Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS
12 June 2025
10.30am

The Boardroom at West Park Hospital, Edward Pease Way, Darlington, DL2 2TS and via MS Teams

AGENDA

NOTE: there will be a confidential session at 10am for the Board of Directors to receive a patient/staff story.

Standard Items

1	Chair's welcome and introduction (verbal)	Chair	10.30am
2	Apologies for absence (verbal)	Chair	
3	Declarations of interest (verbal)	All	
4	Minutes of the board meeting held on 10 April 2025	Chair	
5	Board Action Log	Chair	
6	Interim Chair's report	Chair	
7	Questions raised by Governors in relation to matters on the agenda (verbal) *(to be received by 10.00am on Tuesday 10 June 2025)*	Co Sec	

Strategic Items

8	Board Assurance Framework Summary Report	Co Sec	10.45am
9	Chief Executive's Report	CEO	10.50am
10	Integrated Performance Report	EDS&T	11.05am
11	Our Journey to Change Delivery Plan Quarter 4 2024/25	EDS&T	11.50pm

BREAK 12.00am – 12.15pm

BAF Risk 1: Safe Staffing

12	Report of the Chair of People, Culture and Diversity Committee	Cmt Chair	12.15pm
13	Guardian of Safe Working, 2024/25 Annual Report	GoSW	12.25pm

BAF Risk 2: Demand
BAF Risk 3: Co-creation
BAF Risk 4: Quality of Care
BAF Risk 8: Quality Governance

14	Report of the Chair of the Quality Assurance Committee	Cmt Chair	12.40pm
15	Learning from Deaths Report	EMD	12.50pm

16	Report of the Chair of the Mental Health Legislation Committee	Cmt Chair	1.00pm

BAF Risk 13: Public Confidence

17	Communications update	EDCA&I	1.10pm

Governance

18	Board Assurance Framework (verbal)	Chair	1.20pm

Matters for Information

19	Feedback from leadership walkabouts	EDCA&I	-
20	Register for Sealings	Co Sec	-

Exclusion of the Public

21	**Exclusion of the public:** The Chair to move: *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:* *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office holder or applicant to become an office-holder under, the Trust.* *Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.* *Information which, if published would, or be likely to, inhibit –* *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*	Chair	-

BREAK 1.25pm – 2.10pm

CONFIDENTIAL SESSION

Standard Items

22	Minutes of the confidential session of the last board meeting held on 10 April 2025	Chair	2.10pm
23	Minutes of the confidential extraordinary board meeting held on 14 May 2025.	Chair	
24	Board Confidential Action Log	Chair	

Strategic Items

25	Chief Executive's Confidential report	CEO	2.15pm
26	Reportable Issues Log	CN	2.35pm
27	Report of the Chair of Audit & Risk Committee a. Recommended for approval: - Revised Scheme of Delegation	Cmt Chair EDoFE&F	2.40pm

BAF Risk 4: Quality of Care

28	WTE – quality and equality impact assessment	CN, EMD	2.50pm

BAF Risk 5: Digital
BAF Risk 6: Estate/Physical Infrastructure
BAF Risk 7: Cyber Security
BAF Risk 9: Partnerships and System Working
BAF Risk 12: Financial Sustainability

29	Report of the Chair of Resources and Planning Committee (verbal update from meeting held 11 June 2025) a. Roseberry Park Hospital Business Case b. CYP Getting More Help	Cmt Chair EDFE&F EDS&T	3.00pm
30	2025/26 Month 1 finance report	EDFE&F	3.20pm

Matters for information:

31	To receive and note the minutes of the meetings of the following committees (for information): a. People, Culture and Diversity Committee, 11 December 2024 b. Mental Health Legislation Committee, 13 January 2025 c. People, Culture and Diversity Committee, 23 January 2025 d. Audit and Risk Committee, 17 March 2025 e. Quality Assurance Committee, 3 April 2025 f. Quality Assurance Committee, 1 May 2025	Co Sec	-

Evaluation

32	Meeting evaluation *In particular, have we, as a board of directors:* • *Via the agenda, papers and our discussions, fulfilled our objectives of supporting our communities, staff and stakeholders?* • *Fulfilled our statutory roles?* • *Held the organisation to account for the delivery of the strategy and services we provide?*	Chair	-

B Reilly
Interim Chair
6 June 2025

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

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

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Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD ON 10 APRIL 2025 AT 10.30AM AT WEST PARK HOSPITAL, DARLINGTON AND VIA MSTEAMS

Present:
D Jennings, Trust Chair (Chair)
B Kilmurray, Chief Executive
R Barker, Non-Executive Director
Z Campbell, Managing Director, North Yorkshire, York and Selby Care Group
K Kale, Executive Medical Director
N Lonergan, Interim Managing Director, Durham, Tees Valley and Forensic Care Group
J Maddison, Non-Executive Director
B Murphy, Chief Nurse
J Preston, Non-Executive Director
J Robinson, Non-Executive Director
L Romaniak, Executive Director for Finance, Estates and Facilities
C Wood, Non-Executive Director
A Bridges, Executive Director for Corporate Affairs and Involvement (non-voting)
H Crawford, Executive Director of Therapies (non-voting)
K North, Joint Executive Director for People and Culture (non-voting)
P Scott, Deputy Chief Executive (non-voting)

Present:
P Bellas, Company Secretary
Nick Black, Chief Information Officer
K Christon, Deputy Company Secretary (minutes)
Chris Lanigan, Associate Director of Strategic Planning and Programmes

Observers:
Karl Evenden-Prest, Staff Governor
E Ross, Trainee Psychologist
Jill Wardle, Public Governor

01. CHAIR'S WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and noted this would be the last Board of Directors meeting for the Chief Executive, B Kilmurray. He placed on record the board's gratitude for all the work he had done in the organisation and for his values driven leadership, which had placed the organisation in a strong position to move forward.

02. APOLOGIES FOR ABSENCE

Apologies for absence were received from C Carpenter, Non-Executive Director, B Reilly, Non-Executive Director and S Dexter-Smith, Joint Executive Director for People and Culture

03. DECLARATIONS OF INTEREST

None.

04. MINUTES OF THE LAST MEETING HELD ON 13 FEBRUARY 2025

Agreed: *the minutes are an accurate record of the meeting.*

05. BOARD ACTION LOG

In discussion:

1. The Chair noted that the Workforce Race Equality Standard was a Trust wide issue and queried the role of other committees. In response K North confirmed that, whilst People, Culture and Diversity Committee would consider the diversity of the Trust's workforce and how they would be treated in comparison to others, appropriate links would be made in other committees. H Crawford also noted that Quality Assurance Committee considered the patient and carer race equality framework [action 116].

2. P Scott proposed to reframe action 118 [transformation programme] to support a rounded conversation on quality assurance and oversight of the programme for discussion at the Quality Assurance Committee development day. The Chair also proposed that consideration be given to governance arrangements at board level.

06. CHAIRS REPORT

The Chair presented the report, which outlined area of focus and themes arising from work he had undertaken over the previous two month period. He drew attention to the recruitment process for a new Chief Executive and reflected on how useful the leadership walkabout sessions were for the board and governors.

07. QUESTIONS RAISED BY GOVERNORS IN RELATION TO MATTERS ON THE AGENDA

The board received a Governor question from K Evenden-Prest related to agenda item 18 and estate concerns in Ripon and it was agreed that a written response would be provided by the Executive Director for Finance, Estates and Facilities and circulated to the board for information. **Action: L Romaniak**

In discussion:

1. It was acknowledged that the Trust had responsibility for working conditions and the board was advised that there would be constraints where accommodation was not owned by the Trust, which would lead to a variation between facilities. The Trust had no access to capital funding beyond that of responding to must do concerns, however a longer-term estates solution was in development and would be available within the year. Fans removed during Covid and were now able to be used.

2. It was noted that the concerns about accommodation had also been raised at a recent leadership walkabout and the General Manager had met with the team and alternative options would be explored.

3. It was highlighted that those involved in the leadership walkabout to Ripon had been impressed by the positive work undertaken by the award winning team.

08. BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

The board received the report, which provided information on risks included in the Board Assurance Framework to support discussion at the meeting.

The Chair proposed that focus be given to those risks with greatest variance to determine where further action that may be required and that any concerns be escalated to the board via the relevant committee.

09. CHIEF EXECUTIVES REPORT

B Kilmurray, L Romaniak and P Scott presented the report, which briefed the board on topical issues of concern and summarised strategic and operational developments since the previous board meeting.

In discussion:

1. Caution was expressed that proposed developments, in addition to government imposed requirements, may distract from core services.

   In response, it was acknowledged that the Trust needed to remain agile to respond to external changes, whilst maintaining operational delivery. It was proposed that the operational framework would provide an opportunity to align effort to agreed priorities and would bridge the gap between the transformation agenda, business as usual activity and business planning, which included an understanding of capability and capacity. It was also noted the Trust had invested in clinical and operational leadership within care groups to give focus to delivery of high quality care and provide support where the external landscape became more complicated.

2. The Chair queried if the opportunity to bridge the gap between business as usual, the Delivery Plan and the transformation agenda had been identified on the risk register and it was confirmed that a risk profile was in development.

3. A query was raised about the wording of the report in relation to the Operating Framework, given the Trust's focus on clinically led and operationally enabled and it was agreed that this would be amended.

The Chair summed up the discussion and proposed that the board would reflect on how it would lead the organisation and maximise opportunities that may become available. He invited executives to reflect on how developments would continue be shared with Non-Executive Directors and how the board would be assured on the balance between bandwidth and focus.

10. INTEGRATED PERFORMANCE REPORT (IPR)

P Scott presented the report, which proposed there was good controls assurance regarding the oversight of the quality of services delivered, good performance assurance regarding the Integrated Performance Dashboard, reasonable performance assurance regarding the national and local quality requirements and reasonable performance assurance regarding waiting times.

The board was advised that paired outcomes would not be identified until discharge, which, based on average length of care, would be two years and that consideration would be given to the collection of outcomes where someone transitioned into an adult service. An Outcomes Steering Group had been established to monitor and report to Executive Directors Group on progress against the improvement plan.

N Lonergan and Z Campbell summarised key challenges for Durham, Tees Valley and Forensic Care Group and North Yorkshire, York and Selby Care Group. In addition to matters reported in the IPR, the board was advised of challenges related to Durham and Darlington crisis gatekeeping where further work would be undertaken internally and with local authority partners aligned to a focus on urgent and emergency care through the Transformation and Delivery Board.

In discussion:

1. L Romaniak drew attention to the 38% reduction in agency price cap breaches since January 2025, with a reduction in annualised premia medical breaches from £3.45m to £1.674m and nursing breaches from £446k to £94k. The Trust had also achieved the lowest level of temporary staffing in February 2025 at 5.4% supported through an increase in permanent staff. She welcomed the contribution of all staff to support the reported position.

2. It was agreed that, whilst the report provided assurance, it would be important to maintain a focus on the impact on quality during a period of financial challenge.

3. A concern was raised that organisational pressures on the ICB and local authorities may impact on positive work to reduce waiting times for those clinically ready for discharge and it was noted that there was support from the Integrated Care Board, who had identified this as a priority area. It was proposed that this support would provide a stimulus for further closer working and collaboration with the ICB to shape the future direction of services and focus on key challenges.

4. The board was advised of a visit to HMP Hull, where there had been a significant improvement in the staffing position.

5. N Black welcomed consideration given by care groups to the use of technology to support continued innovation.

6. The board welcomed the granularity and detail provided in the report and it was noted that the 2023 CQC inspection had highlighted the board's knowledge across a range of issues from floor to board. It was agreed that, whilst the report was award winning, there was an opportunity for further improvement to support a focused discussion on key challenges, action taken and impact and to address variation in narrative and provide wider context. Caution was expressed that a streamlined IPR should not lose sight of what the Trust did well.

   The board was advised that the Interim Deputy Chief Executive would lead a small task and finish group to develop an outline proposal to further develop the IPR based on metrics linked to access, flow, impact and experience, for discussion at the next meeting.

7. It was also suggested that consideration be given to refinement of other board papers and proposed there was an opportunity for the board to operate with improved level of confidence and receive reports that provided focused information, in the context of scrutiny, oversight and governance in place through Executive Directors Group.

Agreed: *there is good controls assurance regarding the oversight of the quality of services delivered, good performance assurance regarding the Integrated Performance Dashboard, reasonable performance assurance regarding the national and local quality requirements and reasonable performance assurance regarding waiting times.*

11. CORPORATE RISK REGISTER

B Murphy presented the report, which proposed there was good assurance on the management of risk and oversight of organisational wide risks that were rated as high in the Corporate Risk Register.

In discussion:

1. N Black noted work undertaken to review digital and data risks and to document controls and actions needed to reduce the risk level.

2. J Maddison, Chair of Audit and Risk Committee, welcomed the progress made to embed risk management with oversight from the executive team and he supported the proposal that were was good assurance.

12. OUR JOURNEY TO CHANGE DELIVERY PLAN 2024/25 QUARTER 3

P Scott and C Lanigan presented the report, which provided an update on delivery of priorities that made up Our Journey to Change Delivery Plan in quarter 3 of 2024/25, the improved position at quarter 4 and future developments within the context of Our Journey to Change: The Next Chapter.

In discussion the board was also advised that the Trust had secured £1.2m of national capital investment for additional photo voltaic equipment at Ackland Road Hospital and Roseberry Park Hospital.

[H Crawford and N Black left the meeting]

13. OUR JOURNEY TO CHANGE: THE NEXT CHAPTER

C Lanigan presented the report, which recommended the wording of Our Journey to Change: The Next Chapter, for approval.

B Kilmurray proposed the revision represented a more ambitious and confident position for the Trust and he recommended it to the board for approval. He also commented on the robust process undertaken and welcomed the leadership provided by P Scott, A Bridges and C Lanigan.

In discussion:

1. Executive directors were invited to reflect on: the achievements outlined, which may underplay the Trust's role as a good partner; potential to strengthen the mission statement; and the removal of 'recognising and celebrating' from the Trust values.

2. Caution was expressed about the inclusion of an objective related to providing a timely response, and the Chair confirmed that the board had previously identified this as an ambition, which would be measured through the Integrated Performance Report.

3. A Bridges confirmed a communications plan would be developed and she noted the board agenda included a progress report on delivery of the Communications Strategy.

Agreed: *the wording of Our Journey to Change: The Next Chapter, subject to reflection on comments raised at the meeting.*

14. REPORT OF THE CHAIR OF THE QUALITY ASSURANCE COMMITTEE

J Preston presented the report and summarised the key areas of discussion at the committee meetings held on 3 April and 6 March 2025.

The board was advised that committee would receive a further report on section 17 leave and had noted consistent improvement across NYYS Care Group and adult mental health

services in DTVF Care Group. There would continue to be a focus on older adult services in DTVF Care Group to ensure leave was planned safely.

It was also noted that committee had been advised of an improvement in relation to use of 136 suites for patients who waited to be admitted to an inpatient unit. Whilst the report was not mandatory, it provided an understanding of the impact of high occupancy and on patient experience.

Assurance was provided that Executive Directors Group was sighted on concerns related to a perinatal team within NYYS Care Group and that the executive clinical triumvirate met regularly to maintain oversight of quality risks and to monitor improvement. The Trust had also engaged with and received support from the ICB in relation to clinical supervision and training.

15. COMMUNICATIONS UPDATE

A Bridges presented the communications dashboard, which provided examples of activity against agreed communication objectives and outlined key pieces of work and media and online activity. She advised that future reports would be provided to Executive Directors Group and Resources and Planning Committee to provide assurance prior to the board.

[H Crawford and N Black rejoined the meeting]

The board was advised that the dashboard had been shared with the CQC and attention was drawn to a member of staff who had won the Learning Disability Nurse of the Ward, a film commissioned by the Trust of a family impacted by suicide to support staff training, and a young woman impacted by suicide who had shared her lived experience with the Trust and had gone on to study to become a mental health nurse.

16. REPORT OF THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE

J Preston, Chair of the Charitable Funds Committee, presented the report and summarised the key areas of discussion at the committee meeting held on 3 March 2025. He reminded colleagues that the board was the corporate Trustee of the charity.

In discussion:

1. Committee was invited to consider how the profile of the funds would be raised and the board was advised that committee had discussed the creation of a fixed term post to establish governance arrangements prior to development of a fund identity, fundraising opportunities and a digital platform for donations.

2. J Preston advised that he and A Bridges attended a regional group, where there had been an initial focus on health inequality, which included repurposing laptops to support access to services.

17. BOARD ASSURANCE FRAMEWORK

It was agreed that there were no matters arising from the discussion at the meeting that changed the position outlined in the Board Assurance Framework.

18. LEADERSHIP WALKABOUTS

A Bridges presented the report, which provided high-level feedback from leadership walkabouts that took place in February and March 2025 and provided assurance that the report and action logs from visits were considered and monitored by Management Group.

19. EXCLUSION OF THE PUBLIC

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

On conclusion of confidential business, the meeting ended at 3.22pm

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Board of Directors
Public Action Log

RAG Ratings:

	Action completed
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Board.
	Action outstanding and the timescale set by the Board having passed.
	Action superseded
	Action in progress & date for completion of action not yet reached

Changes since the last board meeting are provided in bold

Date	Minute Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
10/10/2025	118	Transformation Programme	It was requested that a summary be provided to Quality Assurance Committee on each theme of the transformation programme, linked to the Integrated Performance Report/Board Assurance Framework and assurance to be provided to the Board.	P Scott	May-25	in progress	Dec24 update: TSB reported to Resources and Planning Committee in Dec24. Feb25: Report to be provided to Quality Assurance Committee in March 2025 - assurance to be provided to the Board via the committee report. **Jun25 update: P Scott will reframe the action to support a rounded conversation on quality assurance and oversight of the programme for discussion at the next Quality Assurance Committee development day. Board is recommended to close the action.**
10/04/2025	**7**	**Governor question - estates**	**LR to provide a written response to K Evenden-Prest and circulated to the board for information.**	**L Romaniak**	**Jul-25**	in progress	**Jun25 update: site visit has been arranged.**

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Tees, Esk and Wear Valleys NHS Foundation Trust

Board Meeting June 2025

Interim Chair's Report

Interim Chair

I was appointed as Interim Chair formally by the Council of Governors on 12th May 2025. I am delighted to support the Trust in any way I can as we commence a recruitment process for a substantive Chair in due course.

I wish to pay tribute to and offer my thanks on behalf of the Board to our previous Chair, David Jennings stood down for personal reasons in May.

I would like to thank David for his dedication and belief in our improvement programme, Our Journey to Change, aimed at addressing how we work better with our patients and carers, our staff and being a better partner. We wish him well for the future."

Appointment of our new Chief Executive Officer

I had the privilege to chair the formal interview panel for the appointment of our new CEO on 9th May 2025. After a thoroughly rigorous selection process, I am delighted that Alison Smith, currently Deputy CEO at Avon and Wiltshire Mental Health Partnership accepted our offer. We look forward to welcoming Alison into our organisation in early September. I would like to thank everyone who took part in the process, and in particular, colleagues, service users, carers, our governors and partners who supported our stakeholder groups. Along with myself as panel chair, I was gratefully supported by:

Jules Preston, Senior Independent Director

Gary Emmerson, Lead Governor

Fiona Edwards, Regional Director for North East and Yorkshire, NHS England

Sam Allen, Chief Executive Officer, North East and North Cumbria, Integrated Care Board

Roisin Fallon Williams, Chief Executive Officer, Birmingham and Solihull Mental Health NHS Foundation Trust (Technical Expert)

The appointment was ratified by our Governors via a Special Council of Governors Meeting on 12th May 2025.

Alison will start with the trust in September, and Patrick Scott has kindly agreed to remain as interim chief executive until then.

Thank You to Governors

On behalf of the Board, I would like to formally thank our Governors who have completed their terms of office on our Council of Governors. Their dedication and commitment is admirable and appreciated. Particular thanks to:

Hazel Griffiths, Public Governor, North Yorkshire (9 years)

Graham Robinson, Public Governor, Durham (8 years)

Jean Rayment, Public Governor, Hartlepool (11 years with 1 break in service)

The 2025 election results will be published on Friday 20th June 2025

External Meetings of Interest

- Mental Health and Learning Disability Chairs Meeting with Penny Dash, NHS England Chair on 24th May
- NHS England Regional Director, Fiona Edwards held a Chairs and CEO call on the 23rd May.
- Humber and North Yorkshire Chairs and CEO meeting with John Lawlor on 12th May

Internal Meetings of Interest

- Several meetings with fellow Non-Executive Directors
- Meeting with the Interim CEO
- Meeting with the Lead Governor
- NEDs briefing session on the Annual Accounts 2024/25
- Trust Board Nomination and Renumeration Committee
- CoG Nomination and Renumeration Committee (planning meeting)
- North Yorkshire, York and Selby Locality Governor Meeting

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: Board of Directors
Date: 12 June 2025
Title: Chief Executive's Public Report
Executive Sponsor(s): Patrick Scott, Interim Chief Executive
Author(s): Patrick Scott

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
2	**Demand**	There is a risk that people will experience unacceptable waits to access services in the community and for an inpatient bed caused by increasing demand for services, commissioning issues and a lack of flow through services resulting in a poor experience and potential avoidable harm.

Executive Summary:

Purpose: A briefing to the Board of important topical issues that are of concern to the Chief Executive.

Proposal: To receive and note the contents of this report.

Overview: A Range of topics to update the board

Prior Consideration and Feedback n/a

Implications: No additional implications.

Recommendations: The Board is invited to receive and note the contents of this report.

Recruitment of Interim Executive Director of Transformation and Strategy
I would like to inform the Board of the appointment of Kathryn Ellis to the above post on a 6 month contract to provide additional capacity into the Executive team during my interim CEO role.

Kathryn is a strategic and transformation-focused senior leader with over 15 years of Board-level experience in NHS provider and ICS/system leadership roles, across both permanent and interim positions. Specialising in strategy, performance, governance, and large-scale transformation, she has successfully driven improvement and integration across NHS providers, commissioners, and multi-agency partnerships at ICS and Regional Collaborative levels. Kathryn has landed well within the team and Trust and will be leading work to develop and implement the Operating Framework which I have sighted Board colleagues on previously, develop the governance required to support the delivery of the next iteration of the Transformation agenda as well as providing leadership into the deputy CEO portfolio.

ICB and National Agenda
We are still anticipating that the NHS 10 Year Plan will be published soon – probably in July. We know that this will be based around the "3 Shifts", that is:

- Treatment to prevention
- Care in Hospital to Care in the Community
- Analogue to Digital

I welcome the discussion in the media about potential funding for new services for people experiencing mental health crisis. We are working with partners to explore and influence the shape and focus of this initiative.

We are engaging with our two integrated care boards and place leadership teams as they work through how they are going to implement the national ICB blueprint by the end of December. There will be changes in the structure and function of ICBs. This will mean we will need to think about how we work alongside ICBs to support strategic commissioning and collaborative delivery. I'm working with other system chief executives and senior officers to think though how we can all play our part in making the new arrangements work well.

All age Neurodevelopmental (Autism and ADHD) assessments
Board members will be aware that the surge in demand for Autism and ADHD diagnosis has led to an increase in waiting times. This is a national issue. In NENC, our Medical Director is co-chair of a working group looking into possible options for the future. We are working closely with CNTW to agree a joint position to strengthen our influence on future commissioning and investment in this area.

In Humber North Yorkshire the existing provider collaborative developed a proposal which will now be reviewed following discussions by provider chief execs. TEWV operational managers were involved in the development of this. Of course, ADHD and Autism diagnosis for adults is currently commissioned from the independent sector, not from us, but there are still issues about how we prioritise and ensure safety for children and young people seeking a diagnosis.

Quality Board

On 29/05/2025 NHSE confirmed we are out of mandated quality oversight and the CQC endorsed this stating they work well with the Trust and are kept informed of issues of importance. This is an important milestone for the Trust and reflects significant progress that has been made over the past 3 years due to the efforts of all staff across corporate and clinical services. We are considering how we might want to mark and recognise this achievement across and out with the Trust.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12th June 2025**
Title:	**Board Integrated Performance Report as 30th April 2025**
Executive Sponsor(s):	**Kathryn Ellis, Interim Executive Director of Transformation & Strategy** **Naomi Lonergan, Interim Managing Director, Durham, Tees Valley & Forensic Care Group** **Zoe Campbell, Managing Director, North Yorkshire, York & Selby Care Group**
Author(s):	**Sarah Theobald, Associate Director of Performance** **Ashleigh Lyons, Head of Performance**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	Safe Staffing	There is a risk that some teams are unable to safely and consistently staff their services caused by factors affecting both number and skill profile of the team. This could result in an unacceptable variance in the quality of the care we provide, a negative impact on the wellbeing and morale of staff, and potential regulatory action and a lack of confidence in the standard of care.
2	Demand	There is a risk that people will experience unacceptable waits to access services in the community and for an inpatient bed caused by increasing demand for services, commissioning issues and a lack of flow through services resulting in a poor experience and potential avoidable harm.
4	Quality of Care	There is a risk that we will be unable to embed improvements in the quality of care consistently and at the pace required across all services to comply with the fundamental standards of care; caused by short staffing, the unrelenting demands on clinical teams and the lead in time for significant estates actions resulting in a variance in experience and a risk of harm to people in our care and a breach in the Health and Social Care Act.
5	Digital – supporting change	There is a risk of failure to delivery Our Journey To Change goals, organisational and clinical safety improvements, caused by the inability to fully deploy, utilise, and adopt digital and data systems.
6	Estates/Physical Infrastructure	There is a risk of delayed or reduced essential investment caused by constrained capital resources resulting in an inability to adequately maintain, enhance or transform our inpatient and community estate, adversely impacting patient

		and colleague outcomes/experience.
8	Quality Governance	There is a risk that our floor to Board quality governance does not provide thorough insights into quality risks caused by the need to further develop and embed our governance and reporting including triangulating a range of quality and performance information resulting in inconsistent understanding of key risks and mitigating actions, leading to variance in standards.
9	Partnerships & System Working	There is a risk that failure to take a proactive role and engage effectively with partners caused by capacity challenges including spanning 2 ICSs and multiple local authorities limits our ability to influence service transformation and improve the health of the communities we serve.
10	Regulatory Compliance	There is a risk that failure to comply with our regulatory duties and obligations, at all times, could result in enforcement action and financial penalties and damage our reputation.
12	Financial Sustainability	There is a risk that constraints in real terms funding growth caused by government budget constraints and underlying financial pressures could adversely impact on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing
13	Public Confidence	There is a risk that ongoing external scrutiny and adverse publicity could lead to low public and stakeholder perception and confidence in the services we provide

Executive Summary:

Purpose: The Board Integrated Performance Report (IPR) aims to provide oversight of the quality and performance of Trust delivery, providing assurance to the Board of Directors on the actions being taken to improve performance in the required areas.

Proposal: The Executive Directors Group are proposing that Board of Directors receives this report with:

- **Good controls assurance** regarding the oversight of the quality of services being delivered
- **Good performance assurance** regarding the Integrated Performance Dashboard (IPD)
- **Reasonable performance assurance** regarding the National and Local Quality Requirements
- **Reasonable performance assurance** regarding Waiting Times however, recognising we have limited assurance about the quality impact on those patients who are waiting to access our services which Quality Assurance Committee are actively monitoring.

Whilst there is no change in the levels of control and performance assurance this month, Board is asked to note the positive changes outlined in the report below.

Overview: EDG discussed the IPR at the Integrated Performance and Quality meeting late May, in line with the performance management framework. The discussion focused on the areas of concern identified within this report which are outlined below.

Controls Assurance

Our Integrated Performance Approach (IPA) enables us to have **good** oversight (i.e. controls assurance) of performance, by monitoring and reporting key measures that demonstrate the delivery of the quality of services we provide. The IPR is discussed and approved each month at Care Group level and then at Trust level by the Executive Directors Group and bi-monthly, is reported to the Board of Directors to provide assurance that the Trust is continuing to deliver operationally. Whilst we have robust controls in place, there is some slippage in timescales for a small number of measures and a small number of outstanding improvement actions.

Performance Assurance

As part of the transition to a new financial year, and following standard practice, we have removed 2022/2023 data from all Statistical Process Control (SPC) charts and recalculated these from 2023/2024. To ensure integrity of our analysis and use of SPC, we have reviewed all those measures that have changed and can confirm the changes in variation and/or assurance are because of substantive change in performance levels.

Integrated Performance Dashboard (IPD)

The overall **good** level of **performance assurance** for the IPD has been underpinned by the Performance and Controls Assurance Framework, which demonstrates 21 measures (68%) with good or substantial assurance.

