powers Commissioner’s Office oversees and inspects the Council’s use of these powers.

3.5. This report is presented to members in accordance with paragraph 4.47 of the Home Office Code of Practice for Covert Surveillance and Property Interference (August 2018). The Code requires Elected Members to review the authority’s use of powers under the legislation at least annually, to set the relevant policies, and to consider internal reports regularly to ensure that surveillance powers are used consistently with the Council’s policy and remain fit for purpose.

4. RIPA Authorisations – Q4

4.1. In the quarter 4 period there have been the following authorisations:-

Communications Data	0
CHIS	0
Directed Surveillance	0
Non-RIPA	0
External	0

4.2. The authorisations contributed to the detection of illegal trading standards activities.

5. Other Considerations/Implications

Risk Implications	There are no specific risk implications arising from this report. It is for information only.
Financial Considerations	There are no financial implications associated with this report.
Subsidy Control	Not applicable

Legal Considerations	This report supports compliance with the Regulation of Investigatory Powers Act 2000 and associated statutory guidance.
Single Impact Assessment	A Single Impact Assessment is not required as this report is for information only and does not propose any change in policy or service delivery.
Staff Considerations	There are no staffing implications arising from this report.
Asset Management Considerations	Not applicable – the report does not involve or affect council assets.
Environment, Sustainability and Climate Change Considerations	There are no environment, sustainability or climate-related implications associated with this report.
Consultation	(a) Internal consultation has been undertaken with relevant officers. (b) Public consultation is not applicable for this report. (c) No statutory consultees are required for this report.

6. Recommendations

6.1. Members are asked to note the content of the Quarter 4 RIPA Update report.

7. Reasons for Recommendations

7.1. To comply with the legislation and guidance regarding RIPA.

8. Background Papers

8.1. Previous RIPA updates provided to the Audit and Governance Committee.

9. Contact Officers

Hayley Martin, Director of Legal,
Governance and Human Resources
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HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

8 December 2025

The meeting commenced at 10am in the Civic Centre, Hartlepool

Present:

Karen Hawkins - Representative of NHS North East and North Cumbria Integrated Care Board (In the Chair)

Prescribed Members:

Elected Members, Hartlepool Borough Council – Councillors Allen, Little and Roy
Interim Director of Public Health, Hartlepool Borough Council – Chris Woodcock
Executive Director of Adult and Community Based Services, Hartlepool Borough Council - Jill Harrison
Representatives of Healthwatch - Margaret Wrenn and Steve Thomas

Other Members:

Representative of Hartlepool Voluntary and Community Sector – Christine Fewster
Observer – Statutory Scrutiny Representative, Hartlepool Borough Council – Councillor Jorgeson

Also Present: In accordance with Council Procedure Rule 4.2 Stuart Irvine was in attendance as substitute for Neil Atkinson (North Tees and Hartlepool NHS Trust)

Also in attendance:-

Karen Gibson, Alice House Hospice
Adam Guy and Julian Penton – Hartlepool Food Partnership
Philippa Walters, Pharmacy Lead

Officers:

Sylvia Pinkney, Assistant Director (Regulatory Services)
Lisa Adams, Head of Service (Early Help)
Leigh Keeble, Head of Service (Transformation)
Joan Stevens, Democratic Services and Statutory Scrutiny Manager
Jo Stubbs, Principal Democratic Services and Legal Support Officer

28. Apologies for Absence

Councillor Rob Darby, Denise McGuckin (Chief Executive HBC), Neil Atkinson (North Tees and Hartlepool NHS Trust), Fiona Adamson (GP Federation) and Sonya Black (Headteachers)

29. Declarations of interest by Members

Stuart Irvine declared an interest in Item 4.4 (Hartlepool Food Partnership – Progress Update) due to his position as Chair of Governors at Hartlepool College of Further Education.

30. Minutes of the meeting on 29th September 2025

Approved with the following amendment –

That Councillor Jorgeon attended as statutory scrutiny representative rather than Councillor Creevy

31. Health and Wellbeing Board Terms of Reference - Refresh (*Interim Director of Public Health*)

The Democratic Services and Statutory Scrutiny Manager presented the refreshed terms of reference for members' approval. This followed a change in leadership at Hartlepool Borough Council and now allowed for an elected member to chair the Health and Wellbeing Board. The newly appointed Director of Housing, Growth and Communities would also be included in the membership under other members.

Should members approve these terms of reference Councillor Gary Allen would become Chair of the Health and Wellbeing Board. Members were happy to approve the changes with the proviso that any reference to the Health and Social Care Act 2012 within the document be amended to highlight that this had been updated in 2022 for accuracy.

Decision

That the updated Terms of Reference for the Health and Wellbeing Board be approved.