We have a positive shift in assurance (from one of concern to no

significant change) from the previous month's period for several measures:

- CYP Prom
- Bed Occupancy
- Unique Caseload

We have positive assurance (special cause improvement and achieving standard, where relevant) in relation to the following measures:

- Percentage of CYP showing measurable improvement following treatment - clinician reported
- Inappropriate Out of Area Placements (OAPs)
- Staff Leaver Rate and Staff in post with a current appraisal.
- Cash Releasing Efficiency Savings (CRES) Performance – Non-Recurrent as we are ahead of plan by £1.7m.

At the April Board of Directors meeting, there was discussion about the positive assurance we now have regarding the collection of outcomes. To confirm, the analysis showed that collection rates for current caseloads are increasing; however, as some patients have very long journeys, improvements in paired rates will not be visible until the point of discharge (approximately 70% of patients will be discharged within 2 years).

There are a small number of measures, previously identified as an area of concern, that we want to highlight are no longer showing as a concern in the SPC charts, however, we are advising continue to be a focus for improvement.

- **Outcomes: CYP and Adults & Older Persons PROMs -** The Trust-wide Clinical Outcomes Improvement Plan is progressing (*see item below*), and Care Groups continue to progress local improvement actions.
- **Bed Occupancy** - The Urgent Care Programme Board continues its focused work, and an OPEL framework is being developed at Care Group and Specialty level to support improvement actions. To support ongoing oversight of bed occupancy, EDG are recommending that we also report the split of this measure (which combines adult and older adult wards) and report for adults and older adults separately.
- **Agency Price Cap Compliance** - Most price cap breaches relate to medical locum or prison mental health nursing cover for hard to fill vacancies. To address this, we have developed a Performance Improvement Plan. Restrictions on who can fill the post means we will continue to see some breaches until we have completed recruitment, but we are seeing a reduction in breaches.

The actual areas of concern are as follows:

- Whist bed occupancy is not identified as an area of concern, we remain concerned about **patients classified as clinically ready for discharge**. At Trust level (both Care Groups) patients classified as clinically ready for discharge equated to an average of 35.4 Adult and 26.7 Older Adult beds in April 2025, with an associated direct cost of c.£0.65m (including £0.026m independent sector bed costs). Of the cost, c.£0.37m relates to Adult and c.£0.28m relates to Older Adult. A combined level recorded being 16.8% of adult and older adult bed capacity for the period.
- **Mandatory & Statutory Training –** Whilst we are achieving the standard, we remain concerned and continue to focus on the face-to-face training compliance of individual courses below the 85%

standard. There are weekly oversight meetings reviewing compliance in both Care Groups and the Business Managers are working with Training colleagues to reduce DNAs and wasted spaces with a specific focus on ILS and positive and safe training. Whilst Autism is currently not part of the mandatory and statutory training measure as there is a long-term plan to train all staff, there has been an improvement in compliance within the Durham, Tees Valley & Forensic Care Group. EDG identified further assurance was required and it was agreed to review levels of compliance and assurance on improvement actions with a specific focus from a quality and safety perspective which would be reported to People & Culture. The Training and Education Task Group will also review the courses that appear in the mandatory and statutory framework, outside of those that we have focussed on initially, to understand issues driving lower compliance, develop an action plan and report back to EDG in 3 months.

- **Financial Plan: SOCI - Final Accounts - Surplus/Deficit -** The plan for 2025/26 has several risks, with a challenging savings programme and large savings associated with reducing temporary staffing and controlling staff numbers. To support this, Vacancy Control Board principles have been tightened, and Care groups are implementing local vacancy boards to review staffing requests across their remit, and opportunities to fill positions in a different way, or by reallocating staff. The Temporary Staffing and Overtime Subgroup has gained agreement for additional controls on overtime, expansion of staff banks and restrictions on agency usage which will be implemented over the next few months.
- **CRES Recurrent** - The Efficiency Hub oversees the delivery of CRES, supporting early interventions should any schemes fall off track and identifying mitigating schemes and/or new schemes for development. The Hub will co-ordinate and collate trackers for each scheme, receive exception reports, signpost/support on those schemes at risk, and in turn report into Financial Sustainability Board. 2025/26 plans are being developed, with milestones for actions and QIA reviews being planned. There are challenging reductions in temporary staffing costs, which are under-delivering in April, and further work is required to reduce the risk of schemes and explore mitigating actions. Overperformance on non-recurrent schemes is mitigating the recurrent schemes under-performance. EDG received a presentation on last year's delivery of CRES and this year's plan and approach with targeted actions for senior leaders to accelerate scoping and delivery of plans. There is a trust-wide event planned in early July to discuss CRES plans and opportunities for identification and delivery of transformational changes that will support long term quality improvement and efficiency.

In relation to the Trust-wide Clinical Outcomes Improvement plan, there were 4 actions due to completed by end of March 2025 which were not completed. EDG approved extensions for 2 actions and the remaining 2 require new timescales.

National Quality Requirement and Mental Health Priorities

Whilst the National Quality Requirements have remained unchanged for 2025/26, there are several changes to the Mental Priorities which include 2 new measures which are highlighted in the IPR (Average length of stay and people accessing Individual Placement and Support).

The overall **reasonable** level of **performance assurance** for the National Quality Requirements and Mental Health Priorities has been underpinned by Statistical Process Control Charts, which demonstrates **69%** of

measures are achieving standard. We have then analysed each measure in more detail to determine the areas of positive assurance and actual areas of concern.

We have positive assurance (achieving standard) in relation to the following measures:

- 72-hour follow up
- EIP Waiting Times
- Talking Therapies waiting times (6 and 18 weeks)
- Active OAPs (inappropriate).

The actual areas of concern are as follows:

- **Average Length of stay for Adult acute beds** – we have not achieved plan which has been partly impacted by patients who are clinically ready for discharge being delayed.

- **Talking Therapies Reliable Improvement** (County Durham) The Trust-wide Task & Finish Group have developed a Trust-wide action plan, which is being taken through each Care Group Board in May 2025 and will be presented to EDG as part of a focused discussion in May. The Care Group also have a service recovery plan with actions being progressed. A quality impact assessment is being undertaken prior to an 'opt-in' process being implemented in June 2025. This may have an initial impact on the recovery measure as some patients may opt out; however, this should recover longer term with those people remaining in the service being committed to engage.

- **Specialist Community Perinatal Mental Health Services** (North Yorkshire & Vale of York) – The Perinatal teams are continuing to be supported with a service recovery plan. There are several key mitigating actions in place to support improvement including support from the wider Multi-Disciplinary Team for care co-ordination and implementation of a Band 5-6 run through post. In addition, the capacity and demand work has concluded the current staffing is a material factor to meet demand and achieve national targets. Quality Assurance Committee are fully sighted on all underlying issues and actions within the Perinatal Service and monthly meetings are in place with the ICB to ensure system oversight. It should be noted that whilst below the target, there is special cause improvement indicated in the SPC charts.

- **CYP 1 contact** (North Yorkshire and York combined due to changes in GP practice boundaries in 24/25). Section Head of Research & Statistics, Clinical Outcomes and Business Analytics to undertake further analysis of re-referrals to support the identification of improvement actions. This work will be completed by end of June 25.

<u>Waiting Times</u>

The overall **reasonable** level of **performance assurance** for Waiting Times has been underpinned by Statistical Process Control Charts; however, we recognise we have limited assurance about the quality impact on those patients who are waiting to access our services which Quality Assurance Committee are actively monitoring. We have then analysed each measure in more detail to determine the areas of positive assurance and actual areas of concern.

We continue to have positive assurance for **Adult Learning Disabilities Assessment**; however, whilst we have several additional waiting time

measures indicating special cause improvement (i.e. a reduction in the number waiting), we still have more patients waiting, some with a much longer wait, than we would like. We continue to maintain oversight of our patients waiting via the following processes:

- Weekly waiting time reports for EIP and Child Eating Disorder services and monthly waiting time reports for all remaining services. These are overseen by each speciality and include the numbers of people waiting, the time bandings for the waits, the reasons for the longest waits including any planned next appointments. Waiting Times are reviewed weekly within the Care Groups and monthly by both Care Group Boards.

- Within CYP, AMH and MHSOP services we have a Keeping In Touch (KIT) process for all patients that are waiting that keeps contact with the patient and/or their family and supports them with initiating escalation based on need. Within Durham and Tees Valley CYP services, we are also working with system partners to develop a waiting well offer.

The actual areas of concern are:

- **Waiting for neurodevelopmental assessments (Children & Young People and Adults)**

  Durham and Tees Valley

  The Trust is now in advanced discussion with CNTW and the ICB on short- and medium-term actions to reduce demand and longer waiters; a joint paper will be taken to the May Executive Management Group. Following the approval of the specification for the alternative, accredited private providers, the ICB have identified funding to send a small cohort of patients as an initial pilot phase. Work is now underway to identify the patients for that first cohort and timescales will be agreed by the end of May 25. The ICB have commenced training across the Tees Valley footprint to support an increased understanding of neuro developmental concerns and the graduated response, with the aim of supporting a reduction in request of assessments. In addition, a well-functioning multi-disciplinary panel will be re-established to support access to the service.

  CYPS – have a recovery plan in place. Phase 2 testing on dual assessments continues in Darlington; however, this has been impacted by staff vacancies and the full evaluation of the clinical protocol is now due to be completed by the end of June 2025 (previously April 25). All actions within the recovery plan are progressing however demand currently continues to outweigh capacity. The trajectory submitted to NENC ICB, factoring in the additional assessments, remains on track for delivery.

  Adults – the service continues to maximise assessment capacity with weekly oversight by the Care Group. The current KIT process has been redesigned as part of the restructure of community services which will align to the process in CYP and CNTW with implementation planned for 1st April 2025. The first meeting of the all-age neurodevelopmental steering group is scheduled for the 30th May 2025 where Terms of Reference will be agreed. This group will lead and oversee work internally and align with the work externally, across our respective ICB areas and for this group to align to the Community Transformation Programme Board.

  The trajectory submitted to NENC ICB, factoring in the additional

assessments, is not on track. Delivery of the trajectory has been impacted by several factors: issues with the accuracy of data following the electronic transfer of patients from community teams to the new neurodevelopmental teams; CITO issues in relation to referrals and robust validation of the waiting list. The General Manager will undertake further analysis to better understand the increase in the waiting list in April to inform next steps.

North Yorkshire & York

The service continues to engage with commissioners, Humber & North Yorkshire ICB and the Provider Collaborative regarding capacity within our CYP services versus demand and the subsequent impact on waiting times. The ICB has set up a working group in relation to 'Right to Choose' which is looking at aligning assessment pathways across providers. The scope of this work is significant and whilst progressing, at this stage timescales cannot be confirmed.

CYPS - Within Selby and York, work is now underway with Strategic Planning and Finance to explore the impact of the proposed model for the assessment and treatment of neurodevelopmental conditions, following which the group will consider whether the option to share resources to improve the patient journey and capacity is viable. The viability of the proposal will be concluded by end of May 2025.

The Scarborough ADHD team has a recovery plan in place. The service have recruited to all vacant posts and overtime is being offered to staff, and they are working to ensure that they are using their existing resources efficiently and effectively to identify any remaining efficiencies by the end of June 2025 and shared through governance meetings by end of July 2025. Whilst some improvement can be made, the demand outstrips the capacity of the service.

- **Adults waiting for their second contact with Talking Therapies**

  The Trust-wide Task & Finish Group has developed an improvement plan which will be taken to each Care Group Board during May prior to being presented as a focused discussion at Executive Directors Group later that month. In addition, DTVFCG have a service recovery plan with actions being progressed. A quality impact assessment is being undertaken prior to an 'opt-in' process being implemented in June 2025. It is anticipated this will increase capacity as those who have opted out will be removed from the waiting list, enabling those people who want to remain with the service to 'move up' the waiting list and be seen timelier.

Prior Consideration and Feedback

The individual Care Group IPRs have been discussed and approved by the Care Group Boards and the Board IPR has been discussed and approved by Executive Directors Group prior to Board of Directors.

Implications:

The Integrated Performance Report (IPR) is a fundamental component of our Board Assurance Framework. The implications of those measures with limited performance assurance and negative controls assurance and those where we are failing to achieve National and Local Quality Requirements impact on:

- Safe Staffing
- Demand
- Quality of Care
- Digital – supporting change
- Estates/Physical Infrastructure

- Quality Governance**
- Partnerships & System Working
- Regulatory Compliance
- Financial Sustainability
- Public Confidence

The introduction of any new Electronic Patient Record has a negative impact on Data Quality. Following the introduction of Cito in February 2024, data quality issues have impacted several patient-based measures across the organisation. Following discussion at Executive Directors Group it has been agreed with the Chief Information Officer (CIO) that the Performance Team pull together a list of all the known data quality issues across the IPRs, including any intelligence gathered about the issues/actions. This was complete by end of April and shared with both Care Group Boards and with the CIO for review and guidance. In addition, the key care group meetings where data quality is routinely discussed have been identified so the CIO can potentially identify a "Cito Clinical Specialist" to attend and participate with staff. **There will be a focused discussion at Executive Directors Group in June (originally planned for May) on data quality issues impacting the IPR.

They could also affect the Trust's ability to manage relevant risks to target level in accordance with agreed trajectories.

Recommendations: The Board of Directors is asked to:

- either confirm that there is good controls assurance on the operation of the Performance Management Framework; good performance assurance on the IPD and reasonable performance assurance on the National Quality requirements/Mental Health Priorities and Waiting Times and that the strategic risks are being managed effectively; or
- identify the levels of assurance it considers to be appropriate; the reasons for this; and any corrective measures/improvements it considers should be put in place.
- discuss and approve EDG's recommendation to also report the split of bed occupancy (which combines adult and older adult wards) and report for adults and older adults separately.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

For the period ending 30th April 2025

Report produced by: Laura Wheater, Performance Lead and Jane Smith, Senior Performance Manager
Date the report was produced: 30th May 2025

For any queries on the content of this report please contact: Ashleigh Lyons, Head of Performance
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journey to change

CONTENTS

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys
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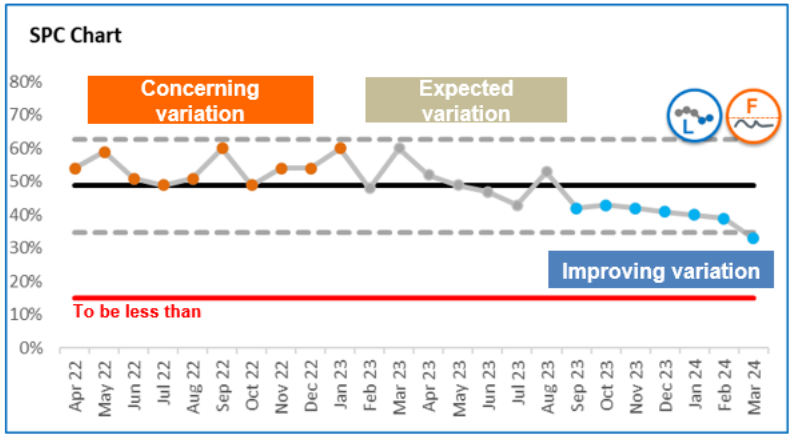
Within our Board Integrated Performance Dashboard we use Statistical Process Control Charts to determine whether we have any underlying causes for concern. A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly). The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented;
Blue – there is a pattern of improvement which should be learnt from;
Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable.



The thick **black** line on an SPC chart is the average.

The dotted (- - - -) lines are the upper (top line) and lower (bottom line) process limits, which describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Our Guide To Our Statistical Process Control Charts: Interpreting summary icons

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These icons provide a summary view of the important messages from SPC charts.

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Our Approach to Data Quality

Tees, Esk and Wear Valleys NHS Foundation Trust

Data Quality

On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The most recent assessment was completed in quarter 3 2024/25. The next assessment will be completed in quarter 1 2025/26.

	Data Quality Assessment		
Icon	***Description***	***What does this mean?***	***What should we do?***
	SUBSTANTIAL assurance; a data quality score of **93% or over**	The measure is reliable.	There is no specific action to take.
	GOOD assurance; a data quality score of **73% - 92%**	The measure is largely reliable; however, there are a small number of improvement actions that need to be undertaken.	**Review** what improvements were identified as part of the assessment and, if possible, take the appropriate action.
	REASONABLE assurance; a data quality score of **47% - 72%**	The measure is reasonably reliable; however, actions are required to improve its construction, data source and/or data.	**Identify** what improvements were identified as part of the assessment and take the appropriate action.
	LIMITED assurance; a data quality score of **46% or under**	The measure is unreliable and there are significant actions required to improve its construction, data source and/or data.	**Investigate** whether the measure is appropriate to be included in the Integrated Performance Report. **Remove** the measure from the Integrated Performance Report to enable improvement actions to be undertaken.

Our Approach to Performance and Controls Assurance

Tees, Esk and Wear Valleys NHS Foundation Trust

Our Performance Assurance

Performance Assurance Rating takes into consideration the Controls Assurance Rating (as per table below), whether we are achieving standard (where appropriate) and any underlying areas of performance.

	Substantial	Good	Reasonable	Limited
	The control is operating effectively in meeting its objective (and managing the associated risk). It is being applied consistently. No remedial action required.	The control is operating effectively in meeting its objective. It is generally being applied consistently. Minor remedial action is required.	The effectiveness of the control in meeting its objective is uncertain. Compliance is variable/inconsistent. Some moderate remedial action is required.	The control is not operatively effectively in meeting its objective. There are low levels of/wide variation in compliance. Immediate and fundamental remedial action is required
Positive	We have Positive Assurance **AND** we are achieving the standard agreed (where relevant)	We have Positive Assurance; **HOWEVER,** we have 1 (or more) underlying areas of concern **OR** we are not achieving standard		
Neutral	We are achieving standard (where relevant); **AND** We have no underlying areas of concern	We are achieving the standard (where relevant) with only 1 area of concern; **OR** There is consistent performance	We have more than 1 underlying area of concern **OR** there is consistent underperformance below the standard	
Negative		We have no underlying areas of concern **AND** there is an improving position visible in the data	We have a small number of areas of underlying concern **OR** there is a deteriorating position visible in the data **OR** performance continues below the mean	We have the Trust and both Care Group/several directorates are all showing a concern **OR** there is a clear deterioration visible in the data **AND** outside the control limits

Our Controls Assurance

Our Controls Assurance is determined based on SPC variance or, where this is not appropriate, using forecast position or national benchmarking data.

Positive	Neutral	Negative
Positive assurance when SPC chart indicates Special Cause Improvement OR • Forecast position is positive • National benchmarking data indicates we are in the lowest (most positive) quartile	Neutral assurance when SPC indicates Common Cause	Negative assurance when SPC indicates Cause for Concern OR • Forecast position is negative • National benchmarking data indicates we are in the highest (least positive) quartile

Glossary of Terms

Tees, Esk and Wear Valleys NHS Foundation Trust

AAR	After Action Review
ADHD	Attention deficit hyperactivity disorder
ALD	Adult Learning Disabilities
AMH	Adult Mental Health
ASD	Autistic Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Services
cCBT	Computerised Cognitive Behaviour Therapy
CRES	Cash Release Efficiency Savings
CROM	Clinician Reported Outcome Measure
CYP	Children & Young People
DNA	Did Not Attend
DTVFCG	Durham Tees Valley and Forensic Care Group
EDG	Executive Directors Group
EIP	Early Intervention in Psychosis
GBO	Goal-Based Outcomes
ICB	Integrated Care Board
ILS	Immediate Life Support
IPD	Integrated Performance Dashboard
IPS	Individual Placement Support
KIT	Keeping in Touch
MHSOP	Mental Health Services for Older People
MoJ	Ministry of Justice
NENC	North East & North Cumbria Integrated Care Board
Neuro	Neurodevelopmental services
NYYSCG	North Yorkshire, York & Selby Care Group
OAP	Out of Area Placement
PaCE	Patient and Carer Experience
PIP	Performance Improvement Plan
PMH	Specialist Community Perinatal Mental Health
PROM	Patient Reported Outcome Measure
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Framework
PWP	Psychological Wellbeing Practitioner
SIS	Secure Inpatient Services
SOCI	Statement of comprehensive income
SPC	Statistical Process Control
STEIS	Strategic Executive Information System
UoRR	Use of Resources Rating
WTE	Whole time equivalent

Board Integrated Performance Dashboard – for the period ending April 2025

NHS
Tees, Esk and Wear Valleys
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Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC		?	92.00%	94.95%	92.00%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	QAC		?	75.00%	73.70%	75.00%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC		?	75.00%	78.11%	75.00%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC		F	35.00%	24.00%	35.00%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC		F	55.00%	46.13%	55.00%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	?	50.00%	58.87%	50.00%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	H	F	30.00%	25.32%	30.00%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC		F	85.00%	95.34%	85.00%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	L			47	
10)	The number of Patient Safety Incident Investigations reported on STEIS	QAC	L			0	
11)	The number of incidents of moderate or severe harm	QAC	L			28	
12)	The number of Restrictive Interventions Used	QAC				843	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				1	
14)	The number of unexpected inpatient unnatural deaths reported on STEIS	QAC				0	
15)	The number of uses of the Mental Health Act	MHLC				320	

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
16)	Percentage of staff recommending the Trust as a place to work	PC&D			60.00%	55.90%	60.00%
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D			65.00%	62.51%	65.00%
18)	Staff Leaver Rate	PC&D	L	?	11.00%	10.21%	11.00%
19)	Percentage Sickness Absence Rate (month behind)	PC&D		?	5.50%	5.41%	5.50%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	H	P	85.00%	89.32%	85.00%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	H	?	85.00%	87.13%	85.00%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
22)	Number of new unique patients referred	S&RC				7,111	
23)	Unique Caseload (snapshot)	S&RC				64,281	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	1,054,000	1,087,382
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	745,000	837,639
25b)	Agency price cap compliance	S&RC	67.00%	55.12%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	1,191,000	397,777
28)	CRES Performance - Non-Recurrent	S&RC	364,000	589,849
29)	Capital Expenditure (CDEL)	S&RC	1,010,000	1,188,270
30)	Cash against plan	S&RC	47,360,000	56,061,077

Board Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

- **Patient and Carer Experience:** there is no significant change for the patient experience, carer involvement and inpatients feeling safe measures. Patient experience and inpatients feeling safe are both achieving standard. There is special cause improvement in the number of responses received for patient experience and carer involvement questions.

- **Outcomes:** in CYP there is no significant change, and we are below standard for the PROM; however, there is special cause improvement for the CROM, and we are above standard. In AMH/MHSOP there is no significant change for the PROM and special cause improvement for the CROM; however, we are below standard for both. Whilst some of the SPC charts indicate special cause improvement, this remains an area of concern as there is special cause concern in the number of timely paired outcomes recorded for all measures.

- **Bed Pressures:** there is no significant change for bed occupancy. There is special cause improvement for the inappropriate out of area bed days, and no active OAPs as at the end of April 2025.

- **Patient Safety:** there is special cause improvement in the number of patient safety incident investigations; however, this is not necessarily an actual improvement, as there was a change in process at the end of January 2024 when the Trust transitioned to the National Patient Safety Incident Framework (PSIRF). There is a reduction (indicated as special cause improvement in the SPC chart) for incidents of moderate or severe harm which looks to align to the new system implementation. There is no significant change for restrictive interventions and medication errors. There were no unexpected inpatient unnatural deaths reported on STEIS during April.

- **Uses of Mental Health Act:** there is no significant change.

- **People:** There is special cause improvement, and we are achieving standard for leaver rate, mandatory training and appraisals; however, there is no significant change in sickness levels, and we are below the standard. Whilst we are achieving the standard for mandatory training, face to face training compliance remains below the 85% standard.

- **Demand:** There is no significant change in referrals, unique caseload and active caseload.

- **Finance:** The Trust's 2025/26 financial plan targets delivery of a break-even position. The financial position to 30th April 2025 is a **deficit** position of £10.087m, which is £0.034m worse than planned for the period. The Trust submitted a breakeven plan for 2025/26 which assumes delivery of a challenging 5.35% £27.41m Cash Releasing Efficiency Schemes (CRES) requirement. CRES delivery in month 1 was below plan, with £0.988m delivered against a target of £1.555m, a shortfall of £567k.

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience -** no significant change in all patient experience measures, however, achieving the standard for patients surveyed reporting their recent experience as good or very good and patients feeling safe. The standard was not achieved for carer involvement. There is no significant change in the responses received for patients rating their experience as good or very good, and patients feeling safe, however, improvement noted in the number of responses received for carer involvement.
- **Outcomes -** special cause concern for CYP for the PROM; however, special cause improvement for the CROM and above standard. There is no significant change in the number of patients discharged with a paired outcome measure. AMH/MHSOP there is special cause improvement in PROM and CROM, but we remain below standard for both. There is special cause concern for the number of patients discharged with a paired outcome measure.
- **Bed Pressures –** special cause improvement in bed occupancy and inappropriate out of area bed days.
- **Patient Safety -** special cause Improvement for patient safety incident investigations and incidents of moderate of severe harm, No significant change for the number of restrictive interventions used, medication errors and for unexpected inpatient unnatural deaths.
- **Uses of Mental Health Act –** there is no significant change.
- **Staff -** for recommending the Trust as a place to work we achieved 53.59% (April 2025 Survey) and for staff feeling able to make improvements we achieved 57.91%. Special cause Improvement in staff leaver rate, mandatory and statutory training and appraisals. No significant change in sickness.
- **Demand -** no significant change in referrals and unique caseload.
- **Finance** The Care Group, planned to spend £22.6m for M1, and actual spend was £23.5m, which is £1.01m more than planned with CRES delivery £0.58m below plan.

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Inappropriate OAP bed days
- People (leaver rate, appraisals)

Risks / Issues*

- Outcomes
- Mandatory and Statutory Training
- Financial Plan

Mitigations

Outcomes: CYP and Adults & Older Persons PROMs – The Trustwide Clinical Outcomes Improvement plan is progressing with most actions on track, or on agreed pause due to the CITO change freeze. 4 actions were due to complete by this point, however requests for extensions to deadline have been made by the action lead responsible. The 4 actions are as follows and the Senior Responsible Officer and Programme Manager will be taking these requests for extension to EDG for formal ratification:

1.Develop Outcomes Dashboards in the IIC.
2.Culture Change: To use data meaningfully at all levels.
3.Migration of historical outcomes data from PARIS into CITO.
4.CYP PROM (Goal Based Outcomes) to flow from CITO into IIC

Mandatory & Statutory Training - Whilst we are achieving the standard, we remain concerned and continue to focus on the face-to-face training compliance of individual courses below the 85% standard. A systematic review of the various training courses has started with Immediate Life support (ILS). Areas for improvement have now been identified, and work has started to progress these. A briefing paper has been shared with all managers and reminders have been sent to those staff that are required to complete the test. Across the Care Group, all specialities continue to utilise a staff tracking list for booking courses and monitoring DNAs. Daily reviews of staffing continue to ensure that the right staff with the right training are in place to respond to any issues that arise, and staff will be moved to ensure we have the right skill mix available on our wards.

Finance - Financial plan
Actions in place include:

- The Care Group General Managers need to revise recovery roadmaps for unfunded posts to address hot spot areas. These roadmaps will be reported via the finance and resource and business development sub groups of the Care Group Board.

NOTE: See individual pages for full details of the improvement actions and expected impact/timescales

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience:** there is no significant change for all patient and carer experience measures. We are achieving standard for Inpatients feeling safe and percentage of Patients surveyed reporting their recent experience as very good or good.
- **Outcomes:** In CYP, there is special cause improvement for both PROM and CROM, we are above standard for the CROM and below the standard for CYP PROM. There is no significant change, and we are below standard in AMH PROM with AMH reporting no significant change and MHSOP reporting special cause improvement. For AMH and MHSOP CROM we are reporting special cause improvement with AMH above the standard, however, MHSOP is reporting below the standard. Overall, there remains concern in the number of timely paired outcomes recorded for all measures. Slides 14-17 highlight the issues that are impacting these measure. Actions to improve performance are in place.
- **Bed Pressures:** there is no significant change for bed occupancy, a change from special cause concern, however MHSOP continues to report special cause concern. Concern continues to be reported for delayed transfers of care in the reporting period for both AMH and MHSOP due to experiencing longer stays within a number of wards, including MoJ restricted patients and pressures resulting from clinically ready for discharge – specifically around accommodation and there being no placements for our patients leading to continuing rise in delayed discharge in the North Yorkshire area.
- **Patient Safety:** there is special cause improvement for patient safety incident investigations; (it should be noted that this is not necessarily an actual improvement, as there was a change in process at the end of January 2024 when the Trust transitioned to the National Patient Safety Incident Framework (PSIRF)). There is no significant change for incidents of moderate of severe harm, and restrictive interventions. There is special cause improvement in the number of medication errors. There were no unexpected Inpatient unnatural deaths reported on STEIS during April
- **Uses of Mental Health Act:** no significant change is reported at Care Group, AMH CYP and MHSOP. ALD continues to report special cause improvement in the reporting period.
- **People:** There is no significant change reported for staff leaver rate, and remaining above standard. There is no significant change for sickness absence, and we are below standard across all specialities. There is no significant change for mandatory training, and above the standard; however, we are aware the face-to-face training compliance is below the 85% standard and understand the reasons for this, actions are in place. There is special cause improvement for appraisals in Care Group, AMH and Management, however they are on a downward trend for the last 3 data points. No significant change is reported for both Adult Learning Disabilities and CYP, with ALD reporting above the standard although CYP is now reporting below the standard.
- **Demand:** There is no significant change in referrals with AMH reporting special cause variation of an increasing nature where up is not necessarily improving nor concerning and caseload is reporting no significant change, We know from the detailed analysis previously undertaken, unique caseload is impacted by the increases in demand and patients waiting for a first contact.
- **Finance:** As in 2024/25, the Trust anticipates significant ongoing pressure on government departmental spending in 2025/26, including for the NHS, meaning we face continued spending restraint. Government, Treasury and NHS England are especially seeking whole time equivalent reductions from the NHS. For us, this means we need to aim to manage back to within budgeted funding levels.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Outcomes for CYP PROM & CROM
- Patient Safety (medication errors)
- People (Appraisals)

Risks / Issues

- Finance (Financial Plan, Agency expenditure, Surplus/Deficit, Agency price cap compliance)

Mitigations

Outcomes

The Trustwide Clinical Outcomes Improvement plan is progressing with most actions on track, or on agreed pause due to the CITO change freeze. 4 actions were due to complete by this point, however requests for extensions to deadline have been made by the action lead responsible. The Senior Responsible Officer and Programme Manager will be taking requests for extension to EDG for formal ratification.

Bed Occupancy

The service continues to be impacted by longer patient stays, including MoJ restricted patients, patients clinically ready for discharge and consultant cover and gaps in leadership posts within inpatient areas. Work is progressing with the leadership team to reduce lengths of stay and delayed transfers of care. Recruitment into leadership posts is ongoing; support is being provided from the senior leadership team. Local Authorities Mental Health Team provision (York) escalation to Director level cross agency meeting regarding attendance at discharge planning meetings.
Trust-wide workstreams are to be established following approval of the merged community transformation and urgent and emergency care boards.
Care groups to work together to develop a Trust-wide clinical model for the MHSOP organic beds base continues with expected completion to be confirmed.
A Trust-wide patient flow workforce model is being developed to create a clearer escalation structure for operational staff both in and out of hours. A paper proposing the plan will be presented to the April EDG; if approved, implementation will be July 2025.

Finance

The Trust has developed an ‘exit run rate-based plan’ for 2025/26. This means that, whilst budgets will be maintained and rolled forward, we will need to deliver, and our performance will be managed in 2025/26 against, the exit run rate based-plan.

NOTE: See individual pages for full details of the improvement actions and expected impact/timescales.

Performance & Controls Assurance Overview

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Controls Assurance Rating	Performance Assurance Rating: Substantial	Good	Reasonable	Limited
Positive	• CYP showing measurable improvement following treatment - clinician reported • Inappropriate OAP bed days for adults that are 'external' to the sending provider • PSII reported on STEIS • Incidents of moderate or severe harm • Staff in post with a current appraisal	• Adults and Older Persons showing measurable improvement following treatment - clinician reported • Staff Leaver Rate • Compliance with ALL mandatory and statutory training		
Neutral	• Patients surveyed reporting their recent experience as very good or good • Inpatients reporting that they feel safe whilst in our care • Restrictive Intervention Incidents Used • Unexpected Inpatient unnatural deaths reported on STEIS • Uses of the Mental Health Act ***Improved performance assurance***	• Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for ***reduced performance and controls assurance*** • Medication Errors with a severity of moderate harm and above ***reduced performance assurance*** • New unique patients referred • Agency price cap compliance ***improved controls assurance*** • Use of Resources Rating - overall score ***improved controls assurance*** • CRES Performance – Non-Recurrent ***improved controls assurance***	• CYP showing measurable improvement following treatment - patient reported ***improved controls assurance*** • Adults and Older Persons showing measurable improvement following treatment - patient reported • Bed Occupancy (AMH & MHSOP A & T Wards) ***improved controls assurance*** • Staff recommending the Trust as a place to work • Staff feeling they are able to make improvements happen in their area of work • Percentage Sickness Absence Rate • Unique Caseload - ***improved performance and controls assurance*** • Financial Plan: Agency expenditure compared to agency ***reduced performance and controls assurance***	
Negative		• Capital Expenditure (Capital Allocation) • Cash balances (actual compared to plan)	• Financial Plan: SOCI - Final Accounts - Surplus/Deficit ***reduced controls assurance***	• CRES Performance - Recurrent

***NOTE**: changes in assurance to the previous month's report are noted in bold.*

01) Percentage of Patients surveyed reporting their recent experience as very good or good

Background / Standard description:
We are aiming for 92% of patients surveyed, reporting their recent experience as very good or good

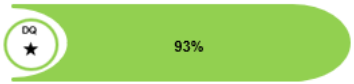
What does the chart show/context:
During April, **1306** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **1240 (94.95%)** scored "very good" or "good".

There is no significant change at Trust and Care Group level in the reporting period; however, there is special cause improvement in the number of patients who have responded to this question at Trust level and for North Yorkshire & York Care Group (Adult Mental Health Services and Children & Young Peoples Services).

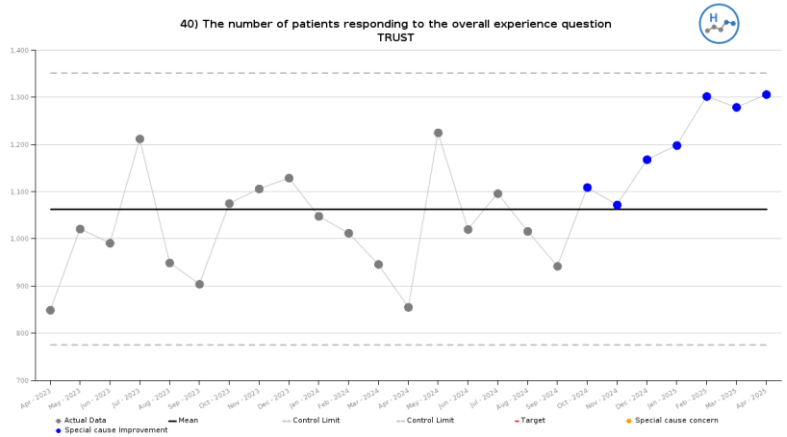
There is no new national benchmarking data available at the time of this report.

Underlying issues:
- Not all wards and teams are routinely facilitating completion of the surveys.

Actions:
- Each month, the Patient and Carer Experience (PACE) team share with the care group leadership teams a list of those wards/teams who have not provided feedback in the month. This is also reflected in the current Quality Assurance and Improvement Group reports to both Care Groups. In addition, the PACE Team use this intelligence to focus on who we see and when, as part of the quality visit programme. *NB. This is standard work for the PACE Team*
- The Patient & Carer Experience Team have procured a new patient experience system, which will increase the methods by which patients can provide survey feedback with a view to increasing response rates. The "I Want Great Care" system will be implemented on 1st August 2025.



The below chart represents the number of patients who have responded to the overall experience question.



02) Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Background / standard description:
We are aiming for 75% of carers reporting they feel they are actively involved in decisions about the care and treatment of the person they care for.

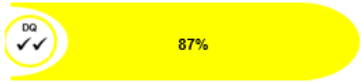
What does the chart show/context:
During April, **559** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **412 (73.70%)** scored "yes, always".

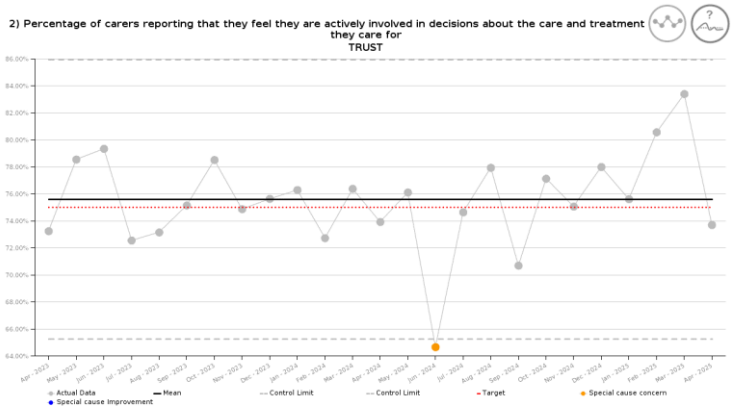
There is no significant change at Trust and Care Group level in the reporting period. There is special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group in the number of patients who have responded to this question. There is special cause improvement for DTVFCG for Adult Learning Disabilities in relation to the overall carer experience question.

Barriers to collecting feedback include:
- Access to and up to date surveys through the various mechanisms
- Up to date carer and team information
- Lack of feedback including display of feedback

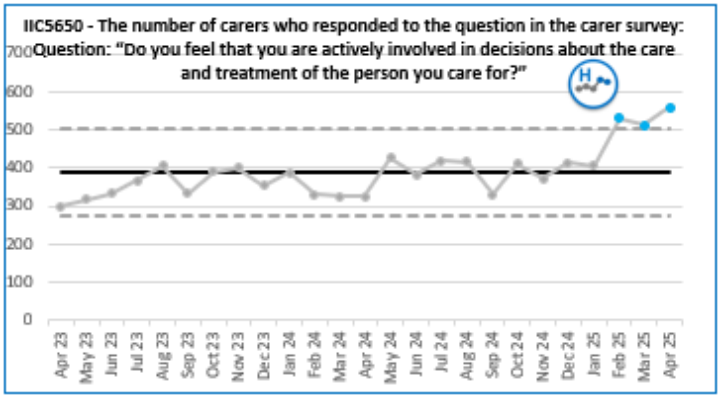
Underlying issues:
- A lack of awareness of the Triangle of Care within Trust Services

Actions:
- The Triangle of Care Principles are being relaunched within both Care Groups; Care Group Directors of Nursing & Quality will provide an update on progress to the PACE Team at the end of May 2025 for the 2024/25 submission to the Carers Trust.





The below chart represents the number of carers that responded to the involvement question.



03) Percentage of inpatients reporting that they feel safe whilst in our care

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 75% of inpatients reporting, they feel safe whilst in our care.

What does the chart show/context:
During April, 201 patients responded to the overall experience question in the patient survey: “During your stay, did you feel safe?”. Of those, **157 (78.11%)** scored “yes, always“ and “quite a lot”.

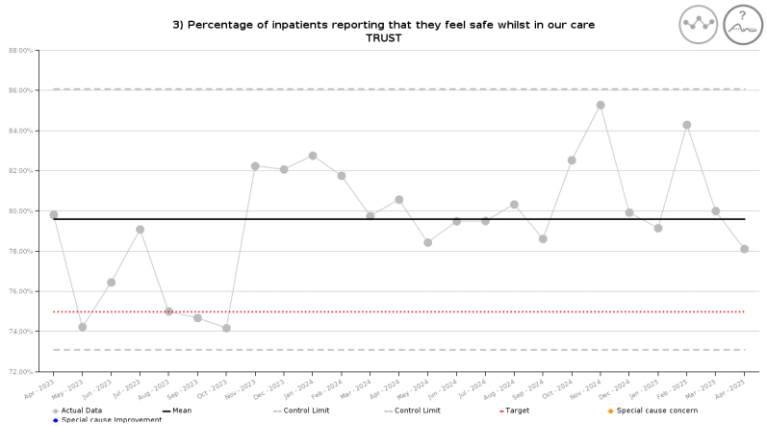
There is no significant change at Trust and Care Group level and in the number of patients who have responded to this question.

There are several factors that can influence whether a patient feels safe, e.g. staffing levels, other patients (including self-harm), environment, the acuity of other patients and violence & aggression and the use of restrictive interventions on wards.

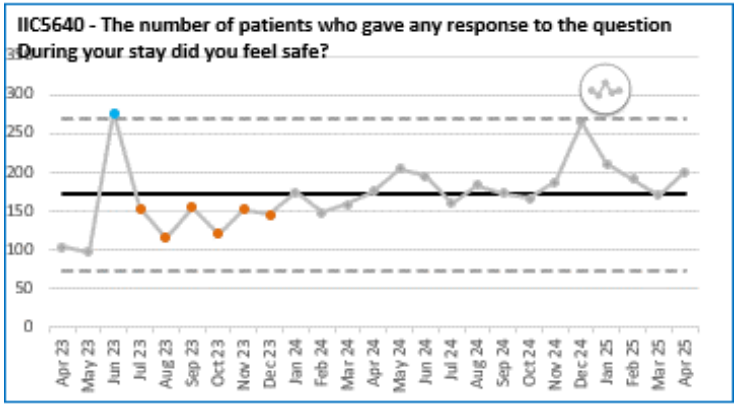
Underlying issues:
There are no underlying issues to report.

Actions:
Whilst there are no specific improvement actions to note, feeling safe on our inpatient wards is one of the core standards of the Culture of Care Programme which we are rolling out as part of the National Inpatient Transformation Programme.

DQ ✓✓ 87%

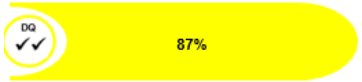


The below chart represents the number of patients that responded to the safety question.



04) Percentage of CYP showing measurable improvement following treatment - patient reported
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported
06) Percentage of CYP showing measurable improvement following treatment - clinician reported
07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



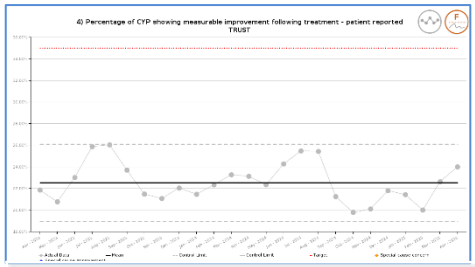
Underlying issues:
There are a range of issues currently impacting the above measures which are outlined in the following pages; however, the following is applicable to all 4 measures.

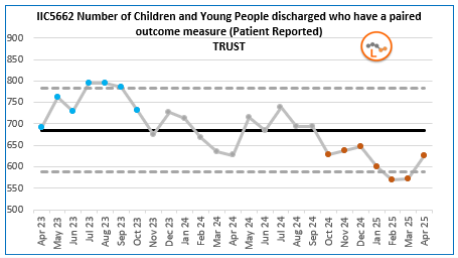
- Analysis shows that collection rates for current caseloads are increasing; however, as some patients remain under our care/treatment for longer periods of time, improvements in paired rates will not be visible until the point of discharge (approximately 70% of patients will be discharged within 2 years).

Actions:
The Trust-wide Clinical Outcomes Improvement plan is progressing with most actions on track or on agreed pause due to the Cito change freeze. Four actions were due to completed by the end of March 2025 which were not completed. There are 2 requests to EDG for extensions to deadline whilst the remaining 2 require new timescales:

1. Development of Outcomes Dashboards in the IIC – An extension to the end of quarter 1 (June 2025)
2. Changing the Culture within the Trust to use data meaningfully at all levels of the organisation - An extension to the end of January 2026 is requested, as the Care Groups have indicated that a culture change will take some time.
3. Migration of historical outcomes data from PARIS into Cito – All reports have been successfully developed and tested and promotion into the live Cito environment is pending Cito Leadership for approval - timescale to be confirmed.
4. CYP PROM (Goal Based Outcomes) to flow from Cito into IIC – The technical work had been completed; however, following a change to the Cito form further work is now required – timescale to be confirmed

04) Percentage of CYP showing measurable improvement following treatment - patient reported





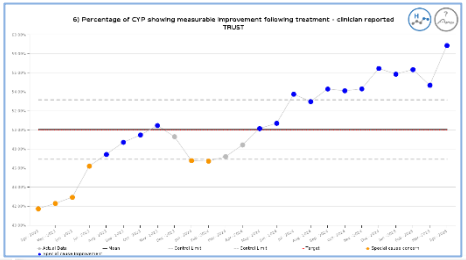
Background / standard description:
We are aiming for 35% of CYP showing measurable improvement following treatment - patient reported

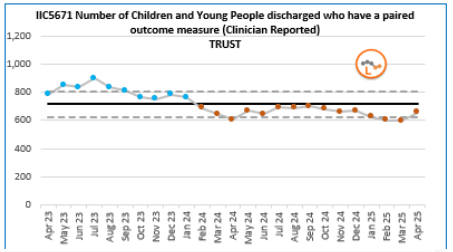
What does the chart show/context:
For the 3-month rolling period ending April, **625** patients were discharged from our CYP service with a patient rated paired outcome score. Of those, **150 (24.00%)** made a measurable improvement.

There is no significant change at Trust level. Special cause concern for Durham, Tees Valley & Forensic Care Group and special cause improvement for North Yorkshire & York Care Group in the reporting period. There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group in the number of patients discharged with a paired outcome measure.

The accepted Patient Rated Outcome Measures are CORS/ ORS/ GBO (goal-based outcomes)/ RCADS/ SDQ/ SCORE-15/ PHQ-9/ GAD-7/CORE-10.

06) Percentage of CYP showing measurable improvement following treatment - clinician reported





Background / standard description:
We are aiming for 50% of CYP showing measurable improvement following treatment - clinician reported

What does the chart show/context:
For the 3-month rolling period ending April, **654** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those, **385 (58.87%)** made a measurable improvement.

There is special cause improvement at Trust and Care Group level in the reporting period, and performance is above standard at all levels. There is special cause concern at Trust and Care Group level in the number of patients discharged with a paired outcome measure.

The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

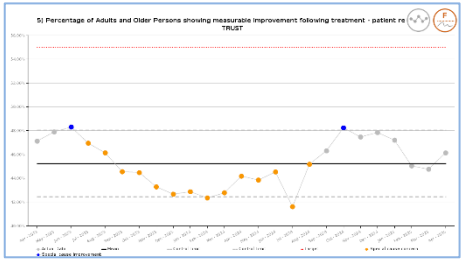
Underlying issues:

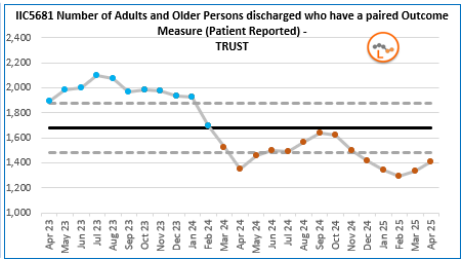
- **PROM only -** this measure currently does not report the full suite of patient-related outcomes as a number of measures do not have a reliable change index, which includes GBO.
- Patients who transition from CYP to AMH are not counted in these measures until they are discharged from TEWV
- A number of paired ROMs have been identified on Cito as complete and showing improvement, but are not showing in the measure

Actions:

- **PROM only** – To support the inclusion of measures that currently do not have a reliable change index, the Business Intelligence and Clinical Outcomes Team are working with the Child Outcome Research Consortium (CORC), and several organisations to establish a national reliable change index for EDE-Q by the end of December 2025. Section Head of Research & Statistics, Clinical Outcomes and Business Analytics to draft the formal research protocol by the end of May 2025.
- Business Intelligence to explore the feasibility of including those patients that transition between CYP and AMH as they are not “discharged” at this point. The changes required have now been identified; however, these require scoping in terms of technical design. The scoping will be completed by the end of Quarter 2 (September 2025).
- The Section Head of Research & Statistics to review the analysis undertaken to understand why a number of paired outcomes demonstrating improvement are not showing in the measure and will present the findings to the CAMHS Outcomes Steering Group on 5th June 2025.

05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported





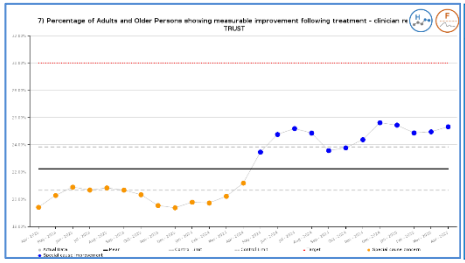
Background / standard description:
We are aiming for 55% of Adults and Older Persons showing measurable improvement following treatment - patient reported

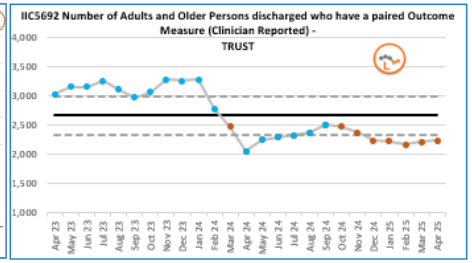
What does the chart show/context:
For the 3-month rolling period ending April, **1409** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 650 (46.13%)** made a measurable improvement.

There is no significant change at Trust level and for North Yorkshire & York Care Group; however, there is special cause improvement for Durham Tees Valley & Forensic. There is special cause concern at Trust and Care Group level in the number of patients discharged with a paired outcome measure.

The accepted Patient Rated Outcome Measure is Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS).

07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported





Background / standard description:
We are aiming for 30% of Adults and Older Persons showing measurable improvement following treatment - clinician reported

What does the chart show/context:
For the 3-month rolling period ending April, **2,243** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 568 (25.32%)** made a measurable improvement.

There is special cause improvement at Trust and Care Group level in the reporting period. There is special cause improvement for both specialties in both Care Groups; however, the low performance in MHSOP continues to be a concern. Adult Mental Health in both Care Groups are achieving standard. There is special cause concern at Trust and Care Group level in the number of patients discharged with a paired outcome measure.

The accepted Clinician Rated Outcome Measure is Health of the Nation Outcome Scales (HoNOS).

Underlying issues:
PROM only - We have identified an issue in the system which is impacting on the data quality; however analysis has shown it's a minimal impact.

Actions:
PROM only - Section Head of Research & Statistics, Clinical Outcomes and Business Analytics has logged a formal call to request a change for the system to ensure that all mental wellbeing scores are reported (this will be added to the Trust-wide Outcomes Improvement Plan to formally govern the progress of the issue).

08) Bed Occupancy (AMH & MHSOP A & T Wards)

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We have agreed to monitor bed occupancy against the commissioned and funded level of 85%, noting that this also represents the best practice level from a quality perspective. (Agreed October 2024)

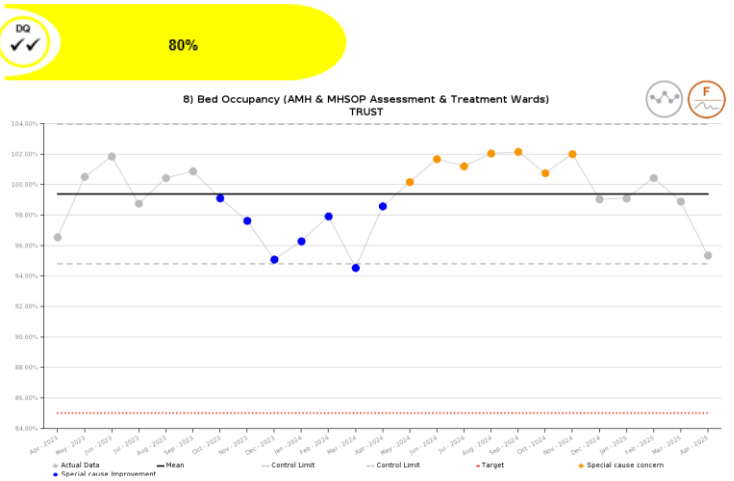
What does the chart show/context:
During April, **10,500** daily beds were available for patients; of those, **10,011 (95.34%)** were occupied. Overall occupancy including independent sector beds was **95.34%.**

There is no significant change at Trust level and in North Yorkshire & York Care Group in the reporting period; there is special cause improvement for Durham Tees Valley & Forensic. There is special cause concern for Mental Health Services for Older People in NYYSCG.

Quality Assurance Committee are fully sighted on bed occupancy and focussed on the potential impact on quality.

Underlying issues:
- Delayed transfers of care – specifically the length of time that patients are delayed in Adult Mental Health Services in DTVFCG.
- The length of delay, for those who are delayed, is having a significant impact, as is the availability of specialist packages of care and specialist placements
- At Trust level (both Care Groups) patients classified as clinically ready for discharge equated to an average of 35.4 Adult and 26.7 Older Adult beds in April 2025, with an associated direct cost of c.£0.65m (including £0.026m independent sector bed costs). Of the cost, c.£0.37m relates to Adult and c.£0.28m relates to Older Adult. A combined level recorded being 16.8% of adult and older adult bed capacity for the period.
- Length of stay for current inpatients (linked to above issues)
- Ministry of Justice (MoJ) patients

Actions:
- Care Groups are working together to develop a Trust-wide clinical model for the MHSOP organic bed base. This will now be completed by the end of Q1 2025/26 (previously Q4 2024/25).
- Trust-wide groups will be established by the end of April 2025 to progress workstreams for Transforming Patient Flow and Transforming Mental Health Discharge within AMH services as part of the Urgent Care Programme Board. **(Complete)**
- A Trust-wide patient flow workforce model is being developed to create a clearer escalation structure for operational staff both in and out of hours. A paper proposing the model will be presented to Executive Directors Group in May (previously April 2025); if approved, implementation will be July 2025.



Costings attached to patients clinically ready for discharge:

FYTD	Average Beds for Patients Classified as Clinically Ready for Discharge		Associated Cost for Patients Classified as Clinically Ready for Discharge	
	AMH	MHSOP	AMH	MHSOP
2024/25	34.4	35.7	£3.48m (inc £1.17 IS bed costs)	£4.07m
2025/26	35.4	26.7	£0.37m (inc £0.026 IS bed costs)	£0.28m

Actions continued:
- DTVFCG Managing Director to present the business case for the full roll out of Optica to Executive Directors Group. This has been further delayed to June 2025 (previously April).
- A Trust-wide process is being developed to respond to patients who abandon calls to our crisis lines, to support the improvement of pick-up rates and patient experience. Timescales will be confirmed once the CITO change freeze has been lifted.
- Durham & Tees Valley Care Group has agreed investment for Safe Havens as part of our admission avoidance work. The Business Case and Specification for this new service was to be developed in Q1 2025/26; however, funding was temporarily paused. Timescales are still to be confirmed.

09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming to have no out of area bed days.

What does the chart show/context:
For the 3-month rolling period ending April, **47** days were spent by patients in beds away from their closest hospital.

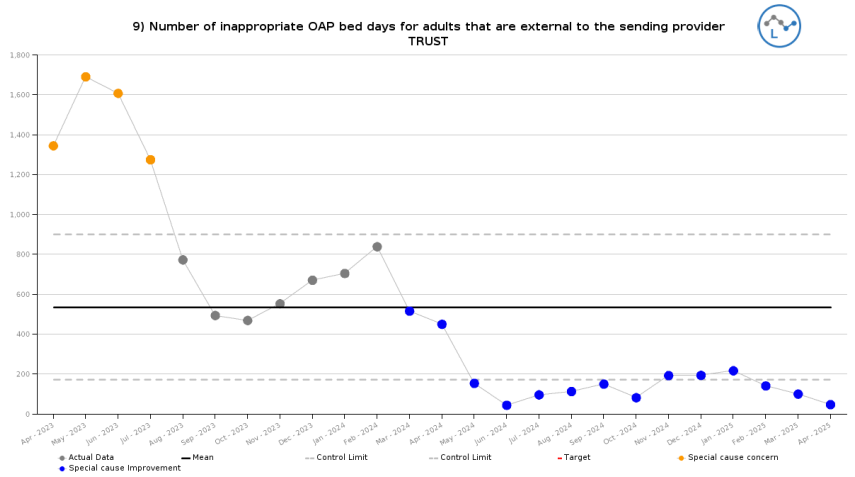
There is special cause improvement at Trust and Care Group level in the reporting period.

There were 0 active OAP placements as at 30th April 2025 in line with our plan.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

DQ 73%



ICB Trajectories versus actual performance for Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)

Active inappropriate adult acute mental health out of areas placements (OAPs)		Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Trust	**Plan**	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0											

10) The number of Patient Safety Incident Investigations reported on STEIS

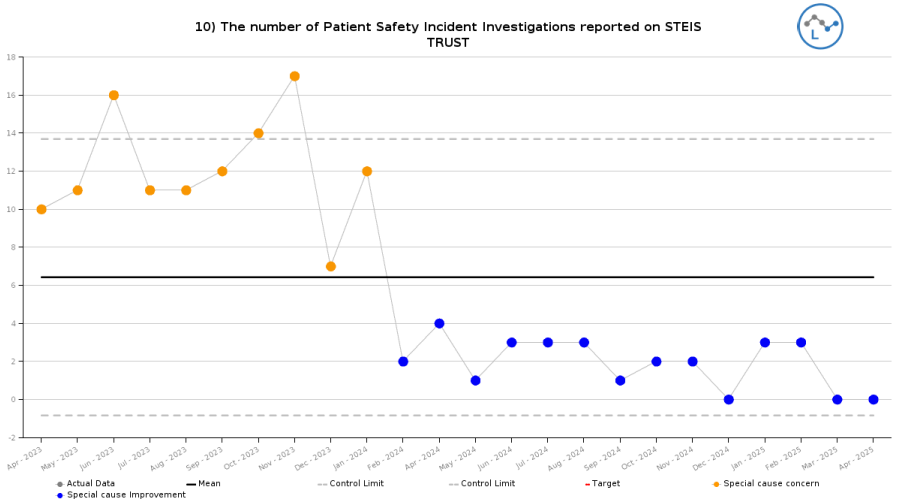
Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
0 Patient Safety Incident Investigations (PSII) were reported on the Strategic Executive Information System (STEIS) during April.