Councillor Gary Allen in the Chair

32. Pharmaceutical Needs Assessment (PNA) 2025 Maintenance Report (*Interim Director of Public Health*)

The report updated the Board in accordance with the process for statutory maintenance of the Pharmaceutical Needs Assessment 2022, to receive notification of applications, decisions or other notice of changes to pharmaceutical services in Hartlepool from the ICB NENC or Primary Care Support England (PCSE) since the date of the last Health and Wellbeing Board Maintenance Report (29 September 2025). In relation to the

requirement to seek approval for publication of any Supplementary Statement to the PNA 2022 required as a consequence of those reported changes to pharmaceutical services, the Board was advised that no new Supplementary Statements had been issued under delegated authority since the last meeting of the Board. However a notification of changes to supplementary hours had been received reporting changes to the opening hours of Healthways Chemist in Middleton Grange Shopping Centre as notified by NENC ICB.

Members were also advised that changes to the 2013 regulations had come into force in October 2025. A full explanation was provided within the report.

Decision

That the change to pharmaceutical services in Hartlepool on Saturday morning, notified by NENC ICB, be noted

That it be noted that no supplementary statements to the Hartlepool PNA 2025 have been issued or are required since the last report to the Board in September 2025

That the Regulatory changes introduced on 1st October 2025 pertinent to maintenance for the Hartlepool PNA 2025 be noted

33. Teeswide Safeguarding Adults Board Annual Report 2024/25 (*Executive Director of Adult Services and Public Health and Independent Chair of Teeswide Safeguarding Adults Board*)

Members were referred to the Teeswide Safeguarding Adults Board (SAB) Annual Report for 2024-25 and Strategic Plan for 2025-2028 appended to the report. It was a requirement under the Care Act 2014 that each SAB published an annual report setting out what had been done during that year to achieve its objective and implement its strategy, the findings of any safeguarding adults reviews and what has been done to implement findings of any reviews. A strategic plan must also be published setting out the strategy for achieving its objectives and what members will do to implement it.

The Chair commended those involved in the production of the report which demonstrated the great work done across Teesside and Hartlepool and those involved in safeguarding as a whole.

Decision

That the Teeswide Safeguarding Adults Board Annual Report 2024/25 and Strategic Plan for 2025-2028 be noted and endorsed.

34. **Hartlepool Food Partnership – Progress Update** *(Julian Penton, Hartlepool Community Trust)*

The Board was updated on progress made by the Hartlepool Food Partnership (HFP) in bringing together the local authority, food-related businesses, the voluntary & community sector, NHS and educational institutions to address multiple aspects of the locality's food system.

Of the food partnerships across the UK, around 100 are members of the Sustainable Food Places (SFP) network. Becoming a member of the SFP required that food partnerships demonstrate a whole system approach to the local food system, based upon multi-sector collaboration, across 6 areas of work.

- Food governance and strategy;
- Good food movement;
- Healthy food for all;
- Sustainable food economy;
- Catering and procurement; and
- Food for the planet.

Details of how the HFP performs against each of the areas required to qualify for membership of the SFP were presented to the Board and attention drawn to the food-related drivers of ill health within Hartlepool, including food poverty, food deserts and the widespread consumption of processed foods and drinks. A benchmarking assessment of the Council's current contribution to addressing food-related issues had recently been issued and it was proposed that this benchmarking continue to be used to inform further cross-departmental working within the Council.

Details of funding for the Hartlepool Food Partnership was given within the report. This would allow current staffing arrangements to continue until Autumn 2026 with further funding to be sought in the coming months.

The Board noted the excellent work which had been carried out through the food partnership. Attention was drawn to the way in which growing food could bring people of all ages together and the benefits of this for people with dementia, the distribution of excess allotment produce and the issue of ultra-processed foods in the town. Concerns were also raised about the high number of takeaways in Hartlepool and the impact this and organisations such as Just Eat and Uber Eats had on people's cooking skills.

Decision

- I. That the continued use of the benchmarking of Hartlepool Borough Council's alignment with Food Partnership objectives to inform further cross-departmental working within the Council be endorsed.

- II. That the financial considerations outlined in the report be noted

35. Dementia Strategy (*Stephen Thomas, Healthwatch*)

The Chair of Dementia Friendly Hartlepool presented the draft dementia strategy to the Board. He explained the reasoning behind the development of the strategy, the priority areas and next steps. This would involve the preparation of a detailed Action Plan which would set out responsibilities, timelines and performance indicators. A monitoring framework would be established to track progress and an annual report presented to the Board. Governance of this would be through a dedicated Dementia Strategy Implementation Group. Members were asked to nominate at least 1 representative from their organisation to be part of this group to participate in meetings and help in the implementation of the strategy.

Representatives of Hartlepool's dementia community spoke at the meeting. They felt that the number of people living with dementia was vastly underestimated and noted that while the work of the implementation group would not help them it could help those who might be affected in the future. Concerns around the lack of specialist health provision for people living with dementia and the impact this had on the length of time it could take to diagnose dementia were highlighted and it was proposed that each GP surgery have at least 1 dementia specialist.