There is special cause improvement at Trust and Care Group level in the reporting period and for all services. *This is not necessarily an actual improvement, as there was a change in process late January 2024, when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). This new framework advocates a more proportionate approach to investigations.*

Underlying issues:
Once a PSII is identified, it is recorded on StEIS and allocated for investigation. The majority of cases that progress to PSII are identified at the point of the incident being reported. On occasions, some incidents identified as requiring investigation by an After-Action Review (AAR) may need to be escalated to a PSII after the AAR is completed based on information identified. Currently there is a delay in receiving completed AARs and potentially this could lead to a delay in identifying PSIIs.

Actions:
- The Patient Safety Team triage all incidents through a daily huddle. Where an AAR has potential to progress to a PSII, this is noted on the patient safety AAR tracker so these can be actively followed up when due. *NB. This is standard work for the Patient Safety Team*.
- The Patient Safety Team are actively engaged with Care Group leaders. The Care Groups have sight of the AAR tracker and receive reports on the position of overdue AARs into Care Group Board on a monthly basis with a view to addressing blockages to completion. *NB. This is standard work for the Patient Safety Team*.



11) The number of Incidents of moderate or severe harm

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
28 incidents of moderate or severe harm were reported during April.

There is a reduction (not necessarily an improvement as indicated in the SPC chart) at Trust and Care Group level in the reporting period, as this change looks to align to the new system implementation. This is mirrored in most services.

Each incident is subject to a multi-disciplinary after-action review by services. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

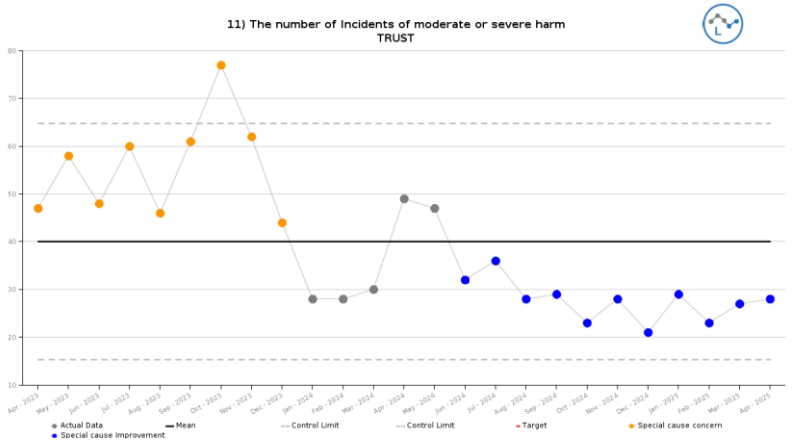
As incidents are reviewed, the severity could be reduced or increased (severity is usually reduced).

Underlying issues:
As at the 12th May 2025, there were 435 patient safety incidents in the 'awaiting investigation' stage. All will have been reported as no or low physical harm, as moderate or above severity incidents are reviewed through the Patient Safety huddle process within 1 working day. There may be a very small number of incidents of moderate or severe harm that have not been identified at the reporting stage at this severity level. This means a potential delay in reporting as these will not be identified until the incident has its first review which should be within 4 days.

Actions:
- A Quality Improvement project is underway to enable the development of a robust ward to Board incident management governance and oversight flow. Workshops have been undertaken with MHSOP and CYP, focusing on what is an incident and incident recording. Further workshops will take place by the end of June 25.

DQ

87%



12) The number of Restrictive Intervention Used

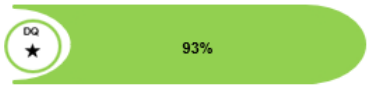
Tees, Esk and Wear Valleys NHS Foundation Trust

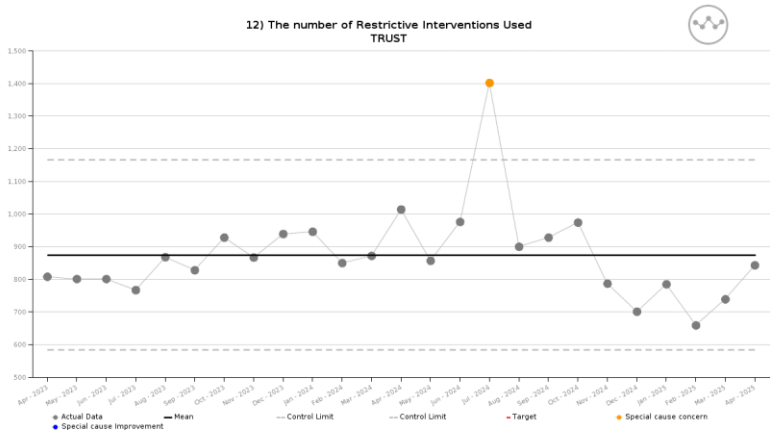
What does the chart show/context:
843 types of Restrictive Interventions were used during April.

There is no significant change at Trust and Care Group level in the reporting period. Whilst there is special cause improvement indicated for Adult Learning Disabilities in DTVFCG, there remain significant concerns (*see underlying issues below*).

Underlying issues:
- Concerns remain in DTVFCG ALD where there are a high number of interventions used for a small number of patients presenting with complex needs.

Actions
- DTVFCG ALD services continue to monitor the use of restrictive interventions, seeking support from the Specialist Practitioner for Positive & Safe where appropriate.
- Collaborative improvement work across both Care Groups and relevant corporate services is underway regarding our approach to 'incident management'. This will include the decisions and definitions about 'restrictive practice', ensuring that incidents are logged appropriately and identifying what we can safely STOP doing, KEEP doing and START doing with the aim of reducing waste in the process. This work will be completed by the end of May 2025. **(Complete)**
- CCTV reviews continue to be key in informing care planning and the aim to reduce restrictive practices and learning from best practice.
- More targeted clinical supervision is being undertaken to support the staff nurses to implement Positive Behaviour Support plans.
- The Service is revisiting Rapid tranquilisation training for staff nurses.





Note: The high use noted in July 2024 relates to one patient within Adult Eating Disorders Inpatients.

13) The number of Medication Errors with a severity of moderate harm and above

Tees, Esk and Wear Valleys NHS Foundation Trust

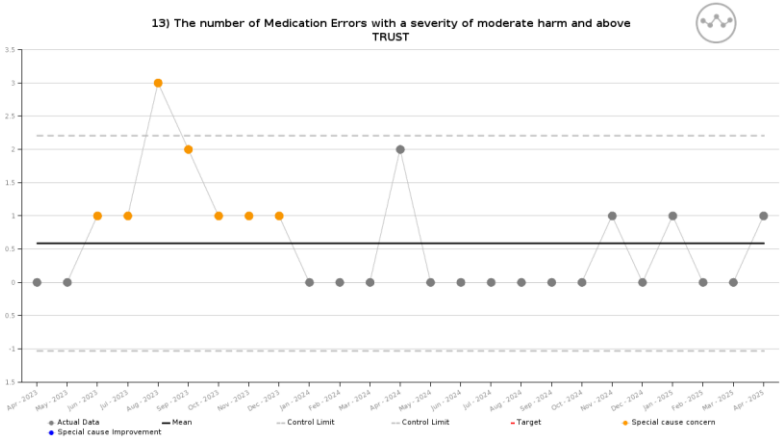
What does the chart show/context:
1 medication error was recorded with a severity of moderate harm, severe or death during April. We are liaising with Pharmacy colleagues to confirm the severity of this medication error.

There is no significant change at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period; there is special cause improvement for North Yorkshire, York & Selby Care Group. There is special cause improvement for Adult Learning Disabilities but special cause concern for Adult Mental Health in Durham, Tees Valley & Forensic Care Group. Within North Yorkshire, York & Selby Care Group there is special cause improvement for all specialties.

As incidents are reviewed the severity could be reduced or increased (usually reduced), which would then be refreshed in future reports.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



14) The number of unexpected Inpatient unnatural deaths reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

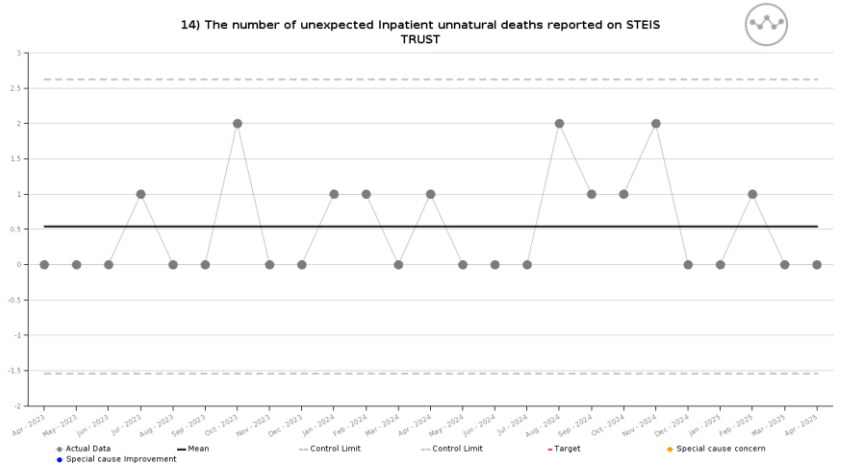
What does the chart show/context:
0 unexpected inpatient unnatural deaths on an inpatient ward (including those on leave) were reported on the Strategic Executive Information System (STEIS) during April.

All unexpected and unnatural deaths in inpatient wards are immediately reported in this data. Once the cause of death is confirmed, where necessary the data is refreshed. Therefore, on occasion we might be over reporting the number of unexpected, unnatural deaths.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

DQ ✓✓ 87%



15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
There were **320** uses of the Mental Health Act during April.

There is no significant change at Trust level and for both Care Groups in the reporting period. There is an unexpected low shift of referrals for Adult Learning Disabilities within North Yorkshire York & Selby Care Group.

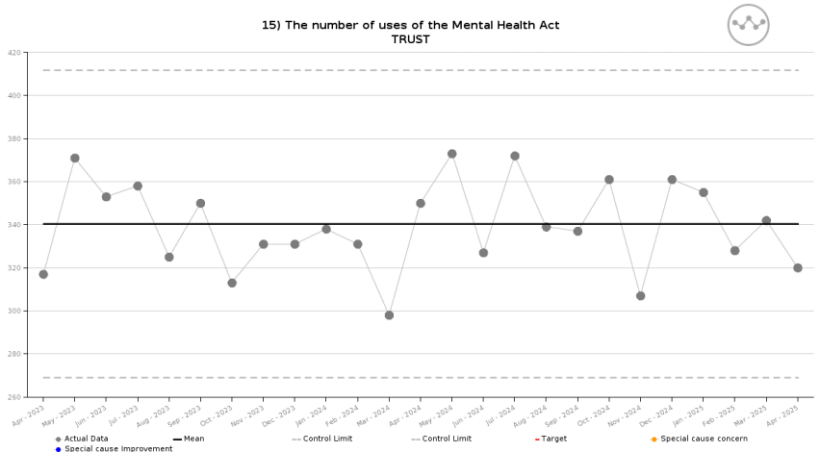
The latest national Mental Health Act data (2023/24) produced by NHS Digital has been analysed by Business Intelligence. Expected rates of detention by gender and ethnicity showed that Trust followed the same trend as the national rate of the higher the level of deprivation, the higher the rate of detention.

The analysis showed that the Trust detains more people than would be expected based on the national rates of detention per 100,000 population and that patients within the White group are 1.79 times more likely to be detained within the Trust, than would be nationally. The Trust rates of detention for Black/Black British are significantly higher than those for any other ethnicity and double the number of Black/Black British Females have been detained within Trust services in comparison to the number we would expect based on national rates.

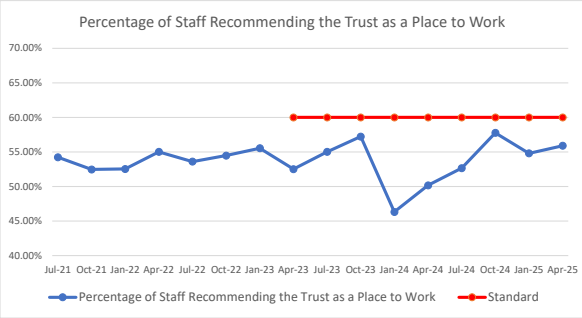
Underlying issues:
Analysis of the latest national Mental Health Act data (2023/24) shows some areas of inequality in our detention rates.

Actions:
The analysis will be taken to the Mental Health Legislation Committee in September (previously the report stated it was shared in February 2025, which was incorrect) to facilitate a discussion on potential reasons behind the inequality seen in detention rates and what actions may be required because of this.

DQ ✓✓ 87%



16) Percentage of staff recommending the Trust as a place to work



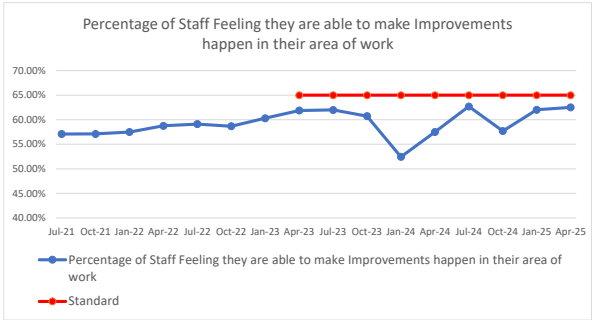
** Please note the survey is only undertaken once a quarter . The National Staff Survey (annual) is October each year; the National Quarterly Pulse Survey is the months of January, April and July*

Background / standard description:
We are aiming for 60% of staff to recommend the Trust as a place to work (agreed March 2024)

What does the chart show/context:
1331 staff responded to the April Pulse Survey. In relation to the question "I would recommend my organisation as a place to work", **744 (55.90%)** responded either "Strongly Agree" or "Agree".

The NHS Staff Survey Benchmarking report 2024, shows the "best result" was 78% and the "average result" was 63% for similar organisations.

17) Percentage of staff feeling they are able to make improvements happen in their area of work



Background / standard description:
We are aiming for 65% of staff to feel they are able to make improvements happen in their area of work (agreed March 2024)

What does the chart show/context:
1331 staff responded to the April Pulse Survey. In relation to the question "I am able to make improvements happen in my area of work", **832 (62.51%)** responded either "Strongly Agree" or "Agree".

The NHS Staff Survey Benchmarking report 2024, shows the "best result" was 66% and the "average result" was 59% for similar organisations.

Underlying issues:
We are not capturing the views of all our staff; therefore, this is not a comprehensive picture. The Pulse Survey is promoted to all staff through a range of communications. Responses to the April Pulse Survey equates to approximately 17% of staff.

Actions:
- Organisational Development have developed a robust communication plan for the Quarterly Pulse Surveys and National Staff Survey, which includes actively promoting the survey through a variety of communication channels, including Team TEWV, email and Trust bulletins. Promotional activity for the Quarter 1 2025/26 survey has started, with 1195 responses received to date. *This is business as usual for the team.*
- All services/teams to develop team-level Staff Survey improvement plans and to present the actions they are taking forward in 2025/26 at the June Trust Leadership Events (commencing the 9th June 2025). The development of these plans will be supported by Organisational Development and the People Partners.
- Organisational Development to implement online and paper processes for completing the 2025 Annual Staff Survey, with a view to increasing response rates for staff that do not have easy access to complete the online survey. This will be in place for the completion of the next annual staff survey in November 25.

18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for our staff leaver rate to be no more than 11% (agreed June 2024).

What does the chart show/context:
From a total of **7315.72** staff in post, **747.2 (10.21%)** had left the Trust in the 12-month period ending April 2025.

There is special cause improvement at Trust level and for most Directorates in the reporting period. However, there is special cause concern for Children & Young Peoples Services within both Care Groups (the service has confirmed there are no underlying issues) and within Management in Durham Tees Valley and Forensic Care Group.

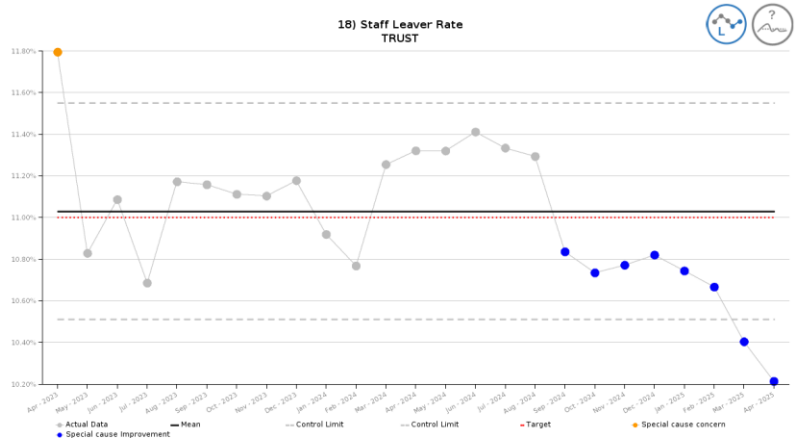
There is no new national benchmarking data available at the time of this report.

Reasons our staff have told us why they are leaving, include:
- Promotion
- Work-life balance/wellbeing
- Relocation
- Pay related
- To undertake further training

Underlying issues:
There are no underlying issues to report.

Actions:
Whilst there are no specific improvement actions required, we have a programme of work that focuses on retention. This includes flexible working opportunities; an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological services, Intention to leave interviews and a wide range of career development opportunities.

DQ ✓✓ 87%



19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for sickness absence to be no more than 5.5% (agreed March 2024)

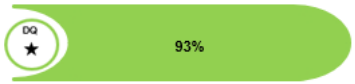
What does the chart show/context:
There were **235,953** working days available for all staff during April 2025 (reported month behind); of those, **12,769 (5.41%)** days were lost due to sickness.

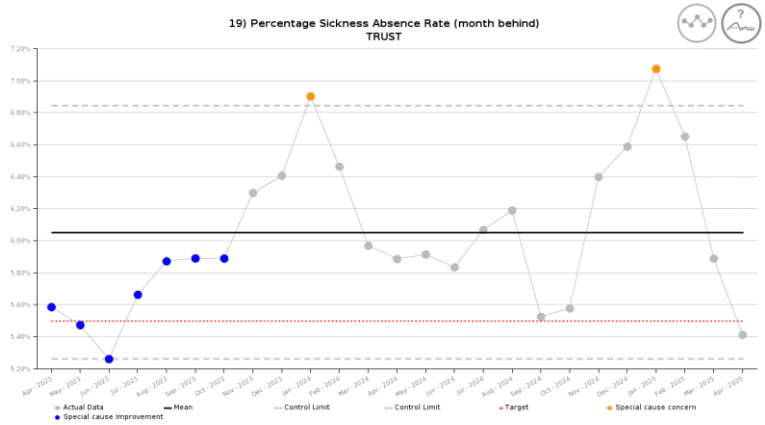
There is no significant change at Trust and for most Directorates in the reporting period. There is special cause concern for Nursing & Governance however, the directorate has confirmed there is no actual concern at this stage.

National Benchmarking for NHS Sickness Absence Rates published 24th April 2025 (data ending December 2024) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.50**%** compared to the Trust mean of **6.04%**, with the Trust ranked 37 of 47 Mental Health Trusts (1 being the best with the lowest sickness rate).

Underlying issues:
- Sickness audits have shown that the Short-Term Sickness Procedure is not being consistently followed through Trust services.

Actions:
- Human Resources Operational Team to develop an escalation process for those services with continued limited assurance within the short-term sickness audits. The process will be in place by the 30th April 2025. **(Complete)**
- The Human Resources Operational Team continue to support the management of both short- and long-term sickness via monthly monitoring of sickness for each service, staff who have 5 or more episodes of absence, and teams/wards that have the highest absence rate, liaising with managers to understand and support any concerns. Analysis is undertaken on the numbers of staff citing stress/anxiety within the last 12 months, liaising with managers on any patterns or concerns, and long-term sickness is monitored, focussing on cases that are in excess of 6 months of absence to support any decisions/barriers, ensuring appropriate support is in place. Sickness clinics are established in all areas experiencing high absence, and support, training and guidance is available for all managers. *NB. This is standard work for the team*





20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

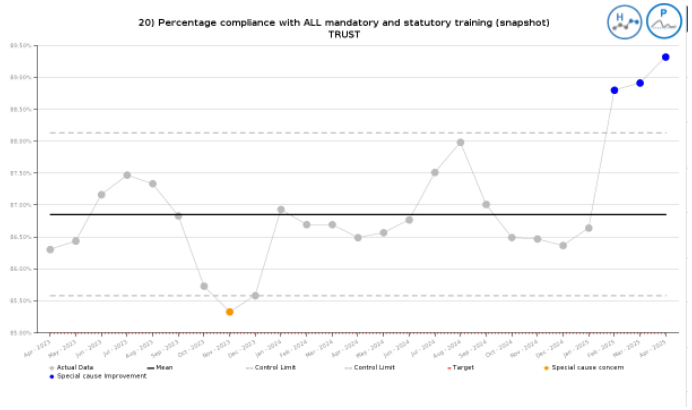
Background / standard description:
We are aiming for 85% compliance with mandatory and statutory training

What does the chart show/context:
152,993 training courses were due to be completed for all staff in post by the end of April. Of those, **136,652 (89.32%)** were completed.

There is special cause improvement at Trust level and for a number of Directorates in the reporting period.

As at the 30th April 2025, by exception compliance levels below 85% are as follows.

	Number of Courses Compliant	Number of Courses Required	Percentage Compliance
TRUST FINANCING (Bank Staff)	551	680	81.03%
CHIEF EXECUTIVE OFFICE	66	79	83.54%



Underlying issues:
- A significant number of Bank staff (Trust Financing) have not completed Information Governance Data Security training; the majority of which are not actively working.
- The volume of courses that staff have to complete is extremely time consuming and above the current headroom calculation.

Actions:
- Temporary Staffing Manager to ensure the outstanding Information Governance training for Bank Staff is undertaken by the end of April 2025 (previously December 2024). **(Not Complete)** Outstanding training will now be completed by June 2025.
- The shortfall in performance for the Chief Executive Office relates to two new Non-Executive Directors. The CEO is working through Company Secretaries to make arrangements to ensure these colleagues complete training by end of May (previously April 2025).
- A systematic review of the various training courses has started with Immediate Life support (ILS). Areas for improvement were identified and actions taken to address these have been completed. **(Complete)**
- An action plan has been developed to rationalise the training portfolio, which includes reducing the duration and frequency of some competencies and the removal of others. The outstanding required actions regarding Rapid Tranquilisation was to be confirmed by the end of March 2025 (previously February). **(Not Complete)** This will be complete by end of May 25**.**

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Courses below standard

Background / standard description:
We are aiming for 85% compliance with mandatory and statutory training

What does the table show/context:
We have **14** courses that are currently below the standard (previously 16 courses). We are currently focusing on the lowest 5 compliance levels.

Underlying issues:
- Staff unable to be released to attend training (high DNA rate and wasted spaces). During April 2025 there has been an average of 32% wasted spaces (including 12% DNAs) across the mandatory face to face training courses.
- Reduced capacity for Positive & Safe Level 2 training courses to manage the backlog

Actions:
- Double booking is in place for all mandatory training courses on a weekly basis, to minimise the impact of DNAs and wasted spaces.
- Workforce Training provide a weekly report, including DNAs for the previous 4 weeks, to the Business Managers for sharing with services, and staff members that do not attend and their managers are contacted directly.
- A number of Trust services have implemented processes whereby staff must escalate cancellations for ILS to service managers for approval.
- A wasted spaces and DNA report is reported into EDG monthly.
- A new process has been implemented for Positive & Safe Care and Moving & Handling. A health screen form for delegates is provided for completion with their line manager prior to training, which will identify any health issues that could result in them not being able to take part in the training and minimise the risk of staff being turned away on the day (wasted space).
- Workforce Development to review the provision of courses with a view to freeing capacity for Positive & Safe Training courses. This review will be completed by the end of April 2025. **(Complete)**
- Daily reviews of staffing are in place across the Care Groups to ensure that the right staff with the right training are in place to respond to any issues that arise, and staff will be moved to ensure we have the right skill mix available on our wards.

	Number of Courses Compliant	Number of Courses Required	Percentage Compliance
ACCT Training	55	82	67.07%
Positive & Safe Care Level 1*	3229	4477	72.12%
Rapid Tranquilisation 1	224	309	72.49%
Positive and Safe Care Level 2 Update*	1210	1669	72.50%
Resuscitation - Level 1 - 1 Year*	1940	2602	74.56%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1540	2063	74.65%
Resuscitation - Level 3 - Adult Immediate Life Support - Test*	708	937	75.56%
MCA - Relationship Between MCA and MHA.	3410	4190	81.38%
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	772	945	81.69%
MCA - Deprivation of Liberty.	3479	4188	83.07%
Annual Medicines Optimisation Module	1730	2070	83.57%
MCA - MCA and Young People Aged 16/17.	800	951	84.12%
MCA - Best Interests.	3528	4188	84.24%
Moving and Handling - Level 2 - 2 Years*	719	847	84.89%

**Indicates face to face learning ** face to face via MST*

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

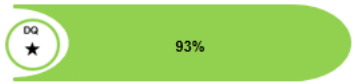
Background / standard description:
We are aiming for 85% of staff in post with a current appraisal

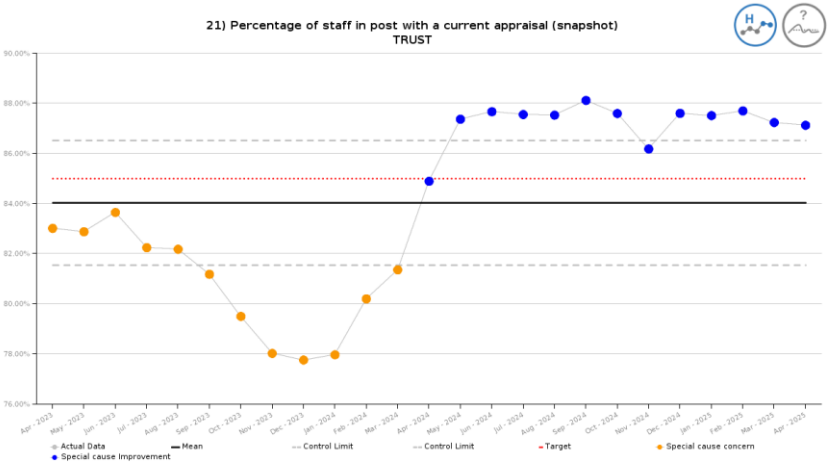
What does the chart show/context:
Of the **6,960** eligible staff in post at the end of April; **6,064 (87.13%)** had an up-to-date appraisal.

There is special cause improvement at Trust level and for Digital and Data Service, Durham Tees Valley & Forensic and North Yorkshire, York & Selby Care Groups. No significant change can be seen in most other areas in the reporting period.

As at the 30th April 2025, by exception compliance levels below 85% are as follows:

	Number of Appraisals Completed	Number of Appraisals Required	Percentage Compliance
CAPITAL PROGRAMME	8	11	72.73%
THERAPIES	33	41	80.49%
PEOPLE AND CULTURE	105	129	81.40%
FINANCE	46	56	82.14%
ASSISTANT CHIEF EXEC	50	60	83.33%
NORTH YORKSHIRE, YORK AND SELBY	1363	1608	84.76%





Underlying issues:
- Whilst there are no underlying issues to report, there are several directorates not achieving standard (as outlined above).
- Resident doctors are incorrectly being counted within the measure.

Actions:
- Outstanding appraisals were to be undertaken in Capital Programme by the end of April 2025 (previously February). **(Not Complete)** These will be completed in May 2025).
- Outstanding appraisals will be undertaken in Therapies by the end of April 2025 (previously February). As at the 13th May 2025, the Directorate is above standard.
- Outstanding appraisals with be undertaken in People & Culture by the end of June 2025.
- Outstanding appraisals to be undertaken in Company Secretary and Medical Directorates by the end of April 2025. **(Complete)**
- Outstanding appraisals to be undertaken in Finance, by the end of June (previously April) 2025.

Actions continued:
- Outstanding appraisals to be undertaken in Assistant Chief Executive by the end of May 2025
- North Yorkshire & York Care Group Management is working to ensure appraisals are booked in and those where staff are absent will be picked up as soon as possible on their return. No trajectory for completion has been provided.
- Strategic Lead Workforce Information & Resourcing Systems was to provide further advice and guidance on how to log appraisals on TEWVision by the end of March 2025. **(Not Complete)** This will be completed by the 6th June 2025.
- Head of Performance to link in with Business Intelligence by the end of May 2025 to discuss the changes required to remove resident doctors from the data and obtain timescales for resolution.

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

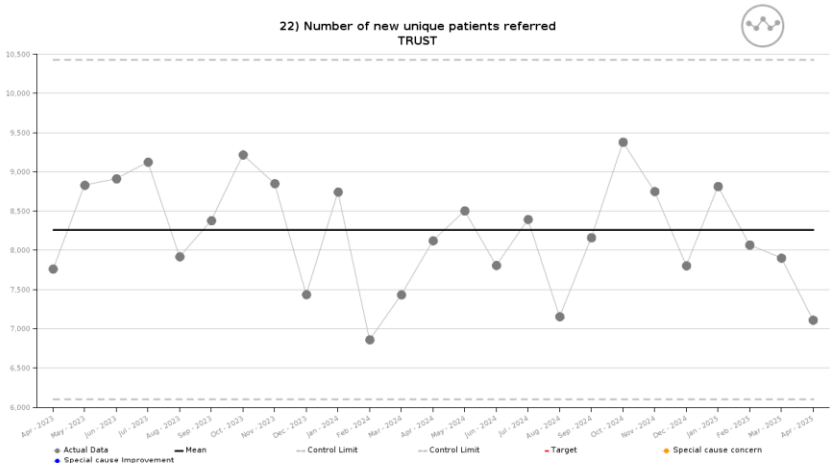
What does the chart show/context:
7,111 patients referred in April that are not currently open to an existing Trust service.

There is no significant change at Trust and Care Group level in the reporting period. However, there are a number of unexpected shifts of referrals. There are low shifts for Health & Justice within Durham, Tees Valley & Forensic Care Group and high shifts for Adult Mental Health in North Yorkshire, York & Selby Care Group. The Care Groups have confirmed there are no underlying issues.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required

DQ ★ 93%



23) Unique Caseload (snapshot)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

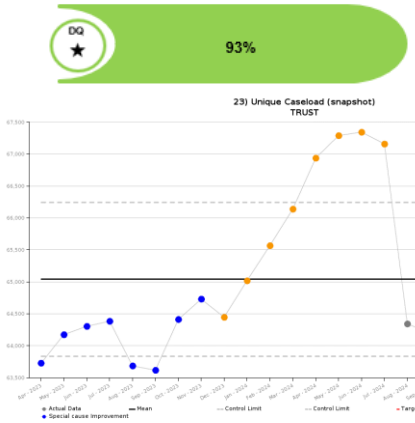
What does the chart show/context:
64,281 cases were open, including those waiting to be seen, as at the end of April 2025; **53,948** were active.

There is no significant change at Trust level and for both Care Groups in the reporting period. For Durham, Tees Valley & Forensic Care Group there is special cause concern in CYP and Special Cause improvement in ALD, AMH, MHSOP and SIS. In North Yorkshire, York & Selby Care Group, there is special cause concern in CYP, and special cause improvement in ALD and AMH.

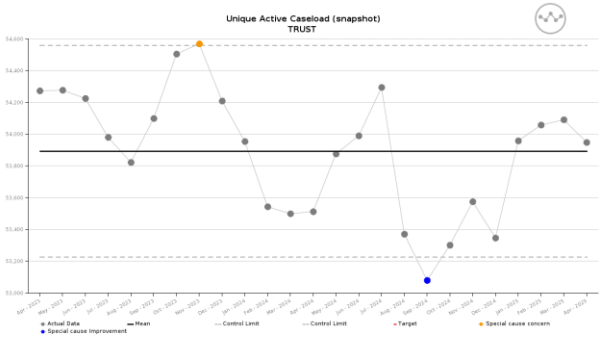
The **additional** SPC chart representing **Active Caseload** (excluding patients waiting for first contact) shows no significant change at Trust level, and for both care groups.

Underlying issues:
- There is an actual increase in demand within the H&J Mental Health Treatment & Requirement Team.
- Middlesbrough EIP Team is potentially impacted by the clinical pathway within the service.
- The active caseload measure includes patients that have received a Keeping in Touch contact but have not had an assessment and are, therefore still on the waiting list.

Actions:
- Findings of the caseload deep dive on CYP services have been shared with the Care Groups who will collectively agree next steps by the end of January 2025 and present back to EDG in February. Findings will be discussed at the April 2025 Board to Board meeting. **(Complete)** *See below action*
- CYP General Managers to lead the development of an action plan to address caseload sizes; timescales to be confirmed.
- Senior Performance Managers to feedback the CYP findings to the Care Boards for consideration as part of the Trust-wide improvement discussion at the April Board to Board. **(Complete)**
- H&J Service Manager to develop a business case with commissioners to increase staffing because of the increased demand within the Mental Health Treatment & Requirement Team. Timescale to be confirmed. **(Complete)**
- DTVFCG AMH General Manager to oversee a review of caseloads within the Middlesborough EIP team, by end of April 25, to identify any concerns and improvement actions (if required). **(Complete)** No concerns identified.



The below chart represents the active caseload, excluding patients waiting for their first contact.



Actions continued:
- Head of Performance & the Section Head of Research & Statistics, Clinical Outcomes and Business Analytics to review the construction of the Active Caseload measure and consider further refinement by the end of April 2025. **(Partially Complete)** *See below action*
- Section Head of Research & Statistics, Clinical Outcomes and Business Analytics to scope the potential options identified by the end May 2025.

24) Financial Plan: SOCI – Financial Performance – (Surplus)/Deficit

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

The financial position to 30th April 2025 against which Trust performance is assessed is a deficit of **£1.087m which is a £0.034m adverse variance against plan**. The Trust submitted a breakeven plan for 2025/26 which assumes delivery of challenging £27.41m Cash Releasing Efficiency Schemes (CRES).

- **Agency expenditure** for the year to date is £0.84m and is £0.16m above plan, reflecting a broadly consistent downward trajectory over the last two financial years. In-month costs were £0.84m and decreased by £0.033m compared to prior month, and remained well below the national cap of 3.2% of paybill; being 2.25% in month, and lower than 24-25 average of 2.56%. The target of a 40% reduction in Agency costs in year requires a challenging reduction in Agency spend month on month, and In April we are behind trajectory. Ongoing usage includes high premia rate locum costs for cover of medical vacancies and some residual price cap breaches where covering remote Health and Justice nursing vacancies. The recruitment and Temporary Staffing Teams have supported significant reductions in the latter. The Trust has **no off-framework agency assignments**.
- **Independent sector beds** - the Trust used 27 non-Trust bed days in April (78 in March); a decrease of 51 bed days compared with the previous month. Year to date costs were £0.026m, including estimates for unvalidated periods of occupancy and average observation levels pending billing and is £0.08m above plan. This remains a key area of volatility, and consequently clinical and management focus including through the Urgent Care Programme Board (chaired by the Managing Director for DTVF) is required. Bed pressures, including from the highest reported average monthly levels of adults and older adults who are clinically ready for discharge, mean that sustaining low (and delivering nil targeted) independent sector bed utilisation remains very challenging. It is hoped that new OPEL and bed management processes (Monday to Friday) will support optimal daily management and flow.
- **Taxis and Secure Patient Transport** costs year to date were £0.122m to 30th April compared to a plan, based on exit run rates, of £188k per month (or £2.26m for 12 months), and a £67k favourable variance to plan. Annual costs for 2024/25 were £2.429m, which was £0.29m higher than plan, and equated to a monthly average run rate of £202k. A procurement fo patient transport services is expected to improve unit costs / oversight in 2025/26.
- 2025/26 plans assumed delivery of £27.41m **Cash Releasing Efficiency Savings (CRES)** for the year, with £16.9m plans being recurrent and £10.525m non–recurrent. Plans on a Page are being worked up, and timetables for QIA submission being documented, Year to date CRES are £0.57m behind plan, but with recurrent schemes delivering £0.79m lower than plan, and non-recurrent schemes delivering £0.23m higher than planned.

24) Financial Plan: SOCI – Financial Performance – (Surplus)/Deficit

Tees, Esk and Wear Valleys NHS Foundation Trust

Underlying issues:

- We need to deliver CRES schemes to achieve our financial plan and deliver recurrent programmes to address our underlying financial pressures. Specific areas of focus are temporary staffing (Agency, Bank and Overtime) costs, Out of Area Placements and decisions on service configuration/ provision.
- We need to reduce bed occupancy, including through reduced lengths of stay, to reduce reliance on independent sector beds. This will require support from local authority system partners, including due to rising and sustained extremely high levels of patients who are clinically ready for discharge.
- We recognise that high occupancy, safe staffing requirements and temporary expenditure are impacting our financial plan, with ward staffing remaining above funded levels. Agency price cap breaches at premia rates, with 45% of (a continuously reducing number of overall) agency shifts being above price cap, are impacting overall value for money, with medical and Health and Justice vacancy hotspots (the latter having reduced markedly in-year).

Actions:

- Please see actions within measures 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider.
- The Agency Reduction PIP is progressing. Three actions have been completed and have had the desired impact: an increased number of bank workers to reduce Health Care Assistant Agency usage in DTVFCG, a review of the outsourcing timeframes within DTVFCG, and an increased number of bank workers to reduce Health Care Assistant Agency usage in NYYCG. In DTVFCG work to reduce the number of shifts filled by agency has been completed and whilst the desired 23% reduction has not been achieved, there has been a 15% reduction. The cessation of accommodation costs has not been completed and an extension to the 30th September 2025 has been approved. An additional action to re-negotiate rates of pay with framework agencies for Health & Justice registered nurses and all new Health & Justice registered nurses to be within price caps did not complete by 31st January 2025 and an extension to the end of September 2025 was approved, with significant reductions already being achieved.
- An Efficiency Hub oversees delivery of CRES and provide support to Care Groups / Directorates. In addition to delivery of planned CRES, the Efficiency Hub will provide support to enable focus on key strategic financial recovery actions. It will also support the transformation programmes to identify and realise associated benefit.
- A Temporary staffing and Overtime sub group has been established to support the delivery of reductions in spend on temporary staff. Central proposals for restricting overtime use, and reducing agency spend, have been supported through recent consideration at the EDG.
- Information on workforce costs and Whole Time Equivalents (WTE) is being continually enhanced and is being shared to support a renewed efficiency focus.

25a) Financial Plan: Agency expenditure compared to agency target

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Year to date agency costs of £0.84m at Month 1 are £0.16m above plan

NHS planning guidance for 2023/24 introduced system agency cost caps of 3.7% pay bill, reducing to 3.2% pay bill in 2024/25 with a national requirement to reduce costs by 40% compared to 2024/25 outturn. Costs were 2.25% paybill in the current month, having continued to reduce continuously due to sustained focus, from c2.6% on average through 2024/25, and representing a significant reduction from c4.5% on average through 2023/24 and 5.4% on average through 2022/23.

Maintaining reductions to date, and continuing to effect further reductions in use of agency shifts and on medical / health and justice shifts paid above national price caps remains a key focus. Agency shifts reduced by the equivalent of 172 worked Whole Time Equivalent (WTE) between April 2023 and April 2025 (falling from 240 to 68 WTE), and related annualised premia for price cap breaches reduced from £4.0m in April 2023 to £2.5m in April 2025 (£1.5m reduction). Whilst the trend for medical WTE and price cap breaches was broadly positive between April 2023 and April 2025, assignments increased in October 2024, going against trend and impacting premia incurred. With that exception, run rates demonstrate the positive impacts from actions taken to date and the benefit from sustained focus to improve framework compliance and reduce numbers of shifts filled using agency.

The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sustained management of sickness absence, but equally to net new recruitment (including to medical, qualified nursing, inpatient, and health and justice hot spots), securing alternative whole system models of care for specialist adult learning disability packages of care and reducing occupancy linked to increasing levels of patients who are clinically ready for discharge and require support to effect discharge.

We recognise that volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan. To address this, we developed a **Performance Improvement Plan (PIP)** to track actions being taken to support improvement and increased assurance (Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus) / Deficit).

Underlying issues:

We need to continue to ensure a sustainable permanent workforce, and in key shortage professions including medical and nursing (the latter notably to continue successful actions to tackle price cap breaches in Health and Justice), to manage high occupancy levels and delayed inpatient transfers (with system collaboration) and to use temporary staffing more optimally, including through improved rostering and by regularly reviewing our safer staffing levels relative to clinical need.

Actions:

The Executive Directors Group will oversee the following actions to improve rostering:

- Re-visit roster rules to ensure optimal rosters and equity for colleagues: This work is ongoing and is reviewed in the monthly safe staffing meeting. Training is being provided for teams to optimise their use of the roster. Care Groups are being asked to hold monthly governance meetings reviewing roster KPIs such as timely publications of rotas and management of headroom. Safe Staffing Group using internally developed roster performance reports to ensure oversight at Ward and Care Group level.
- Develop roster training programme (ran 3 x weekly January to March 2024) – Planned Programme Completed and extended on an ongoing basis.

25b) Agency price cap compliance

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

1,279 agency shifts were worked in April 2025, with **705 shifts compliant** (55%) and **574 non-compliant** (45%) (prior month 892 shifts compliant or 61% and 560 non-compliant or 39%) **with national price caps**. Whilst the proportion non compliant deteriorated, the actual number fell by 14 shifts due to lower overall numbers of shifts worked.

Most price cap breaches have related to medical or prison nursing cover for hard to fill vacancies. In month 77% of non-compliant shifts (94% by value of breaches) were medical and 23% of non-compliant shifts (16% by value of breaches) are nursing. Of the nursing agency breaches, 91% of shifts related to prisons (87% by value of shifts). Medical shifts breaching increased by 69 shifts, increasing from 372 shifts in March to 441 in April 2025 (100% shifts breach price cap).

173 fewer overall agency shifts were worked this month compared to last, with shifts worked being equivalent to **approximately 43 shifts per day** (47 in March and 49 in February). However, the 173 shifts decrease masked an increase to 69 more higher cost medical (40% increase),125 fewer nursing agency (72% decrease), 4 fewer AHP agency shifts (2% decrease), and 113 fewer HCA agency shifts (65% decrease). If sustained this would adversely skew the cost per average WTE agency worker due to medical premia rates.

This reflects **a reduction in total shifts worked of 932 (42%) over the last 12 months** from 2,211 shifts worked in April 2024 and **a reduction of 30% or 249 shifts breaching price cap since April 2024** (823 shifts breached).

- The Trust's ability to reduce price cap breaches now almost entirely stems from recruitment challenges for medical and health and justice vacancies, but with both on downward trajectories currently.
- Further refinement of shift data relating to the above takes place up to the point that NHSE Temporary Staffing data is submitted mid-month, which may result in minor differences between reported data.
- We recognise that volume pressures and particularly price cap breaches and rate premia associated with agency expenditure significantly impact our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance (Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit).

Underlying issues:
Particularly persistent challenges relate to levels of medical staffing and prison mental health nursing vacancies requiring cover from premia rate locum assignments which consistently breached price caps during 2024/25 and have continued into 2025/26.

Actions:
In addition to actions from 25a) supporting improved compliance, the Trust has approved a business case for a second phase of International Recruitment to aim to recruit a more sustainable medical workforce (nursing business case approved previously) and reduce reliance on higher rate agency assignments, targeting SAS locum medical assignments initially. Medical assignments attract the highest value and percentage premia rates. Social media and other targeted recruitment activities are seeking to attract new colleagues to Health and Justice (prison) vacancies.

26) Use of Resources Rating - overall score

80%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

The overall rating for the trust is a **3** for the period ending 30th April.
The **Use of Resources Rating** (UoRR) was impacted by Covid-19 with national monitoring suspended. The Trust has continued to assess the UoRR based on plan submissions compared to actual performance.

- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period (YTD). The Trust has a capital service capacity **rating of 4**.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is **rated as 1.**
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover. The Trust has an I&E margin of -2.51% which is a **rating of 4**.
- The Income and Expenditure **(I&E)** margin distance from plan is 0.88% which is a **rating of 1.**
- The agency expenditure metric assesses agency expenditure against our plan for agency spend of a 40% reduction against 2024/25. Costs of £0.84m are above plan by £93k and would therefore be **rated as a 2.** The Trust's year to date agency costs were 2.25% of pay bill.

Specifically for agency please refer to **25a) Financial Plan: Agency expenditure compared to agency target & 25b) Agency price cap compliance.**

The Trust's financial performance results is an **overall UoRR** of **3** for the period ending 30th April compared to a planned UoRR of 3.

Underlying issues:

the Trust's forward liquidity position is of concern, including as cash balances are deployed to progress capital programmes. As recovery actions are identified to support delivery of the Trust's planned breakeven position and improved agency compliance are targeted and progressed these will support achievement of the associated individual UoRR metrics and overall UoRR rating.

Actions:
There are no specific improvement actions required albeit that the Trust's wider financial strategy and medium term financial plan are subject to continued review.

27) Cash Releasing Efficiency Savings (CRES) Performance - Recurrent

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Recurrent CRES performance for the period ending 30th April was £0.40m which was below plan by £0.79m.

2025/26 financial plans assumes composite recurrent and non-recurrent delivery of £27.41m Cash Releasing Efficiency Savings for the year.

Following the submission of our financial plan, confirmed key recurrent CRES plans included:

- **Pay schemes** (£9.3m) with temporary staffing reductions, from Agency (40% reduction), Bank (10% reduction) and Overtime (£2.1m reduction). Actions to control access to agency and overtime, and manage bank shifts, are in train.

- **Non Pay schemes** with actions to eliminate Independent Sector bed reliance, Section 12 Mental Health Act Assessments, water rectification works, security contracts, printing and taxi usage.

Underlying issues:
We need to deliver recurrent CRES schemes to achieve our in-year financial plan and improve our underlying financial sustainability. Delivery of CRES non-recurrently increases the CRES requirement the following the year. Central opportunities on Overtime (£2.1m) and Agency (£0.2m) are being worked up, supported by the Temporary Staffing and Overtime group.

Actions:
Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit.

28) Cash Releasing Efficiency Savings (CRES) Performance – Non-Recurrent

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Non Recurrent CRES performance was ahead of plan by £0.23m for the period ending 30th April, with £0.59m having being achieved.

2025/26 plans assume composite delivery of £27.41m recurrent and non-recurrent Cash Releasing Efficiency Savings for the year.

The Trust plans to deliver **£10.525m (38.4% of CRES) of non-recurrent** Cash-Releasing Efficiency Savings (CRES) for the year.

The non-recurrent target includes centrally identified opportunities of £2.2m which are now being worked up into schemes. 2025/26 CRES planning has considered whether any of the additional schemes could be delivered recurrently (or non-recurrently) to optimise recurrent delivery.

The £0.23m over achievement year to date on non-recurrent schemes includes, £0.023m additional income from secure bed capacity, £0.133m depreciation and PDC savings, £0.081m management of cash to achieve maximum interest, offset by under achievement of ALD LRH service provision £0.050m.

Underlying issues:
It was necessary to target non-recurrent CRES to aim to target a break-even plan, however reliance on non-recurrent schemes leave an underlying unmitigated financial challenge moving into future years unless further recurrent schemes are identified in the coming months.

Actions:
Work is ongoing to develop plans for all schemes, and identify QIA timelines, as well as solidify schemes for the central opportunities.

29) Capital Expenditure (Capital Allocation)

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Capital expenditure was **£1.19m** at the end of April, which was £0.22m more than planned.

£13.80m 2025/26 capital schemes were approved by the Trust, including from nationally delegated capital allocated via North East and North Cumbria Integrated Care Board (ICB) system arrangements.

There is £3.29m of central cash backed funding support allocated to TEWV from the Capital Collaborative Group (ICB working group). In 2024/25 TEWV supported system partners by agreeing to broker £1.4m capital slippage to support wider pressures, with those funds being returned and included in the 2025/26 £13.8m capital pr0gramme.

We additionally have been allocated £1.21m of centrally cash backed funding to support Solar panel installation, and above our initial plans.

The plans assumed phase 2 Roseberry Park rectification works commence in August due to capital programme pressures. Trust Board will consider a business case for the works in June which is expected to recommend a start date of July 2025. Consequential implications for the Trust and system capital forecast have been discussed with the Capital Collaborative lead ahead of consideration by the Board.

Underlying issues:

Liquidity, due to reducing Trust cash balances and increasingly constrained national and regional capital allocations relative to need are of significant concern going forward, especially given significant capital required for works at Roseberry Park Hospital.

Actions:

The Trust has needed to risk assess and prioritise capital investments more rigorously in each of the last three to four financial years and work increasingly with system partners throughout the year to ensure outturn in line with individual provider and/or aggregate system limits for capital.

30) Cash balances (actual compared to plan)

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

The Trust had cash balances of **£56.06m** at the end of April 2025 which exceeded planned cash balances of **£47.36m** by **£8.70m** (favourable variance) which included a £4.6m higher than planned opening cash balance.

- **Prompt Payment of Creditors:** The Trust has achieved a combined Better Payment Practice Code (BPPC) compliance of 96.2% to date for the prompt payment suppliers, which is above the 95% target. We continue to support the use of Cardea to make processes as efficient as possible, and to ensure suppliers are paid promptly.
- Aged Debt: The value of debt outstanding at 30th April 2025 was £2.2m, with debts exceeding 90 days amounting to £0.99m (excluding amounts being paid via instalments and PIPS loan repayments). Progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged.

Underlying issues:

In addition to information at measure 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit, the Trust needs to expend significantly more via its annual capital programme budget than is generated internally from depreciation, meaning the Trust's annual cash reserves are gradually reducing, and significantly impacted by the significant works programmed at Roseberry Park Hospital.

Actions:

See actions at measure 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit.

Which strategic goal(s) within Our Journey to Change does this measure support?

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measure	Goal 1 - To Co-Create a great experience for our patients, carers and families	Goal 2 - To Co-Create a great Experience for our Colleagues	Goal 3 - To be a great partner
1	Percentage of Patients surveyed reporting their recent experience as very good or good	✓	✓	
2	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	✓	✓	
3	Percentage of inpatients reporting that they feel safe whilst in our care	✓	✓	
4	Percentage of CYP showing measurable improvement following treatment - patient reported	✓		
5	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	✓		
6	Percentage of CYP showing measurable improvement following treatment - clinician reported	✓	✓	
7	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	✓	✓	
8	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	✓	✓	✓
9	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	✓		
10	The number of Patient Safety Incident Investigations reported on STEIS	✓	✓	
11	The number of Incidents of moderate or severe harm	✓		
12	The number of Restrictive Intervention Used	✓	✓	
13	The number of Medication Errors with a severity of moderate harm and above	✓		
14	The number of unexpected Inpatient unnatural deaths reported on STEIS	✓		✓
15	The number of uses of the Mental Health Act	✓		
16	Percentage of staff recommending the Trust as a place to work	✓	✓	✓
17	Percentage of staff feeling they are able to make improvements happen in their area of work	✓	✓	✓
18	Staff Leaver Rate	✓	✓	✓
19	Percentage Sickness Absence Rate	✓	✓	✓
20	Percentage compliance with ALL mandatory and statutory training	✓	✓	✓
21	Percentage of staff in post with a current appraisal	✓	✓	✓
22	Number of new unique patients referred	✓	✓	✓
23	Unique Caseload (snapshot)	✓	✓	✓
24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit	✓	✓	✓
25a	Financial Plan: Agency expenditure compared to agency target	✓	✓	✓
25b	Agency price cap compliance	✓		✓
26	Use of Resources Rating - overall score	✓	✓	✓
27	CRES Performance - Recurrent	✓	✓	✓
28	CRES Performance - Non-Recurrent	✓	✓	✓
29	Capital Expenditure (CDEL)	✓	✓	✓
30	Cash balances (actual compared to plan)	✓	✓	

Which risk(s) within our Board Assurance Framework does this measure support/provide assurance towards?

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measure	1. Safe Staffing	2. Demand	3. Co-Creation	4. Quality of Care	5. Digital - supporting change	6. Estate / Physical Infrastructure	7. Data Security and Protection	8. Quality Governance	9. Partnerships and System Working	10.Regulatory compliance	11. Roseberry Park	12. Financial Sustainability	13. Public confidence
1	Percentage of Patients surveyed reporting their recent experience as very good or good	✓	✓	✓	✓									✓
2	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	✓		✓	✓									✓
3	Percentage of inpatients reporting that they feel safe whilst in our care	✓		✓	✓									✓
4	Percentage of CYP showing measurable improvement following treatment - patient reported	✓	✓		✓	✓			✓	✓			✓	✓
5	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	✓	✓		✓	✓			✓	✓			✓	✓
6	Percentage of CYP showing measurable improvement following treatment - clinician reported	✓	✓		✓	✓			✓	✓			✓	✓
7	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	✓	✓		✓	✓			✓	✓			✓	✓
8	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	✓	✓		✓				✓				✓	✓
9	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	✓	✓		✓				✓				✓	✓
10	The number of Patient Safety Incident Investigations reported on STEIS	✓		✓	✓		✓				✓			✓
11	The number of Incidents of moderate or severe harm	✓		✓	✓				✓		✓			✓
12	The number of Restrictive Intervention Used	✓		✓	✓		✓				✓			✓
13	The number of Medication Errors with a severity of moderate harm and above	✓			✓	✓			✓		✓			✓
14	The number of unexpected Inpatient unnatural deaths reported on STEIS	✓		✓	✓		✓			✓	✓			✓
15	The number of uses of the Mental Health Act	✓	✓						✓	✓	✓			
16	Percentage of staff recommending the Trust as a place to work	✓	✓				✓		✓	✓	✓			✓
17	Percentage of staff feeling they are able to make improvements happen in their area of work	✓		✓					✓	✓	✓			✓
18	Staff Leaver Rate	✓							✓		✓		✓	✓
19	Percentage Sickness Absence Rate	✓	✓								✓		✓	✓
20	Percentage compliance with ALL mandatory and statutory training	✓			✓			✓	✓	✓	✓		✓	✓
21	Percentage of staff in post with a current appraisal	✓			✓				✓		✓			✓
22	Number of new unique patients referred		✓		✓				✓	✓	✓		✓	✓
23	Unique Caseload (snapshot)	✓	✓		✓				✓	✓	✓		✓	✓
24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit					✓		✓	✓		✓	✓	✓	
25a	Financial Plan: Agency expenditure compared to agency target	✓	✓		✓				✓		✓		✓	
25b	Agency price cap compliance	✓							✓		✓		✓	
26	Use of Resources Rating - overall score	✓	✓		✓				✓		✓		✓	
27	CRES Performance - Recurrent	✓	✓				✓		✓		✓		✓	
28	CRES Performance - Non-Recurrent								✓		✓		✓	
29	Capital Expenditure (CDEL)					✓	✓		✓		✓	✓	✓	
30	Cash balances (actual compared to plan)					✓	✓				✓	✓	✓	

National Quality Requirements and Mental Health Priorities

Tees, Esk and Wear Valleys NHS Foundation Trust

National Quality Requirements	Variation	Assurance	Annual Standard	FYTD Standard	Actual (FYTD)
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	H	?	80%	80%	87.08%
Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care		?	60%	60%	70.97%
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	L	P	75%	75%	92.52%
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period		P	95%	95%	100.00%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)		F	95%	95%	88.67%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)		F	95%	95%	72.22%

Mental Health Priorities	Variation	Assurance	Annual Standard	FYTD Standard	Actual (FYTD)
Number of active inappropriate adult acute OAPs that are either 'internal' or 'external' to the sending provider (OAPs)		?	0	0	0
Average length of stay for Adult Acute Beds		P	42.0	42.6	42.86
Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness		?	48%	48%	49.81%
Talking Therapies - Reliable improvement rate for those completing a course of treatment		?	67%	67%	68.67%
Number of women accessing (1+ contact) specialist community PMH and MMHS services in the previous 12 months	H	N/A	N/A	N/A	1591
Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact	L	N/A	N/A	N/A	29947
Number of people accessing IPS services (rolling 12 month)	L	N/A	N/A	N/A	884

Mental Health Priorities

There are Provider (Trust) level plans for the first 2 measures shown in this table which is what is displayed in the "standard" columns.

There are ICB-level plans for the remaining measures which vary by ICB. The "standards" displayed are the current national ones.