Members endorsed the draft strategy and thanked the Chair of Dementia Friendly Hartlepool and the members of Hartlepool's dementia community for their efforts and input. They noted the request for representatives to be part of the Dementia Strategy Implementation Group. The Chair confirmed these nominations would be forwarded to the group following the meeting.

Decision

- I. That the Hartlepool Dementia Strategy be endorsed
- II. That at least 1 representative from each of the Health and Wellbeing Board organisations to nominated to the Dementia Strategy Implementation Group

36. Carers Strategy (*Christine Fewster, Hartlepool Carers*)

The Chief Executive of Hartlepool Carers presented the carers strategy to the Board. She explained the reasoning behind the development of the strategy, the vision, values and priorities. Carer Focus Groups would be established to monitor delivery of the strategy and members of the Board were asked to nominate a representative to participate in these focus group sessions. An annual progress report will come to the Health and Wellbeing Board.

Members noted the clear link between those living with dementia and those caring for them. The Chief Executive of Hartlepool Carers and Chair of

Dementia Friendly Hartlepool both confirmed they would work closely to align the 2 strategies. The Vice-Chair committed support from the North East and North Cumbria ICB in terms of involvement from GPs. The need to acknowledge the caring responsibilities of young people was also highlighted. The Chief Executive of Hartlepool Carers confirmed that funding had been received to employ representatives of young carers to attend schools and provide support to young carers.

This would involve the preparation of a detailed Action Plan which would set out responsibilities, timelines and performance indicators. A monitoring framework would be established to track progress and an annual report presented to the Board. Governance of this would be through a dedicated Dementia Strategy Implementation Group. Members were asked to nominate at least 1 representative from their organisation to be part of this group to participate in meetings and help in the implementation of the strategy.

Members endorsed the draft strategy and thanked the Chief Executive of Hartlepool Carers. They noted the request for representatives to be part of the Carer Focus Groups. The Chair confirmed these nominations would be forwarded to the group following the meeting.

Decision

- I. That the Carers Strategy be endorsed
- II. That to ensure appropriate governance, and support implementation of the Carers Strategy, a representative from each member organisation be nominated to sit on the Group.

37. Drug and Alcohol Strategy Update (*Interim Director of Public Health*)

The Interim Director of Public Health gave an update on the implementation of the Drug and Alcohol Strategy. In 2023 and following a needs assessment the drug and alcohol strategy had been refreshed and the following priorities outlined:

Prevention and early intervention
 Reducing drug and alcohol related harms
 Supporting wider health needs
 Reducing drug and alcohol related crime and disorder

Progress against each of these priorities was set out and noted. Six monthly updates would be brought to the Board.

The Chief Executive of Hartlepool Carers highlighted the link between substance abuse and caring responsibilities. The Head of Service (Early Help) confirmed there were existing links in place.

Decision

That progress in relation to the implementation of the Drug and Alcohol Strategy be noted

38. Tobacco Control Strategy (*Interim Director of Public Health*)

The Interim Director of Public Health gave an update on the delivery of the Tobacco Control Strategy Action Plan and Specialist Smoking Service for Hartlepool. This was implemented in 2023 with 8 priority areas as follows:

- I. Building infrastructure, skills and capacity for local tobacco control delivery
- II. Advocacy for evidence-based policies and legislation to achieve a Smokefree 2030 and to minimise influence of the tobacco industry
- III. Reducing exposure to tobacco smoke and normalising smokefree environments
- IV. Year round, media communications and education
- V. Supporting smokers to stop and stay stopped and also to reduce harm
- VI. Raise price and reduce illicit trade
- VII. Tobacco and nicotine regulation including reducing tobacco promotion
- VIII. Data research and public opinion

Members highlighted the increase in vaping particularly amongst young people. The Interim Director of Public Health agreed that while vaping was a useful tool in enabling smokers to stop it should not be seen as an alternative for those who do not smoke particularly young people. The Assistant Director (Regulatory Services) noted that the purchase of vapes was age restricted and premises could be targeted if officers were made aware that illegal sales were taking place. Members thanked the enforcement team for their work in this area.

Decision

That the progress against the Tobacco Control Action Plan be noted and regular progress updates continue to be received.

39. Director of Public Health Annual Report (*Executive Director of Adult Services and Public Health*)

Elected Members were referred to the requirement for the Director of Public Health to write an Annual Report on the health status of the town, and the Local Authority duty to publish it, as specified in the Health and Social Care Act 2012. The 2025 Annual Report focuses on the challenges from smoking, a major driver of ill health and health inequalities in Hartlepool. The report was again accessed via a link included in the report with a copy of the Director's report also appended to the report. The previous Director of Public Health presented a video to the meeting from the Annual Report.

Decision

That the contents of the Director of Public Health Annual Report 2025 be noted and work continues to reduce smoking in Hartlepool

The Meeting concluded at 11:50am.

CHAIR