NOTES: 1. The above tables reflect the Trust-wide position (not the sum of commissioned services). 2) Financial Year to Date (FYTD) position reflects April 2025 only

National Quality Requirements and Mental Health Priorities Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

National Quality Standards

- **72 hour follow up:** Achieved standard at Trust and commissioned place level
- **EIP waiting times:** Achieved standard at Trust and commissioned place level
- **Talking Therapies waiting times (6 and 18 weeks):** Achieved standard at Trust and commissioned place level
- **Child Eating Disorders waiting times:**
  - Routine Referrals - We have failed standard at Trust level and commissioned place level and there is special cause concern in North Yorkshire and York. For the month of April there was only one patient that did not receive treatment within the 4-week standard, which is due to patient choice.
  - Urgent referrals - We have failed standard at Trust level and commissioned place level with the exception of Tees Valley. There is cause for concern for North Yorkshire and York. For the month of April there were two patients that did not receive treatment within the 1-week standard. One patient was due to a breakdown in process; however, the second patient has been incorrectly recorded as an urgent referral. This latter patient did not receive treatment within the 4-week standard, which is also due to a breakdown in process.

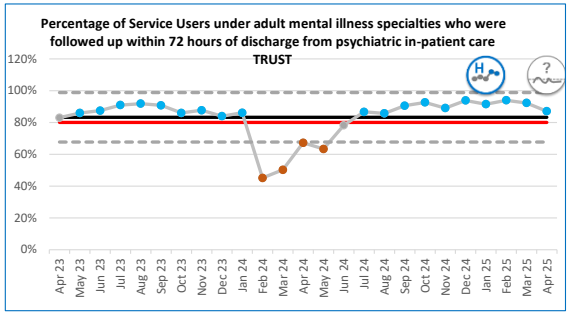
Mental Health Priorities

- **Active OAP (inappropriate):** Achieved Trust plan for April.
- **Average Length of stay for Adult acute beds *(new measure)*:** Trust plan not achieved for April.
- **Talking Therapies Reliable Recovery:** National Standard achieved at Trust and commissioned place level with the exception of York.
- **Talking Therapies Reliable Improvement:** National Standard achieved at Trust and commissioned place level with the exception of County Durham.
- **Specialist Community Perinatal Mental Health (PMH) services** Plans not achieved at commissioned place level in North Yorkshire and York; however, there is special cause improvement in both places.
- **Children: 1 contact** We have provisionally agreed with Commissioners to focus on no significant change for this measure; however, this is not being achieved across North Yorkshire & York places as there is special cause concern across the combined position for the ICB.
- **Number of people accessing individual placement support (*new measure*):** plans for this measure are being confirmed with both Integrated Care Boards as they link to baseline funding agreed in 2024/2025 and further expansion funding for 2025/26.

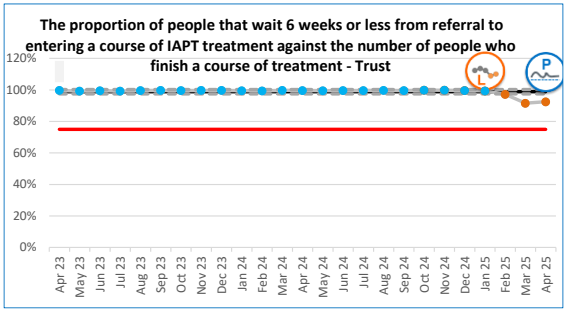
*All headlines are based on financial year to date unless otherwise stated. 80

National Quality Requirements

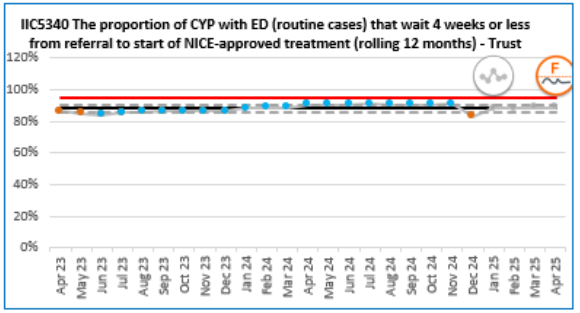
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



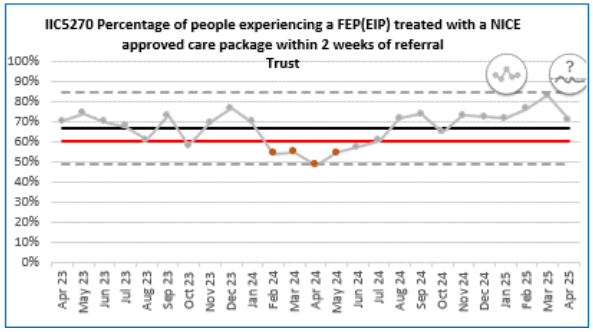
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	80%	87.08%			
County Durham	80%	88.16%			
Tees Valley	80%	88.57%			
North Yorkshire	80%	86.44%			
York	80%	84.62%			



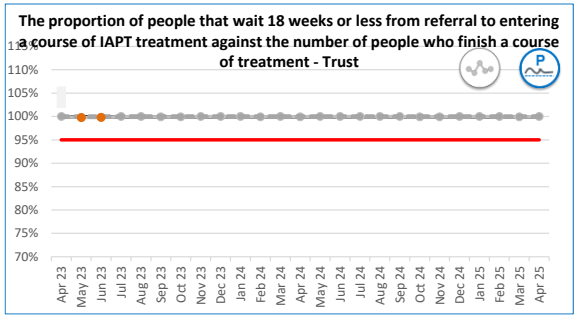
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	75%	92.52%			
County Durham	75%	84.21%			
Tees Valley	75%	87.95%			
North Yorkshire	75%	100.00%			
York	75%	96.28%			



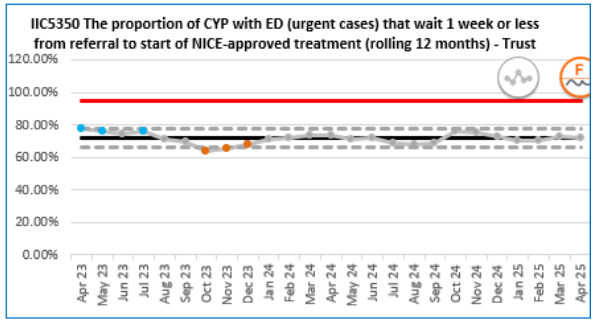
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	88.67%			
County Durham	95%	84.29%			
Tees Valley	95%	94.62%			
North Yorkshire	95%	81.67%			
York	95%	93.55%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	60%	70.97%			
County Durham	60%	75.00%			
Tees Valley	60%	60.00%			
North Yorkshire	60%	100.00%			
York	60%	75.00%			



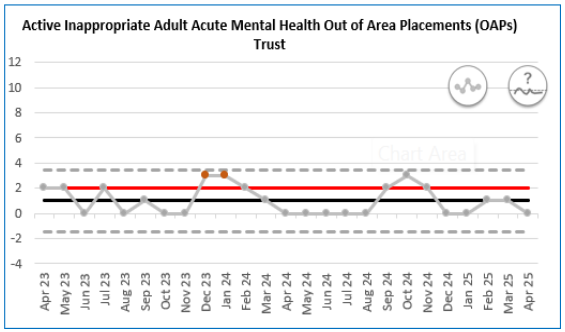
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	100.00%			
County Durham	95%	100.00%			
Tees Valley	95%	100.00%			
North Yorkshire	95%	100.00%			
York	95%	100.00%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	72.22%			
County Durham	95%	73.08%			
Tees Valley	95%	100.00%			
North Yorkshire	95%	55.56%			
York	95%	42.86%			

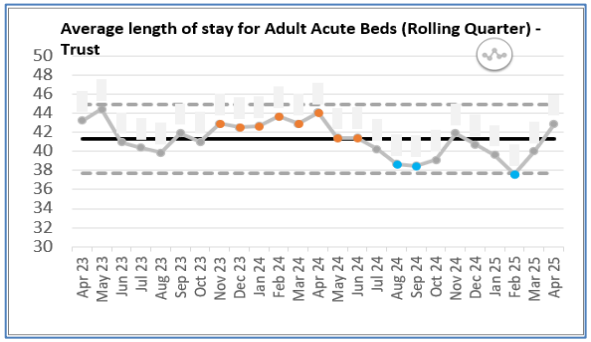
Mental Health Priorities

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

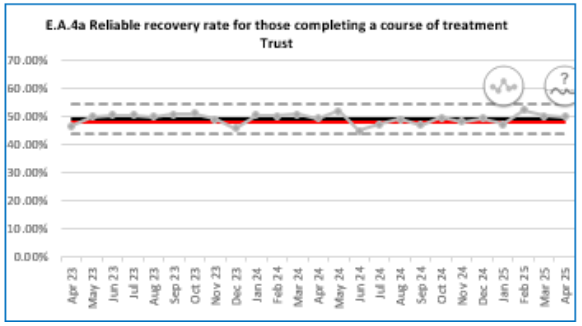


Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	0	0			

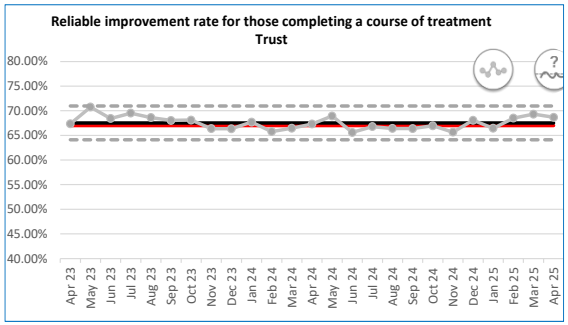
Please note the plan for this measure is zero for 25/26



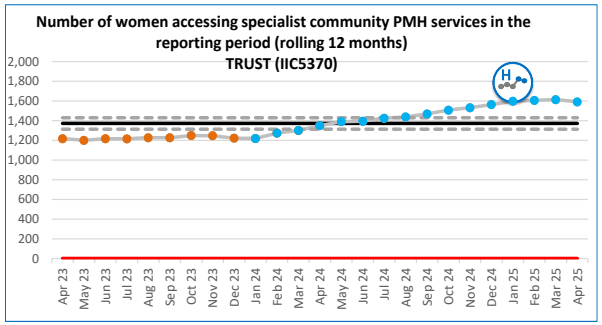
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	42.6	42.9			



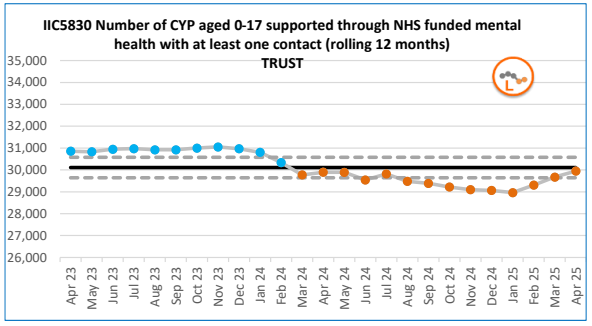
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	48%	49.81%			
County Durham	48%	48.27%			
Tees Valley	48%	48.00%			
North Yorkshire	48%	52.71%			
York	48%	46.15%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	67%	68.67%			
County Durham	67%	65.60%			
Tees Valley	67%	67.47%			
North Yorkshire	67%	71.48%			
York	67%	69.30%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	N/A	1591			
County Durham	456	588			
Tees Valley	447	491			
North Yorkshire	368	345			
York	156	136			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	N/A	29947			
County Durham		10469			
Tees Valley		11647			
North Yorkshire		4572			
York		2865			

Number of people accessing IPS services (rolling 12 months)

Organisation	Standard	Actual
Trust	N/A	884
County Durham	TBC	262
Tees Valley	TBC	314
North Yorkshire	TBC	182
York	TBC	120

Average length of stay for Adult Acute Beds

Tees, Esk and Wear Valleys NHS Foundation Trust

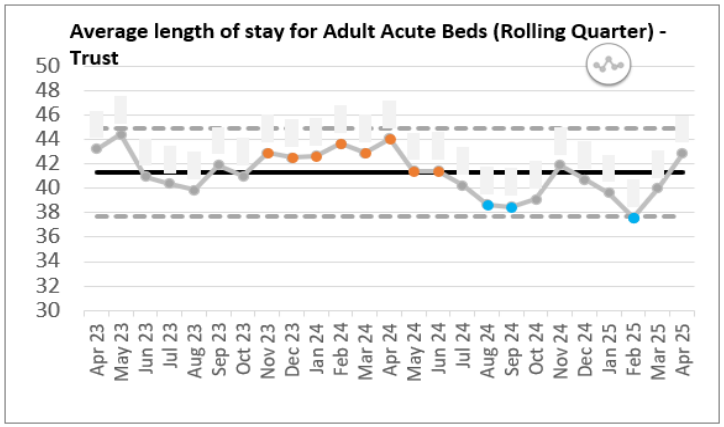
Background / standard description:
Whilst we are aiming to reduce our average length of stay within our adult acute inpatient beds to 42.0 days by the end of March 2026, by the end of April we are aiming to have an average length of stay of **42.6** days.

What does the chart show/context:
During the 3-month period ending April 2025, there were **715** discharged hospital spells from adult acute beds for patients aged 18+, accounting for a total of **30,643** bed days which equates to an average length of stay of **42.9** days.

There is no significant change at Trust level; however, there is special cause improvement in DTVFCG and special cause concern in NYYSCG.

Underlying issues:
This is a new measure for 25/26 and includes Adult Acute wards, Adult PICU wards and MHSOP Acute Wards. The initial analysis has highlighted MHSOP wards in both care groups having high lengths of stay for the period ending April.

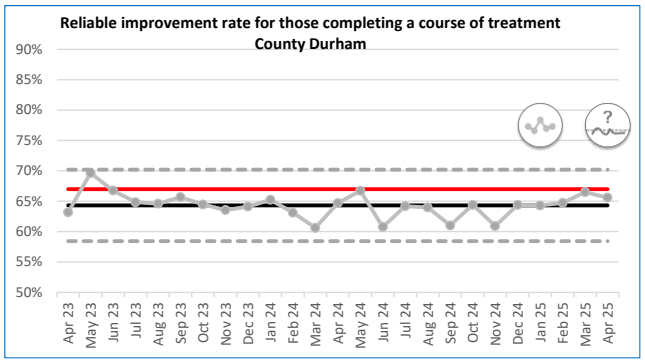
Actions:
The Performance Team will analyse the data at ward level and share the findings with Care Groups to better understand the issues. This will be completed by the end of May 2025.



Average Length of Stay in Adult Acute MH Beds (rolling 3 months)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Plan	42.6	42.6	42.6	42.6	42.6	42.6	42.5	42.4	42.3	42.2	42.1	42.0
Actual	42.9											

Talking Therapies: Reliable improvement rate for those completing a course of treatment – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



Background / standard description:
We are aiming for 67% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:
During April **532** patients completed a course of treatment, of which **349 (65.60%)** demonstrated reliable improvement within **County Durham**.

Underlying issues:

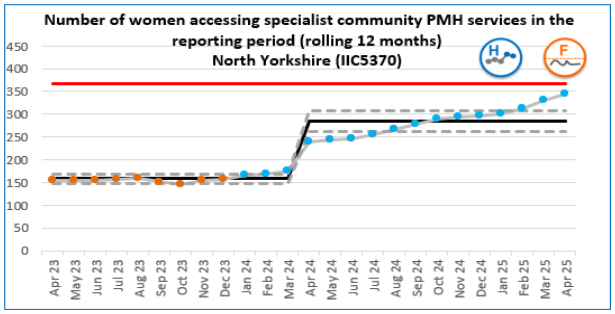
- High levels of complex patients are seeing a reliable improvement on two outcome measures (Patient health questionnaire - PHQ9 and Generalised anxiety disorder - GAD7); however, if an Anxiety Disorder Specific Measures (ADSM) is also undertaken and does not report an improvement, that supersedes the other scores.
- The measure includes patients that are not at clinical caseness (as per national construction) and therefore, may not show reliable improvement.
- A high number of patients do not attend appointments and, therefore, are not attending enough appointments to enable reliable recovery or improvement to be achieved.
- High levels of sickness is resulting in caseloads being reallocated or patients being added back to the waiting list which is impacting on both measures.

Actions:

- The Trust-wide Task & Finish Group have developed a Trust-wide action plan, which is being taken through each Care Group Board in May 2025 and will be presented to EDG as part of a focused discussion in May.
- DTVFCG have a service recovery plan with actions being progressed. A quality impact assessment is being undertaken prior to an 'opt-in' process being implemented in June 2025. This may have an initial impact on the recovery measure as some patients may opt out; however, this should recover longer term with those people remaining in the service being committed to engage.

Number of women accessing (1+ contact) specialist community PMH and MMHS services in the previous 12 months – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust

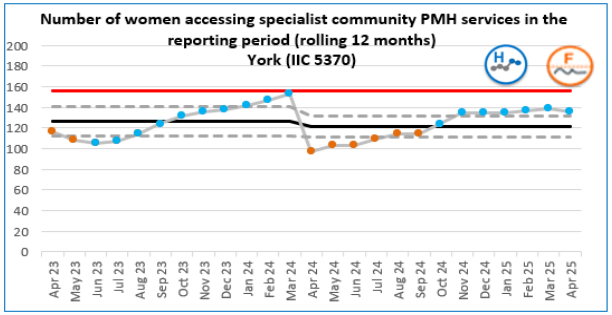


Background / standard description:

We are aiming to achieve **368** number of women to access a specialist community Perinatal Mental Health Service within a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending April 2025 there were **345** women accessing a specialist community Perinatal Mental health services.

There is special cause improvement as indicated in the SPC chart above.



Background / standard description:
We are aiming to achieve **156** number of women to access a specialist community Perinatal Mental Health Service within a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending April 2025 there were **136** women accessing a specialist community Perinatal Mental health services.

There is special cause improvement as indicated in the SPC chart above.

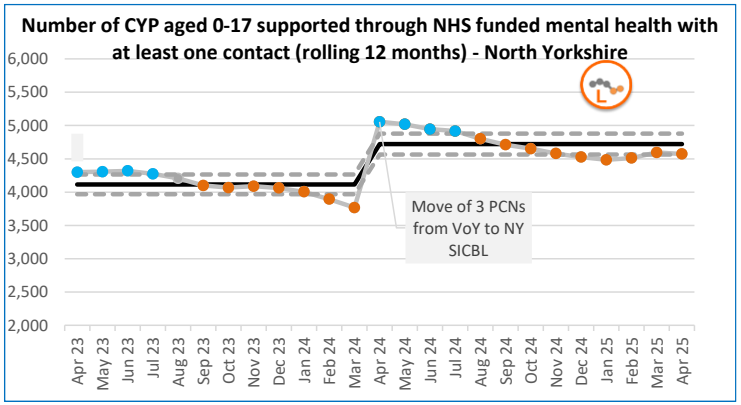
Actions:
Underlying issues:

- Capacity issues within the Perinatal services, linked to sickness, vacancies and staff on formal support processes.

Actions:
The Perinatal teams are currently being supported through a service recovery plan in line with business continuity processes. Mitigating actions are:

- Short term sickness and vacancy is currently being mitigated by support from the wider Multi-Disciplinary Team for care co-ordination and implementation of a Band 5-6 run-through post to mitigate against the difficulties to recruit to a B6 care-coordination post.
- The Service Manager was working with the Planning Team to undertake a capacity and demand exercise to inform the ongoing actions for the recovery of the longer term structural and capacity pressures. The first draft was completed at the end of March 2025 (originally December 2024) (**Complete**) The capacity and demand work has concluded the current staffing is a material factor to meet demand and achieve national targets.
- Quality Assurance Committee are fully sighted on all underlying issues and actions within the Perinatal Service and monthly meetings are in place with the ICB to ensure system oversight.

Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months) – *by exception*



Background / standard description:
We are aiming to have no significant change or improvement in the number of children or young people aged between 0-17 to be supported through NHS funded mental health with at least one contact.

What does the chart show/context:
In the 12-month period ending April 2025, **4,572** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **North Yorkshire**.

There is special cause concern as indicated in the SPC chart above.

Underlying issues:
The national metric is only including new patients being referred to services within a rolling 12-month period and does not consider demand on services from a patient who has been previously referred within that same period. Therefore, the measure does not account for a child/young person who appropriately moves between services within the same organisation, for example a TEWV Early Help offer e.g. Wellbeing in Mind Team to a TEWV Community CAMHS team.

Actions:
Section Head of Research & Statistics, Clinical Outcomes and Business Analytics to undertake further analysis of re-referrals to support the identification of improvement actions. This work will be completed by end of June 25.

Waiting Times Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Waiting Times Dashboard (Assessment and Treatment)	Variation	Actual Number Waiting (Snapshot)	0-1 months	1-2 months	2-3 months	3-6 months	6-9 months	9-12 months	1-2 years	2-3 years	Over 3 years	Average Wait (weeks)	Longest Wait (weeks)
Adults Waiting for an Assessment		2955	1043	634	349	625	171	67	65	0	1	11	197*
Adults with a learning disability Waiting for an Assessment		67	46	12	2	5	0	0	0	1	1	13	543*
Adults in Health and Justice services Waiting for an Assessment		49	35	11	3	0	0	0	0	0	0	3	11*
Older People Waiting for Assessment		2653	731	602	377	602	300	40	1	0	0	12	53
Children and Young People Waiting for an Assessment		949	418	289	131	74	14	6	15	2	0	8	150
Children and Young People Waiting for Treatment (excluding Neuro)		1961	124	352	299	481	216	112	192	84	101	37	317

Waiting Times Dashboard (Neuro Services)	Variation	Actual Number Waiting (Snapshot)	0-1 months	1-2 months	2-3 months	3-6 months	6-9 months	9-12 months	1-2 years	2-3 years	Over 3 years	Average Wait (weeks)	Longest Wait (weeks)
Adults waiting for an ADHD Assessment		4711	212	148	110	355	310	261	1467	1114	734	90	351*
Adults waiting for an Autism Assessment		3952	183	106	62	201	159	213	1200	1078	750	100	363*
Children and young people waiting for an Autism Assessment		5861	83	130	147	549	368	596	2643	1196	149	75	201
Children and young people waiting for an ADHD Assessment		4845	135	301	215	531	370	708	1636	602	347	67	247
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		2178	30	28	34	169	253	225	256	1094	89	89	191

Waiting Times Dashboard (National Waiting Times)	Variation	Actual Number Waiting	0-1 Week	1-2 Weeks	2-4 Weeks	4-6 Weeks	6-8 Weeks	8-12 Weeks	Over 12 Weeks	Average Wait (weeks)	Longest Wait (weeks)
Children & Young People Waiting for Eating Disorders Services - Urgent Referral (1 week standard)		4	1	0	1	0	0	1	1	18	57*
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		32	5	9	6	2	3	1	6	9	53*
Adults Waiting for EIP Treatment (2 week standard)		59	19	24	8	6	0	0	2	2	17

Waiting Times Dashboard (Talking Therapies)	Variation	Actual Number Waiting (Snapshot)	0-4 weeks	4-6 weeks	6-12 weeks	12-18 weeks	18-28 weeks	Over 28 weeks	Average Wait (weeks)	Longest Wait (weeks)
Adults waiting for their second treatment contact in Talking Therapies		4141	332	475	1343	855	807	329	14	77

NOTE: *an asterisk denotes a data quality issue*

Waiting Times Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

Waiting Times Assessment & Treatment

- **AMH** There is special cause improvement (a reduction) in the numbers waiting for an assessment. Our longest genuine wait time is **71 weeks** in DTVFCG. The majority (90%) of adults are waiting less than 6 months for an assessment.
- **ALD** There is special cause improvement (a reduction) in the numbers waiting for an assessment. Our longest genuine wait time is **15 weeks** in NYYSCG. The majority (86%) of adults are waiting less than 2 months for an assessment.
- **CYP** There is no significant change in the number waiting for treatment (excluding Neuro). Our longest wait time is currently **317** weeks in DTVFCG. The majority (64%) of children and young people are waiting less than 6 months for treatment.
- **CYP** There is no significant change in the number waiting for an assessment. Our longest wait time is currently **150** weeks in DTVFCG. The majority (74%) of children and young people are waiting less than 2 months for an assessment.
- **H&J** There is no significant change in the numbers waiting for an assessment. Our genuine longest wait time is **11** weeks in DTVFCG. The majority (94%) of adults are waiting less than 2 months for an assessment.
- **MHSOP** There is no significant change in the numbers waiting for an assessment. Our longest wait time is currently 53 weeks in NYYSCG. The majority (98%) of older adults are waiting less than 9 months for an assessment.

Waiting Times Neuro Services

- **AMH ADHD** There is special cause improvement (a reduction) in the number of waiting for an ADHD assessment. Our longest genuine wait time is **333** weeks (6.3 years) in DTVFCG. The majority (70%) of adults are waiting between 1-3 years for an assessment.
- **AMH Autism** There is no significant change in the number waiting for an autism assessment. Our longest genuine wait time is **323** weeks (6.1 years) DTVFCG. The majority (79%) of adults are waiting between 1-3 years for an assessment.
- **CYP Autism** There is no significant change in the numbers waiting for an autism assessment. Our longest wait time is **201** weeks (3.8 years) in DTVFCG. The majority (68%) of children and young people are waiting between 1-3 years for an autism assessment.
- **CYP ADHD** There is special cause concern (an increase) in the numbers waiting for an ADHD assessment. Our longest wait time is **247** weeks (4.7 years) in DTVFCG. The majority (68%) of children and young people are waiting between 9 months and 3 years for an assessment.
- **CYP both/not yet categorised** There is special cause concern (an increase) in the numbers waiting for a neuro assessment. Our longest wait time is **191 weeks (3.6 years)** in DTVFCG. The majority (50%) of children and young people are waiting between 2-3 years for an assessment.

National Waiting Times

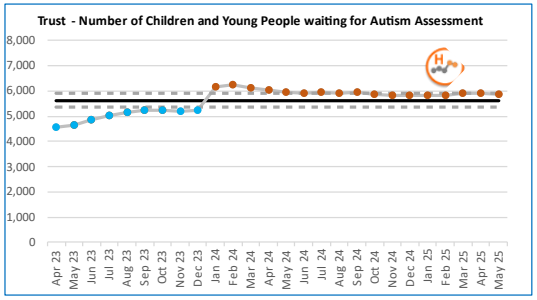
- **CED Urgent** There is no significant change in the number waiting from an urgent referral within our Eating Disorder Service. There are currently no children waiting for an urgent assessment.
- **CED Routine** There is no significant change in the number waiting from a routine referral within our Eating Disorder Service. Our longest genuine wait time is **6.1** weeks in NYYCG. The majority (62%) of children and young people are waiting less than 4 weeks for treatment.
- **EIP** There is no significant change in the number of waiting for EIP Treatment. Our longest wait time is currently **17** weeks in DTVFCG. The majority (87%) of adults are waiting less than 2 weeks for treatment.

Waiting Times Talking Therapies

- There is no significant change in the number of adults waiting for their second contact with Talking Therapies. Our longest wait time is currently **77** weeks in NYYSCG. The majority (81%) of adults are waiting between 6 and 28 weeks for their second appointment.

Waiting Times Neuro Services: Children & Young People

Tees, Esk and Wear Valleys NHS Foundation Trust

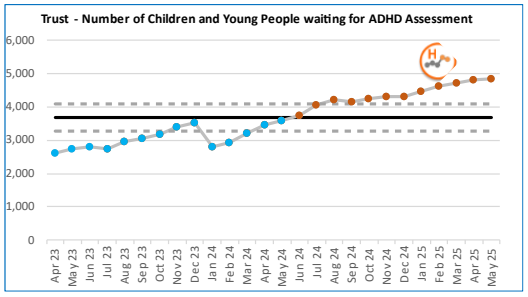


Children and young people waiting for an Autism Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	5861	75	201	
DTVF Care Group	4929	80	201	
NYY&S Care Group	932	45	119	

Commentary on Longest waits

DTVF: Genuine Wait - Specialist Assessment Booked
NYY&S: Data Quality - Specialist Assessment Complete (longest genuine wait - 834 days - specialist assessment booked)

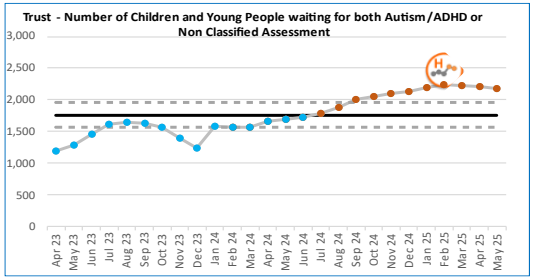


Children and young people waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4845	67	247	
DTVF Care Group	4012	71	247	
NYY&S Care Group	833	46	139	

Commentary on Longest waits

DTVF: Specialist Assessment Required
NYY&S: Data Quality - Specialist Assessment Commenced (longest genuine wait - 833 days - specialist assessment required).



Children and young people waiting for both Autism/ADHD Assessment or Not Categorised

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	2178	89	191	
DTVF Care Group	1675	107	191	
NYY&S Care Group	503	30	98	

Commentary on Longest waits

DTVF: Genuine wait - Specialist Assessment Required
NYY&S: Genuine wait - Specialist Assessment Required

Underlying issues:

- High levels of demand outweighing capacity
- High levels of inappropriate referrals
- Long wait times and projected waiting times in the County Durham areas.
- Long-term sickness absences and vacancies within the Scarborough ADHD team

Actions (Partnership-wide):

- The Trust is in advanced discussion with CNTW and the ICB on short- and medium-term actions to reduce demand and longer waiters and a joint paper will be taken to the May Management Group.
- Following approval of the specification for the alternative, accredited private providers, the ICB have identified funding to send a small cohort of patients as an initial pilot phase. Work is now underway to identify the patients for that first cohort. Timescales will be agreed by the end of May 25.
- The ICB have commenced training across the Tees Valley footprint to support an increased understanding of neuro developmental concerns and the graduated response, with the aim of supporting a reduction in request of assessments.
- In addition, a well-functioning multi-disciplinary panel will be re-established to support access to the service. Timescale to be confirmed
- In North Yorkshire & York the service continues to engage with commissioners, Humber & North Yorkshire ICB and the Provider Collaborative regarding capacity within our CYP services versus demand and the subsequent impact on waiting times. The ICB is reviewing the process around “Right to Choose”’ with a view to aligning assessment pathways across providers. Whilst workshops have been held to explore a new pathway, there is no definitive outcome from those as yet. The Collaborative lead has confirmed there will be new specifications developed for both adults and CYP.

Waiting Times Neuro Services: Children & Young People

Tees, Esk and Wear Valleys NHS Foundation Trust

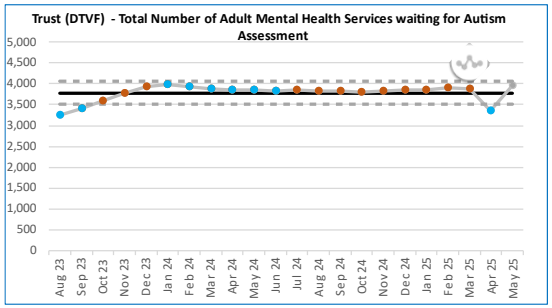
Actions (Trust):

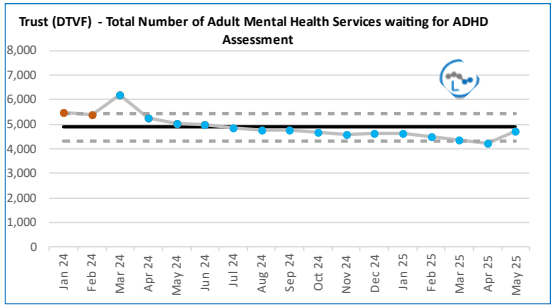
- DTVFCG have a recovery plan in place. Phase 2 testing on dual assessments continues in Darlington; however, this has been impacted by staff vacancies and the full evaluation of the clinical protocol is now due to be completed by the end of June 2025 (previously April 25). All actions within the recovery plan are progressing however demand currently continues to outweigh capacity.
- Within Selby and York, work is now underway with Strategic Planning and Finance to explore the impact of the proposed model for the assessment and treatment of neurodevelopmental conditions, following which the group will consider whether the option to share resources to improve the patient journey and capacity is viable. The viability of the proposal will be concluded by end of May 2025.
- The Scarborough ADHD team has a recovery plan in place. The service have recruited to all vacant posts and overtime is being offered to staff, and they are working to ensure that they are using their existing resources efficiently and effectively to identify any remaining efficiencies by the end of June 2025 and shared through governance meetings by end of July 2025. Whilst some improvement can be made, the demand outstrips the capacity of the service.
- The first meeting of the all-age neurodevelopmental steering group is scheduled for the 30th May 2025 where Terms of Reference will be agreed. This group will lead and oversee work internally and align with the work externally, across our respective ICB areas and for this group to align to the Community Transformation Programme Board.

To Note: The trajectory submitted to NENC ICB, factoring in the additional assessments, remains on track for delivery.

Waiting Times Neuro Services: Adult Services

Tees, Esk and Wear Valleys NHS Foundation Trust





Adults waiting for an Autism Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
rust (DTVF Care Group)	3952	100	363	

Commentary on Longest waits

DTVF: Data Quality - Assessment Complete (longest genuine wait - 2265 - specialist assessment required)

Adults waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
rust (DTVF Care Group)	4711	90	351	

Commentary on Longest waits

DTVF: Data Quality - Assessment Complete (longest genuine wait - 2332 - Assessment Required).

Underlying issues:

- High levels of demand outweighing capacity
- There are a small number of patients that have been transferred to the new Neuro teams with an incorrect referral action.
- Delivery of the trajectory has been impacted by several factors: issues with the accuracy of data following the electronic transfer of patients from community teams to the new neurodevelopmental teams; CITO issues in relation to referrals and robust validation of the waiting list

Actions (Partnership-wide):

- The Trust is in advanced discussion with CNTW and the ICB on short- and medium-term actions to reduce demand and longer waiters and a joint paper will be taken to the May Management Group.

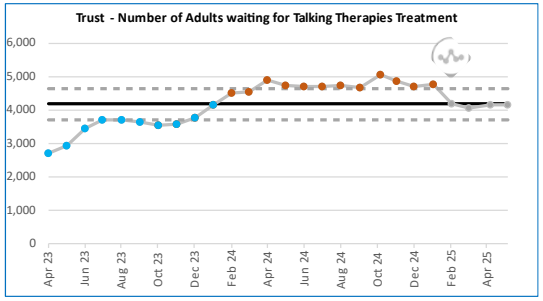
Actions (Trust):

- The current KIT process is being redesigned as part of the restructure of community services this will align to the process in CYP and CNTW with implementation planned for 1st April 2025. **(Complete).** The service continues to maximise assessment capacity with weekly oversight by the Care Group.
- The first meeting of the all-age neurodevelopmental steering group is scheduled for the 30th May 2025 where Terms of Reference will be agreed. This group will lead and oversee work internally and align with the work externally, across our respective ICB areas and for this group to align to the Community Transformation Programme Board.
- The General Manager will undertake further analysis to better understand the increase in the waiting list in April in order to inform next steps. This will be completed in June with findings reported to the June Care Group Board.

To Note: The trajectory submitted to NENC ICB is not on track.

Waiting Times Talking Therapies

Tees, Esk and Wear Valleys NHS Foundation Trust



Talking Therapies - adults waiting for their second treatment contact*

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4141	14	77	
DTVF Care Group	2284	15	59	
NYY&S Care Group	1857	13	77	

Commentary on Longest waits

DTVF: Genuine Wait - 1st Treatment Required
NYY&S: Genuine Wait - 1st Treatment Booked

Underlying issues (DTVFCG):

- Capacity of Psychological Wellbeing Practitioner (PWP) (high levels of step 2 vacancies/absence/sickness)
- High levels of people accessing Step 3 care, bypassing Step 2 appropriately
- Fewer people being allocated to Computerised Cognitive Behaviour Therapy (cCBT) and workshops due to their complexity of need
- Higher demand for face-to-face appointments in specific localities
- Counselling for Depression demand exceeds capacity
- High levels of priority group (perinatal, veterans, high risk) patients

Underlying issues (NYYSCG):

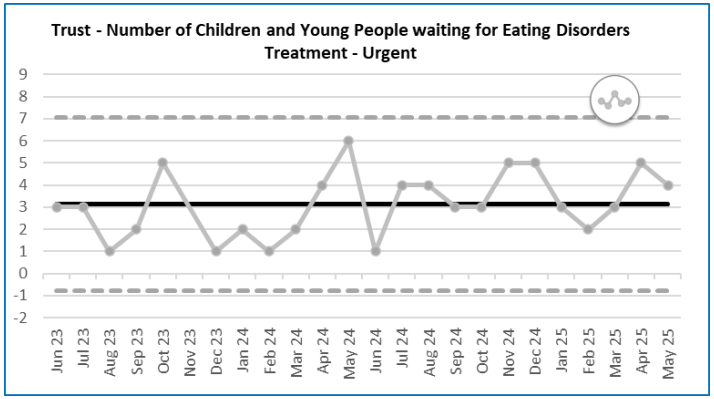
Underfunding within Step 2 and Step 3

Actions (Trust-wide):

- The Trust-wide Task & Finish Group has developed an improvement plan which will be taken to each Care Group Board during May prior to being presented as a focused discussion at Executive Directors Group later that month.
- DTVFCG have a service recovery plan with actions being progressed. A quality impact assessment is being undertaken prior to an ‘opt-in’ process being implemented in June 2025. It is anticipated this will increase capacity as those who have opted out will be removed from the waiting list, enabling those people who want to remain with the service to 'move up' the waiting list and be seen timelier.

Waiting Times Children's Eating Disorders – Urgent Referrals (1 week National Standard)

Tees, Esk and Wear Valleys NHS Foundation Trust



Children & Young People Eating Disorders Services - 1 week standard for Urgent referrals*

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4	18	57	
DTVF Care Group	2	10	57	
NYY&S Care Group	2	8	12	

DTVF: Data Quality - Assessment Complete and treatment commenced. There are no patients genuinely waiting).
NYY&S: Data Quality - Assessment Complete and treatment commenced (there are no patients genuinely waiting).

Summary:
There are 3 children and young people **reported** as waiting more than 1 week; however, **none** of these are genuine waits:

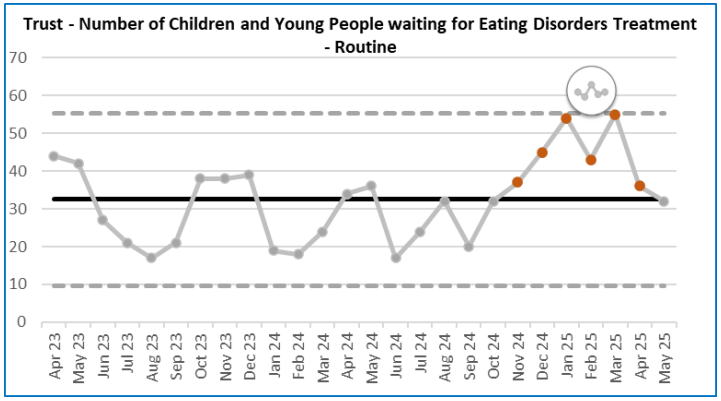
- 2 patients are attributable to data quality
- The remaining patient has been assessed and is not suitable for treatment therefore the service are in the process of referring the patient to a more suitable service

Underlying issues:
Data Quality

Actions:
Data Quality – Steps are being taken to resolve these in CITO

Waiting Times Children's Eating Disorders – Routine Referrals (4 weeks National Standard)

Tees, Esk and Wear Valleys NHS Foundation Trust



Children & Young People Eating Disorders Services - 4 week standard for Routine referrals*

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	32	9	53	
DTVF Care Group	19	5	48	
NYY&S Care Group	13	16	53	

DTVF: Data Quality - Treatment commenced (longest genuine wait - 26 days - treatment not yet commenced)
NYY&S: Data Quality - Treatment Commenced (longest genuine wait - 43 days - treatment not yet commenced)

Summary:
There are 12 children and young people **reported** as waiting more than 4 weeks; however, only **1** of these is a genuine waiter:

- 1 patient (6 weeks) cancelled an appointment during April, which was offered within the 4-week national standard, and a further appointment has been offered in May.

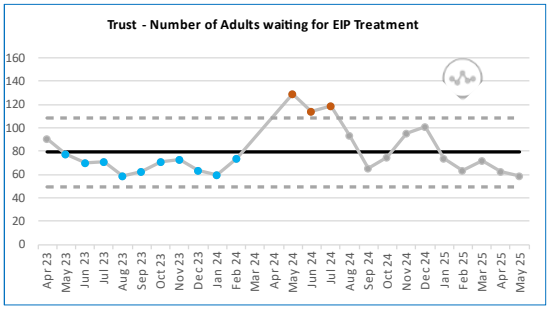
Of the remaining 11 patients:
- 8 patients are attributable to data quality
- 3 patients were assessed, however eating disorder services are not appropriate for their needs. Two patients have been subsequently discharged from the service and the remaining patient is being further assessed to determine the most suitable treatment option for their mental health needs.

Underlying issues:
Data Quality

Actions:
Data Quality – Steps are being taken to resolve these in CITO

Waiting Times EIP Treatment – Adults (2 weeks National Standard)

Tees, Esk and Wear Valleys NHS Foundation Trust



Adults Waiting for EIP Treatment - 2 week standard*

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	59	2	17	
DTVF Care Group	39	3	17	
NYY&S Care Group	20	2	5	

Summary:

There are 16 adults **reported** as waiting more than 2 weeks of which 14 are genuine waits

- 1 patient (reported as **17 weeks**) was referred into service in January 2025 and discharged having failed to attend appointments. A new referral was received in April; however, the first noted symptoms of psychosis were incorrectly dated back to January 25 (as per previous referral). The patient failed to attend their first offered appointment and a further appointment is booked in May; therefore, still waiting.
- 1 patient (waiting 12 + weeks) was referred into EIP in April; however, their first noted symptoms of psychosis was identified in January 2025 by the Access Team. An appointment is booked in May**.**
- 4 patients cancelled/failed to attend an appointment offered within 2 weeks; 1 patient has been sent an offer of service letter after failing to attend a further appointment and the remaining 2 patients have appointments booked in May.
- 4 patients have appointments outside of 2 weeks due to patient choice.
- 1 patient was offered an appointment within 2 weeks which was cancelled by the service. An appointment is booked in May.
- 2 patients attended appointments within 2 weeks. One patient has been placed on an extended pathway with an appointment booked in May; the service are validating the assessment for the second patient.
- 1 patient attended a joint appointment with CAMHS outside 2 weeks (the earliest opportunity for both teams) and was placed on an extended pathway. An appointment is booked in May.

The remaining 2 patients:

- 1 patient failed to attend multiple appointments and is now in the process of being discharged.
- 1 patient is attributable to data quality.

Underlying issues:

- First noted symptoms of psychosis being applied correctly (*see longest waiting times*)
- Delay in referring patients from Access to EIP
- Cancelled/Failed Appointments

Actions:

- Head of Performance to discuss application of standard in relation to first noted symptoms of psychosis with EIP Clinical Lead as a matter of urgency **(Complete)**
- DTVFCG AMH General Manager, Middlesbrough Team Manager and Community Modern Matron to develop standardised guidance to ensure that patients with a suspected psychosis are promptly forwarded to the EIP services. This will be completed by the end of April 2025. **(Complete)**

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Meeting of:	Board of Directors
Date:	12th June 2025
Title:	Our Journey to Change Delivery Plan quarter 4 (October – March 2025) update
Executive Sponsor(s):	Kathryn Ellis, Interim Executive Director of Transformation and Strategy
Author(s):	Strategy Team

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

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

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

Strategic Risks relating to this report:
The *Our Journey to Change Delivery Plan 2024/25* is informed by an understanding of all of the BAF risks and the differential levels of risk appetite for each of the risks within it.

Executive Summary:

Purpose:

This report monitors the 17 priorities which make up the OJTC delivery plan for 24/25. As part of the delivery plan development process, each of the 17 priority leads was asked to complete a plan on a page (POAP). Each plan on a page details the deliverables (actions) which make up the delivery plan and which need to be completed to ensure that each plan on a page and the overall **delivery plan** is achieved.

As this is the final report for the 24/25 delivery plan, it contains information around the progress of all work (deliverables) within the plan including RAG ratings of each deliverable (key p2). This report only gives specific details of deliverables which are either Red. Or Amber.

An additional section has been added to look at the impact/benefits of the delivery of work to date by journey, where this is available and where this has already been realised. This is a work in progress and not all journeys have been able to demonstrate impact at this point. As it is only the end of Q4 it is not possible to see all the benefits and impact that the work carried out in 24/25 will bring. In most cases the impact will take some time to be realised. However, if there is further impact to be seen, this will be reported upon at the end of quarter 2 25/26, where available.

Proposal: Board members are asked to review the updates on journey, priority and deliverable progress over the fourth quarter of 24/25. The report also provides a summary delivery position as a percentage at a deliverable and overall journey level. The report details how work which was not delivered in 24/25 will be taken forward. Board members are also asked to review the impact section of the report. Any deliverables which are carried over into 25/26 will be monitored by the appropriate trust governance structure - Care Group and corporate.

Overview: The updates to this report were provided from various sources via verbal & written reports. The legend outlining RAG categories is below:

Complete	
On track	
Delayed – will still meet end date	
Delayed – end date will not be met	
Not started/paused	
Not reported	

This report includes:

- Deliverable status per journey for 2024/25
- Deliverable status overall for 2024/25
- Journey updates as at Q4
- A summary of impact and benefits of work to date where this is available and has been realised.

Prior Consideration and Feedback Where appropriate, progress and issues have been discussed within Care Group or Executive Group meetings. This report was also received at Management Group on 15th April where all extensions of timescales into 25/26 were approved. Planning and Resources committee also received this report on 11th June.

Implications: There are 26 deliverables which have not been delivered within agreed timescales. These have been flagged in within the report with rationale given and any agreed way forward or completion dates in **bold and underline text.** These deliverables will be monitored via the appropriate governance structures be this Care Group or corporate.

As the reporting period has just ended, some of the deliverables within the plan are not yet able to demonstrate impact as this will be longer term.

The tables below outline the percentage of deliverables which have been completed per journey (Table 1) and overall (Table 2).

Table 1: % status of Deliverables per Journey for Q1 – Q4

Deliverable status per Journey for 2024/2025 Delivery Plan (Q1-Q4)					
	Journey RAG status				
	Complete	Ongoing / continuing	Delayed		Paused
Clinical	63%	13%	0%	24%	0%
Q&S	75%	13%	6%	6%	0%
Co-Creation	65%	29%	0%	6%	0%
People	75%	25%	0%	0%	0%
Infrastructure	43%	18%	11%	14%	14%

Table 2: % status of deliverables overall for Q1 - Q4

% Status of deliverables for 2024/2025 Delivery Plan (Q1-Q4)				
Complete	Ongoing/ continuing	Delayed		Paused
61%	**17%**	**3%**	**17%**	**3%**

61% of deliverables for 24/25 are complete and 17% were ongoing and not due to complete in 24/25. 3% are paused. 20% will not meet the agreed timescales of Q4 24/25. Of the 20% which will not be delivered by 24/25:

20	Work will carry on into 25/26 (8 already have completion dates)
1	Requires ongoing monitoring
1	Out of TEWV control
1	Taken forward as part of the Transformation programme
2	Are now business as usual
1	Requires an Executive decision on way forward

Recommendations: **Board members are asked to:**

a) Note the information and analysis provided in this report.

b) Provide any feedback or comments where necessary.

Clinical Journey – Quarter 4 24/25

Transforming Community Services: There are 31 deliverables within this piece of work,19 of which are complete. 2 are on track with end dates of June 2025. There are 10 deliverables which are red. These are:

- *All adults and older adults within TEWV community services are offered appropriate evidence-based interventions*:
  - *Durham/Tees Valley-* Clinical Transformation working group developed to support the delivery of EBI. Highlights reports sent to steering group. Work is continually ongoing to ensure appropriate workforce is maintained. This priority **continues in 25/26** and forms part of transformation group plan and will be monitored via this group.
  - *North Yorkshire and York-* There is a baseline understanding of current capacity and significant resource gap. The NHSE WT&E PTSMHP programme of training is being utilised to maximise offer from existing workforce. In 24/25 we did not utilise salary support opportunities from PTSMHP programme owing to financial constraints and significant gap in capacity remains. This work will **continue in 25/26.**
- Durham & Tees Valley - To continue to develop *the system neurodevelopment offer and to implement the recovery plan to reduce the neurodevelopment assessment backlog* - A number of strands of work have had a positive impact to increase capacity. A revised shortened diagnostic tool has been piloted. Positive findings show released capacity which means more diagnostician time created. This has resulted in extra funding for a band 6 post in Tees which will support the increase of assessments. Work with ICB to support work to introduce a framework for approved providers. New staff appointed and joining the team in the next 2 months. This has **transferred to the 25/26 Care Group plan** with agreed actions and timescales.
- *Durham - To review PCN ARSS roles and explore options to have full coverage across DTV* - This deliverable will **transfer to 25/26** to work with commissioners to identify options to extend coverage.
- *Tees Valley - CYP ARRS roles evaluation - This priority will **continue into 25/26** to work with commissioners and system partners to use the evaluation findings demonstrating a reduction into CAMHS, to develop a plan for expansion should opportunity/investment arise.*
- *Durham - To expand MH support team in schools' provision in County Durham* - This priority is **extended to 25/26**, linked to national planning guidance and its priority referenced within.
- *Tees Valley - Physical healthcare model in place across all 5 Tees Valley localities* - Currently only two Physical health practitioners - Darlington and Redcar & Cleveland. Interviews completed for Stockton and Middlesbrough with 2 posts offered. This work will **continue in 25/26.**
- *Tees Valley - All Tees Valley AMH community hub referrals assessed within 28 days* - Waits currently standing at 7 weeks for Stockton and 7 weeks for Hartlepool. Waits in Darlington escalating but constant vigilance to support delivery of target monitored through Q&P with Director. New national waiting times metrics will also support diligence. This metric will require **ongoing monitoring** to ensure performance is maintained beyond the target date.

Transforming Urgent Care: There are 5 deliverables within this piece of work. 2 are complete. One is green / on track and due for completion by March 2026. 2 are red and have not been completed within the agreed timescales.

- Implementation and embedding of the OPTICA system - Optica's transition to the NHSE Federation Data Platform was smooth and incident-free. The pilot is nearing its end although there is system development work outstanding however this could resume at a later date. The local authority wasn't onboarded in time for NECS's pilot evaluation. A business case is anticipated in March 2025 which if supported will facilitate the roll out and embedding of the system across all inpatient wards excl SIS. This work will be **completed by June 2025.**
-
- Scoping of Right Care Right Person with partners - Groups are embedded in practice. Good relationship with police constabularies. No significant issues raised. This deliverable is.working to the regional deadline that has been agreed and the proposed end date is now June / July 2025. This work will be **completed by July 2025.**This will be monitored via the Urgent Care programme board.

NENC Secure Services Provider Collaborative Bed Model - there are 8 deliverables within this piece of work, 5 are complete. 2 deliverables are green / on track and are due for completion by Q2 25/26. One deliverable is red.

- Female Model: MI business case supported at DTVF Care Group Board. Presentation to Commissioning Group and Partnership Board by end of March. Commissioning Group was not quorate, and the Partnership Board was cancelled and therefore the papers were not presented. **This is out of TEWVs control.**

Expanding our Health & Justice services - there are 3 deliverables within this piece of work, with 1 complete. The 2 remaining deliverables on track as one is ongoing and the other due for completion in May 25.

Autism: there are 4 deliverables within this piece of work, with 2 of which are complete and 2 ongoing which are on track and will become **business as usual.**

Young Adult Services: there are 7 deliverables within this piece of work with 5 complete. 2 deliverables are due by Q4 are red.

- *Develop revised proposals for how we oversee services for young adults* and *after scoping a clearer programme of work will be developed* - Whilst good progress has been made against the milestones within this piece of work, it has been agreed that it will be **subsumed into the trust wide transformation programmes** as this work covers community, inpatient and urgent care. The trust wide transformation programmes are best placed to take forward and make progress on this agenda.

Reducing health inequalities: there are 10 deliverables within this piece of work. 9 of these deliverables are complete. One remaining deliverable is red

- *Trial a mode of closing the gap on did not attend/was not brought by* – a pilot team have been identified, and project initial project trialled. There have been a number of challenges in implementing both in terms of capacity and available technology. The team are adopting an alternative approach to review compliance with the new DNA/WNB policy. This work will need to **roll forward to 2025/26** with improved data and governance.

Quality & Safety Journey – Quarter 4 24/25

Personalised Care Planning: there are 7 deliverables within this piece of work with 5 complete. 2 deliverables are ongoing one of which is on track and the other is amber. The amber deliverable is:

- *Work with ICBs to establish effective interoperability between systems.* Conversations continue to take place with ICBs around the interoperability of systems. This work will continue into 2025/26 as **business as usual.**

Physical Health: there are 4 deliverables within this piece of work 3 are now complete and 1 is red.

- *Communication plan developed and engagement through to March 2025* - Work has been completed on the intranet and empathy mapping took place in January. Further planning is now in progress as part of a wider internal communications campaign throughout 2025-26. This work will continue into 2025/26 as **business as usual.**

Improved patient safety: there are 5 deliverables within this piece of work of which 4 of which are now complete. The remaining deliverable is on track and due for **completion by June 2025.**

Co-creation Journey – Quarter 4 24/25

Further develop our co-creation infrastructure: there are 5 deliverables within this piece of work, all 5 deliverables are complete .

Lived Experience/ Peer Roles: there are 6 deliverables within this piece of work, 5 deliverables are complete but one is red.

- *S.I.S (including carer) roles appointed to – Peer Co-ordinator in post.* Senior peer worker in post and delivering peer support onto the SIS wards. Peer Worker posts currently out to advert. Carer role to follow soon. This role was delayed as we carried out additional groundwork with carer focused VCSE and an evaluation of our first carer role to ensure all available learning incorporated into set up of role. This will be completed by the end of **April 2025**.

Improve Patient Experience: there are 6 deliverables within this piece of work, 1 was complete by the end of Q2. 5 remaining deliverables are not due until **August 2025** but are all on track.

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People Journey – Quarter 4 24/25

Deliver our people plan: There are 4 deliverables within this piece of work, 3 are complete at the end of Q4. There is 1 remaining deliverable which is not due until the end of Q1 25/26, which is on track.

- *Newly procured Occupational Health Service in place* – the new provider will be in place on time. Handover plans are in place and communications have started to all staff about the change in provider.

Infrastructure Journey – Quarter 4 24/25

Estates: There are 9 deliverables within this piece of work, 4 of which are complete. and 3 are due in 25/26 and are on track, 1 due in June 2026 is amber and one due in March 2025 is red which is:

- *Trust Collaboration & leadership hub (Stockton)* - Financial options continue to be modelled to identify an affordable scenario for the revenue cost. Paper developed for **EDG for decision on way forward.**

The Green Plan: There are 7 deliverables within this piece of work, 3 of are complete. One is on track and due by March 2026. One is amber and due for completion by **Q4 2026.** 2 are red with one due for completion in July 2025 and another due for completion by March 2025 however this deliverable will be complete by July 2025.

- *Key area of focus - Energy and Sustainability Manager to identify workstream leads and milestones for 2024-25* - Eleven sub-groups have been set up with core membership from Sustainability Group members and wider trust staff. Comms team issued requests in Jan/Feb 25 for volunteers to support Green Plan development and delivery. Sub-group membership will be strengthened from volunteers with expertise and interest in specific topic areas. Meetings of all sub-groups will take place in April/May 25 to inform the Green Plan refresh and allow time for wider consultation with the aim of **completing by 31/07/25** in line with NHSE target date.

- *Pledge for Greener - The Energy & Sustainability Manager, when in post, will be instrumental in completing the Green Plan refresh, establishing and delivering the milestones* - NHSE Green Plan Refresh guidance was issued 06/02/25 so refreshed Green Plans should be approved by the organisation's board, published in an accessible location on the Trust website and shared with NHSE by **31/07/25.** Developing the new plan will involve reviewing progress to date and engaging with key stakeholders to refresh priorities, in particular clinical and staff groups who underpin delivery. The plan will incorporate national guidance and targets issued since the last Green Plan was developed. To increase engagement, the trust Comms team issued requests in Jan/Feb 25 for volunteers to support Green Plan development and delivery. 37 volunteers to date from across the trust will form a Green Champions network with a dedicated Teams channel to support ongoing engagement. Volunteers with specific expertise/interest in topic areas will be added to relevant sub-groups. Monthly staff drop-in sessions on Teams will be developed to focus on topic areas and provide staff with general updates to Green Plan progress.

Digital and Data: There are 12 deliverables within this piece of work, 5 deliverables are complete. 4 are grey and have not yet started. One is on track and due to complete by June 2025. One is amber and due by **May 2025** and one due by March 2025 is red.

- *All inpatient wards have inpatient internet* - amber - Following agreement from EDG on the move away from the current platform provided by Advanced - The migration of the Business Intelligence (IIC System) to the IBM cloud will be **completed by April 2025.**

- *Move Business Intelligence system to cloud. deliver network bandwidth across 20 Trust sites experiencing performance issues and deliver MFA* - red - NHS Wi-Fi available for patients wishing to use their own devices when in inpatients areas - although some restriction in WiFi coverage. The PC's and Tablets devices have been ordered and received. Work is now ongoing to review the configuration of devices, review the account process and update all supporting documentation with a change to LAN being produced identifying roll out of kit to ward areas - to be **completed in May 2025.**

Deliverable Impact Statements

Clinical Journey - Impact

Transforming Community Services – York and North Yorkshire

It is still too early to detail the impact of the deliverables for the community hubs as there is only one thus far. The biggest impact to report is the First Contact MH Practitioners in Primary Care, which has received around 30,000 referrals in the last 12 months of which less than 5% are referred on to TEWV. However, we do not have these practitioners in every PCN so GPs still directly refer. We are awaiting data regarding current referrals and conversion rates, and information from the hubs and FCMHPs is currently not recorded on CITO, making it difficult currently to effectively measure impact at the moment.

Transforming Community Services – Durham

Positive recruitment across the service including to AHP vacancies. Positive feedback from partners, families and carers on improvement of quality of life. Reduced restrictive practices, as seen within recent benchmarking returns (see below Quality & Safety Journey inpatient safety).

Autism

The autism leadership team believe that an impact across TEWV services has been made through the delivery of training, consultations and support. Access to consultation/ support has increased and feedback from clinicians has identified that the training has 100% met their needs. Whilst the feedback we have received from both training and clinical consultations has been extremely positive the autism leadership team are looking at completing a further review of these to identify next steps and areas that have not accessed. There is an increased demand for attendance at formulations, MDTs, complex case discussions across both community and inpatient areas.

There are pockets of excellent practice where the clinical needs of autistic people accessing our services have been provided in autism informed way. However, there is still work to be done, as we have not achieved sustained change across all clinical and corporate areas across the trust.

Clinical Journey - Impact

NENC Secure Services Provider Collaborative BED Model

The number of external patients waiting for admission has decreased since the April 2024 and the total time waited has also decreased. Our longest waits are associated with stepdown from High Secure**.**

We are working towards the national aim for prison transfer within 28 days from referral. Although we have made improvements with access targets, particularly in male low secure units with the opening of Jay ward, we are still challenged to meet the national aim, however, this is reflective of the national picture.

The total number of Secure MH inpatients originating from the NENC at the end of the month is 212. This is an increase since April 2024, with the increase in bed capacity positively impacting on the male medium secure position. Further impact will be made in 25/26 when additional male low and medium secure beds come on in line at CNTW.

The total number of MH patients in placements out of area the end of the March is 36. This is an increase in position since April 2024. The pressure remains in the male medium pathways with delays in the opening of the additional ward at CNTW having an impact. A detailed repatriation plan sits behind this work which identified

Reducing Health Inequalities

A co-creation video on health inequalities was completed and shared, the event evaluations showed that all respondents learned something from the event that they would take it back to their teams.

The new model of specialist substance use inpatient, has received over 200 referrals and is showing positive results in terms of partnership working and individual outcomes.

The naloxone pilot is completed, and a model of practice has been adopted by both care groups.

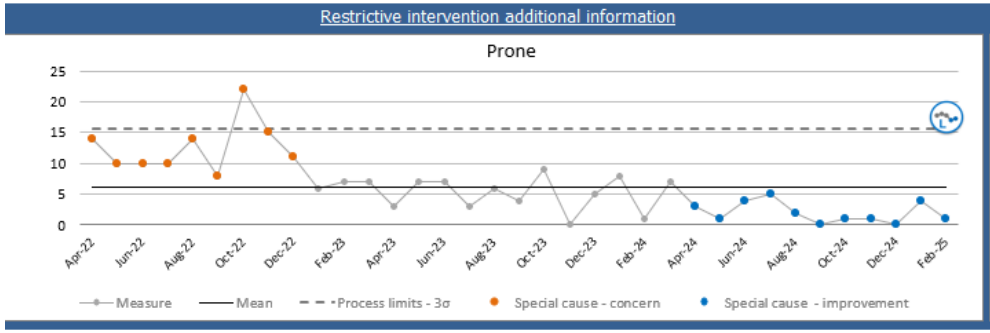
The pilot area has not seen a reduction in the DNA/WNB following initial pilot active which was restricted by available resource. Further work will be required.

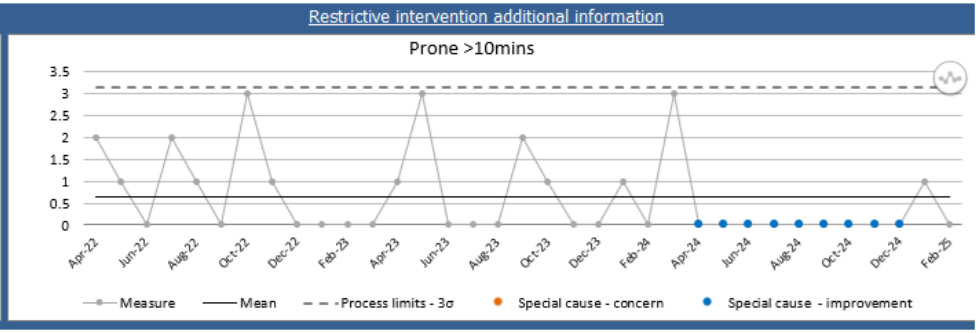
A longer-term time frame will be required before we will be able to determine if there are higher levels of engagement between services, Gypsy, Roma Traveller communities following the work will that has been in undertaken.

Quality & Safety Journey – Impact

Inpatient Safety

There has been reduced use of restrictive interventions including the use of Prone restraint. We have continued to demonstrate progress, and it is reported via a monthly Positive and Safe dashboard. See evidence from most recent dashboard below:





Co-creation Journey - Impact

Further develop our co-creation infrastructure

Our service users, carers and families have had many more opportunities to have their voices heard and have been given opportunities to meaningfully engage in supporting change and making a difference in service development in TEWV. The overall impact of these co-creation deliverables will hopefully see improvements in positive feedback from patients, carers, families and staff in the future.:

The most co-produced recruitment process took place in the history of TEWV's recruitment, over a period of 4 months, resulting in, Beth Allan's appointment. Beth who has a wealth of lived experience and professional knowledge.

A Co-creation communication and engagement strategy was developed through the summer and autumn of 2024 with the input of service users and carers. This has resulted in intranet pages being redeveloped and updated and new media and mediums used that have all been co-created.

The co-creation framework was launched in January 2025 and over 500 carers patients, partners and staff actively engaged with launch events. As a result of this work the next phase of the co-creation strategy has been developed.

27 co-creation champions have now been inducted and trained, with further expansion planed.

Lived experience/ Peer roles

We have successful implemented a peer support structure and recruited to peer leadership roles in care groups and in key localities, workstreams and specialities, increasing from 6 to 44 roles, and on track to pass 50 roles this calendar year.

We have a We have a 1-year retention rate within peer support roles of 88%, a 2 year retention rate of 80%, and a 3 year retention rate of 71%.

Feedback from service users and colleagues remains excellent, with peers reporting a strong connection and sense of meaning from their work. We are working with a user led VCSE to develop our strategy for routinely collecting feedback.

Peer support training and supervision has been set up alongside Teesside University and peer support networks in collaboration.

The full impact of the increase in lived experience and peer roles with the trust and our collaboration with partnership initiatives developed throughout 2024/2025 will take time to evolve.

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

People, Culture and Diversity Committee: Key Issues Report	
Report Date: 12 June 2025	**Report of: People, Culture and Diversity Committee**
Date of last meeting: 29 May 2025	The meeting was quorate.

1 **Agenda: The following agenda items were considered during the meeting:**

- Colleague Story/Experience
- Minutes of the meetings held on 11 December 2024 and 23 January 2025
- Key Issues Reports for 11 December 2024 and 23 January 2025
- Safer Staffing – Use of Resources
- Corporate Risk Register
- Board Assurance Framework
- People Journey Delivery Report
  - People and Culture Dashboard and IPR
  - Equality Diversity and Inclusion
  - Health and Wellbeing (including: Long Term Sickness Absence Report (April 2024 to March 2025); Employee Psychology Services outcome measures; Termly Report for TEWV Staff Mindfulness Service January 2025 to March 2025)
  - Culture and Retention
- Apprenticeship Update
- Freedom to Speak Up Guardian Update Report
- Workforce Planning – 'Deep Dive'
- Terms of Reference
- Committee Evaluation
- Workplan

2a **Alert: The Committee wishes to alert the Board on the following matters:**

Freedom to Speak Up Guardian Report (FTSU)
The Committee takes good assurance from the processes in place in relation to FTSU and notes the 70 individual cases currently on caseload and the recent proactive work with 2 teams experiencing relationship challenges. The Committee notes that a report will be submitted to the Executive Directors Group (EDG) soon to finalise the procurement process for the Freedom to Speak Up Guardian service. It confirms the importance of both retaining the FTSU function and ensuring a successful handover to an external organisation due to the risks of not having an effective service in place.

2b **Assurance: The Committee can confirm assurance on the following matters:**

Corporate Risk Register
The Committee agrees good assurance in respect of the risk management processes in place, the consideration of risks for inclusion in the Corporate Risk Register and the ongoing management of these risks. It notes the improvement in risk review compliance to 100% for CRR and increases across the board for all levels of risk, rising this month to 85%. In addition, it notes that a new 6-monthly cyclical process of risk review for risks at 15+ (although not limited to that) is being introduced to replace the review of 'static' risks. The risk owner will attend Executive Risk Group to discuss the risk, successful control and mitigation and any blockages or issues where the Executive may be able to help. A new template is being trialled to strengthen the review process. The Committee agrees that Risk 1137 currently assigned to DTVF Management should be Trust-wide: 'Due to vacancies, staff absence and clinical activity compliance with the clinical supervision of Registered and unregistered nursing staff is below the desired compliance. Current system unable to provide assurance. The lack of opportunity to discuss clinical cases and reflect on the care delivered reduces opportunities for staff development and support of their wellbeing and in turn potentially impacts on the quality and effectiveness of care delivered'. The Committee identifies the Joint Executive Directors of People and Culture as the new Risk Owners to enable assurance to be provided regarding TEWVision and the relevant dashboards.

Board Assurance Framework
The Committee confirms there is good assurance that the strategic 'Safe Staffing' risk continues to be managed effectively. The predicted reduction in the risk score for Quarter 1, 2025-26 was driven by workforce plans being in place for all services. However, it acknowledges the impact of financial

pressures and environmental changes on the ability to reduce the risk score, despite strong controls and mitigations. It also notes that new Governance fora have been established to improve the quality of training through increased oversight.

People Journey Delivery Report

The Committee confirms good assurance, noting the progress on the following:

- Integrated Performance Report: There has been a reduction in DNAs for Mandatory and Statutory training and time taken for investigations. Improvements have been made in automated processes of repetitive HR tasks which releases staff time for other work. In addition, the sickness absence rate has stabilised. The Internal Transfer scheme has been opened up to operate all year rather than over two fixed periods of time;
- Staff Networks: Continue to play an important role in supporting staff, examples include the work of the Long-Term Health Conditions Group in sharing awareness of 'Access to Work' and the Reasonable Adjustments Team and the Rainbow Network in supporting LGBTQ+ staff. All networks have an 'Upstander' programme for allies;
- Gender Identity Work: The programme of **'**Lunch and Learn', face-to-face sessions and online training sessions held with Dr. Debbie Wood has been paused awaiting national guidance on the Supreme Court ruling;
- Supreme Court Ruling: The impact of the Supreme Court ruling on staff, particularly the Rainbow Staff Network was highlighted, including feelings of being undervalued. The role of the Trans Advisory Group was noted in addressing concerns and providing resolutions;
- Pride Month Events: The importance of engaging with communities and showcasing their work via the Durham and York Pride events was acknowledged. There were also celebration activities such as lighting up West Park in rainbow colours;
- Anti-Racism work: An Anti-Racism Steering Group has been established to address and combat racism within the organisation, including providing support for the further implementation of the Anti-Racism Charter, collaboration with Show Racism the Red Card and Unison on anti-racism initiatives and the provision of training sessions for staff;
- Partnership Work: Noted the various partnership programmes, including the STEP into Health Programme, Armed Forces Programme (which support individuals transitioning from the armed forces to careers in the NHS) and Volunteer to Career Programme (which focuses on supporting volunteers to transition into paid employment within the organisation), and the need for further engagement with local community partners.
- Disparity in staff experiences: The Workforce Race Equality Standard remains helpful in monitoring and addressing the disparities between BAME and white staff in terms of bullying, harassment, progression opportunities, and discrimination, in addition to ensuring accountability and progress;
- National Reporting: Noted the various forthcoming compliance reports, including the publication of patient information data, workforce quality standards, and equality objectives;
- Interpretation and Translation Contract: The importance of the interpretation and translation contract was highlighted, given that the service had been accessed 1,753 times in the previous year, along with the need to keep it under review;
- Reasonable Adjustments Team: Noted that the Team supports existing staff and new staff before they commence in post to identify necessary adjustments and reclaim funding from 'Access to Work' to pay for equipment and support. It was clarified that a further paper requesting continuation of the Team (on a permanent basis) was to be considered by Executive Directors' Group, given the range of expertise the team had developed, the level of support they were able to provide to both Managers and staff and the funding they could attract;
- Health and Well-Being: There was a new occupational health provider with updated KPIs; the long-term sickness team was working hard to ensure adherence to the absence policy; data was provided from the Employee Psychology Service and in relation to Mindfulness provision for the first time and in future trends would be explored. It was planned to provide a future report on the work on violence and aggression;
- Culture and Retention: Further work to be undertaken on alignment of interventions and cultural competency at Board level, including a focus on belonging. Noted the role of the Leadership and Management Academy, and the importance of promoting Staff Networks in this work.

The Committee expresses its appreciation of the work of the Reasonable Adjustments Team and acknowledges the importance of people feeling that they are valued at work and having a sense of belonging which the Staff Networks greatly assisted with.

	Safer Staffing – Use of Resources The Committee takes good assurance that 'Safer Staffing' is in line with national quality standards and limited assurance of meeting KPIs for Inpatient safer staffing. The Committee acknowledges the improvements in: roster timeliness; the use of the 'Safe Care' IT solution on Wards to assess dependency; and the increase in professional nurse advocacy (from 3 to 65 in number). It also notes the pause in international recruitment due to national drivers and the support for international nurses who are already working with the Trust through links with Professional Nurse Advocates and Staff Networks, particularly the BAME (Global Majority) Network. Where service modelling work affects international nurses, the Trades Unions will be involved at an early stage, recognising the depth of support which they give to this staff group. The Committee notes the contribution of 'Safe Care' and the overall approach to 'Safe Staffing' to ensuring quality, consistency and increasing support for regular agency nurses. It endorses the proposal that the Therapy Directorate and AMH Urgent Care Teams will be included in the Safe Staffing monitoring process in future. **Apprenticeship Update** The Committee notes that there is good assurance that the Trust has followed a robust process in developing its Apprenticeship provision based on the update for Quarter 4 of 2024/2025. In addition, it takes reasonable assurance regarding the way the Trust uses the 465 Apprentices to support the Trust's strategic goals. It confirms that Level 7 Apprenticeship options for future years will no longer be funded by this route. Where clinical models require the skills these courses offered, alternative funding will be sought. The Committee expresses concern regarding the numbers of HCAs not completing (or projected not to complete) their Care Certificate, Maths and English qualifications or the HCA Framework within the necessary time periods and notes the range of actions being taken to improve the position. The Committee notes that current funds in the Apprenticeship Levy are standing at £2.2m. As an anchor institution and within the spirit of being a 'Great Partner', the Trust wishes to explore the option, in principle, of transferring some of its Apprenticeship Levy to support VCSE partners.
2c	**Advise: The Committee would like to advise the Board on the following matters:** **Colleague Story/Experience** A member of the Volunteering Team from People and Culture who has lived experience of reasonable adjustments provided her story, highlighting the importance of senior management support when on long term sickness absence, the need for accessible Trust buildings and the challenges/impacts of working with long term health conditions. The Committee notes the value of the Reasonable Adjustments Team. It suggests that the topics of the accessibility of Trust buildings and proposals to eliminate the requirement to convey needs to the Training Team multiple times be discussed at the 'Time Out' on 14 July 2025. In addition, where Managers are not supporting their staff with long term health conditions, this should be seen as a capability or conduct issue within the Leadership and Management Framework. **Workforce Planning – 'Deep Dive'** The Committee notes the external factors impacting on the Trust's workforce, particularly the significant increase in demand which led to rises in WTE across most staff groups since 2020. Approximately 20% of the total workforce is now aged over 55, with a higher figure for Consultant Psychiatrists. The clinical model work is seen as pivotal as it provides the evidence base for what is required in relation to skills and roles. Gaps have been identified in relation to Estates, Consultant Psychiatry roles in specific Specialties/skill areas and Specialist Nursing roles. A rounded offer is in place for the AHP and Psychology 'communities of practice'. Work is progressing on developing more Apprenticeship opportunities and conversations have commenced with the wider system to develop a greater understanding of working with the voluntary sector and local authorities. Whilst the main reasons for leaving are not always recorded, they are usually linked to: relocation; promotion outside the Trust and improving work-life balance. The Committee acknowledges that 'Safe Staffing' is at the heart of the ongoing workforce planning journey. **Terms of Reference** The Committee approves the updated Terms of Reference which reduces the number of meetings from four to three a year to reflect the relative time periods over which meaningful change occurs.

	Committee Evaluation The Committee notes the membership changes during the year and the 80% response rate (n=10) to the questionnaire. Overall, the feedback was positive. It was acknowledged by one respondent that reducing the frequency of meetings would be a challenge as whilst 'people are our greatest asset', our number one strategic risk was people in respect of adequate staffing levels. Nevertheless, the pressures of time on Executives and NEDs was understood. The Committee notes comments made in respect of: the learning curve for new members; the work which had recently been put into developing reports for PCDC and actively engaging with those who write them to ensure clear lines of accountability and relating them to the BAF; in addition to the work and role of the Corporate Governance Manager in supporting the Committee. **Workplan** The Committee proposes to hold a 'Time Out' session on 14 July 2025. Possible topics include: an update on the North East and Cumbria 'Scaling-up Programme'; the accessibility of Trust buildings; a 'Deep Dive' on the use of AI and analytics in People and Culture processes; and support for people to access training (for example: information on the intranet about sites; enabling people to register a range of needs so that the Trust can pro-actively support individuals who would no longer have to repeat their needs to each trainer).	
2d	**Risks**	Two new risks were identified in relation to: firstly, the loss of Apprenticeship funding for Level 7 courses and the potential impact on clinical models; and secondly, the risk of HCAs falling behind and not being able to complete the Framework. Both risks are being added to the Risk Register. Concerns were expressed in relation to the FTSU procurement process. It was suggested that the position regarding the outsourcing of the FTSU service should be closely monitored in view of the potential risk of not having a service in place.
Recommendation: The Board is asked to note the contents of the report.		
3	**Any Items to be escalated to another Board Sub-Committee/Board of Directors**	The Committee wishes to highlight the importance of securing permanent funding for the Reasonable Adjustments Team. As an anchor institution and within the spirit of being a 'Great Partner', the Committee wishes to explore the option, in principle, of transferring some of the £2.2m funds currently standing in the Apprenticeship Levy to support VCSE partners.
4	**Report compiled by:** Deborah Miller, Corporate Governance Manager, Roberta Barker, Non-Executive Director (Committee Chair), Kate North and Sarah Dexter-Smith, Joint Executive Directors of People and Culture	

DM/5/06/2025

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 June 2025**
Title:	**Annual Report by Guardian of Safe Working Hours for Postgraduate Doctors**
Executive Sponsor(s):	**Dr Kedar Kale**
Author:	**Dr Sharon Beattie, Guardian of Safe Working**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
5	**Staff retention**	The experience of postgraduate doctors, and compliance with their terms and conditions of employment, is important to maintain viable training positions.
1	**Recruitment**	The experience of postgraduate doctors, and compliance with their terms and conditions of employment, is important to make TEWV an attractive place to work for doctors considering substantive appointment at completion of their training.

Executive Summary:

Purpose:

This report aims to provide assurance that postgraduate doctors are safely rostered and that their working hours are safe and in compliance with their terms and conditions of service.

The Board receives annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for postgraduate doctors. This is the annual report for 2024-2025, and there is also quarterly data relating to Q4. Appendices 1 to 4 have been provided to me by Medical Staffing, and they include aggregated data on exception reports, details of fines levied against departments, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting, when needed, good practice and/or persistent concern. Appendices are shared with the corresponding NHS England body for the different sectors.

The 2016 national contract for postgraduate doctors introduced the role of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and are compliant with safe working hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.

The Guardian role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The Guardian is required to levy a fine against a department(s) if a postgraduate doctor:

- works on average over 48 hours/week
- works over 72 hours in 7 days
- misses more than 25% of required rest breaks
- when on non-residential on call (NROC) does not have a minimum of continuous rest for 5 hours between 22:00 and 07:00
- does not have the minimum 8 hours total rest per 24 hour NROC shift
- has more than the maximum 13 hour residential shift length
- does not have the minimum 11 hours rest between resident shifts

Proposal:

- I am satisfied that all exception reports submitted by doctors on the 2016 contract have been actioned by Medical Staffing. In terms of timescales for Q4, 0% of exception reports in the North, and 100% in the South, were responded to within 7 days. I have liaised with the Head of Medical Staffing who advises that staffing changeovers and communication issues in the North have impacted on this but there is now a new standard process in place with diary prompts and regular supervision to address the delays in the North.

- There have been some resident doctor vacancies across the Trust. The Trust has an ongoing approach to filling these posts through the Trust Doctor Scheme. The use of locums on the 1st tier rota have been linked with sickness/maternity leave and the occasional vacant post. The use of locums on the 2nd tier rota is linked with vacant ST3-7 posts or an area having fewer ST3-7/SAS posts than are needed to staff the rota. Over the next year we will be monitoring the take up of locums in quarterly reports to ensure this is not resulting in unsafe working practices for individual doctors.

- This year there have continued to be issues with workload concerns and breaches in the two non-residential first tier rotas in the NYY&S Care Group. Throughout the year, fines levied

have predominantly been in relation to these rotas. These issues are likely to resolve as there are planned changes to these rotas. From April 2025 the Scarborough 1st tier rota has moved to a hybrid with a non-resident rota Mon-Fri and a resident rota at weekends, when the workload is reported to be the highest. From August 2025 the York/Northallerton/Harrogate rotas will move from being hybrid to being fully resident.

- There is a well-functioning Postgraduate Doctors' Training Forum in each of the Care Groups with good attendance by trainee representatives from localities across the Trust.

Overview:

Q4 Position

- **Appendices 1 and 2** give details relating to DTV&F (North) and NYY&S (South) Care Groups respectively for the quarter January to March (inclusive) 2025.

- In the North there was an increased number of exception reports (17), which continued the pattern of a higher rate of reporting seen in Q3 (17). These were all related to staying late. Although this incurred no fines it remains higher than previous quarters. In Q4 a significant number of these reports (8) were submitted by one doctor. I have liaised with the clinical supervisor and foundation tutor and this post is being monitored. We have not had reason to request a work schedule review yet as the pattern of reporting has now reduced but I am monitoring this location for any ongoing patterns of concern.

- There have been 4 exception reports related to the NROC rota out of a total of 7 exception reports in the South in Q4. This is a significant reduction in overall exception reports on previous quarters with 20 in Q3, 39 in Q2 and 15 in Q1. The Q4 breaches incurred an aggregate fine of £407.47.

- There have been no exception reports related to the 2nd tier rotas. It is difficult to know if this is linked with non-reporting on locum shifts, non-reporting by SAS doctors on the rota and/or linked with cohort. Medical staffing and I continue to encourage exception reporting, and over the next year we will look at addressing factors that might be impacting on reporting on this rota.

- The reasons for the exception reports are given within the appendices. There seems to be a higher rate of reporting linked with staying late in the North which I am monitoring.

Annual Position

- **Appendix 3** gives annual data relating to Trustwide postgraduate doctor vacancies (normal working day positions), as well as the number and value of Guardian fines. Each are

given by location.

- Across the year for the whole Trust, vacancies have averaged to 21.59 WTE per quarter. I am advised by the Medical Staffing Manager, that Training vacancies as well as service posts are filled through the Trust Doctor Scheme if we are aware of the vacancy in advance. Recruitment rounds for Trust Grade doctors are run frequently with a programme of training provided, and support provided from the Trust Doctor Tutor and the International Medical Graduate Tutor. Any vacancies not covered by Trust Doctors are then covered through locum agency use when necessary. The remaining uncovered normal working day shifts, after accounting for annual leave, have been presented in appendix 3.

- It is important to note that the Trust does not cover GP ITP and ST4-7 resident doctor vacancies as these posts are considered to be primarily for training. Also, not all posts can be filled at any one time as there are more available training posts than trainees.

- Over the year the majority of 1st tier rota gaps trustwide were incurred linked with sickness/ mat leave etc. There have been occasions where in the past the rota had gone out but then a resident doctor did not come to work in the Trust or maybe left half-way through the rotation leaving a gap on the rota. In these cases the on-call gaps are covered by internal locums. On occasion when locums could not be found the 2nd tier doctor has had to act down into these.

- For the 2nd tier rota the frequency of the rota is 1 in 8 currently, apart for the N Durham one that is 1 in 6. The N Durham, Scarborough, NORTH and SOUTH CYPS 2nd tier rotas rely on locums quite a bit whereas the Teesside, South Durham and NYY are well staffed. The number of locums in any rota can fluctuate between training years as ST4-7 resident doctor posts can be vacant if a trainee isn't allocated. The impact of using locums from our training grade doctors is something that needs to be monitored in the coming year. This data has not been collected within previous guardian reports.

- Over the previous year the majority of fines have been generated in the South Care Group. These have been predominantly in relation to the 1st tier NROC rotas, and doctors not achieving a period of continuous rest between the hours of 22:00 and 07:00. The changes planned to the rotas that have been implemented in Scarborough in April 2025 and which are planned to be implemented in York/Northallerton/Harrogate should reduce the risk of rota breaches and fines.

- Details about Guardian fines, and disbursements, are given in **appendix 3**. A detailed list of expenditure is given in **appendix 4**. There was an underspend of Guardian fines in 2024/2025 of £3293.84, however there was not a Guardian in place for the

majority of this time period.

Implications:

- **Compliance with the CQC Fundamental Standards:**
  The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour.

- **Financial/Value for Money:**
  The new contract is underpinned by the principle that postgraduate doctors are paid for the work they do. It is necessary that the Board understands that extra costs will be incurred for breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to postgraduate doctors is necessary and appropriate.

- **Legal and Constitutional (including the NHS Constitution):**
  The Learning Agreement signed by the Trust with NHS England sets out the expectations on placement providers. The organisation must ensure that the work schedules in the new contract allow postgraduate doctors to fulfil their curriculum needs within a sound learning environment.

- **Equality and Diversity:**
  The Champion of Less Than Full-time (LTFT) Working is a core member of the Postgraduate Doctors' Training Forums.

- **Other Implications:**
  With the move to resident on-call rotas throughout all 1st tier posts (with exception of Scarborough from Mon-Fri), there should be a reduced risk of breaches and fines.

  There is an increased pattern of exception reporting in certain areas within the North, which requires ongoing monitoring for patterns by the Guardian. If a pattern is maintained there may be a need for work schedule reviews of specific posts.

Recommendations:

- The Board are asked to read and note this annual report from the Guardian of Safe Working.

Background Papers:

Appendices 1, 2: detailed information on numbers, exception reports and locum usage - North and South Care Groups respectively. Annual summary data in **appendix 3**. These appendices have been written and provided by the Medical Staffing Manager. **Appendix 4** is the detailed expenditure from the Guardian fines provided by the finance department.

Appendix 1

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING (DTV&F)

High level data

Number of doctors / dentists in training (total): 145

Number of doctors / dentists in training on 2016 TCS (total): 145

Amount of time available in job plan for guardian to do the role: 1 PA

Admin support provided to the guardian (if any): 4 days per quarter

Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Exception reports (regarding working hours) from 1st January 2025 – 31st March 2025.

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services	0	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	8	8	0
F2 - Teesside & Forensic Services	0	0	0	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2/GP - Teesside & Forensic Services	0	3	3	0
CT1-2/GP –North Durham	0	0	0	0
CT1-2/GP – South Durham	0	3	3	0
CT3 – Teesside & Forensic Services	0	0	0	0
CT3 – North Durham	0	2	2	0
CT3 – South Durham	0	0	0	0
ST4-6 – Teesside & Forensic Services Seniors	0	0	0	0
ST4-6 –North & South Durham Seniors	0	0	0	0
Trust Doctors - Teesside	0	1	1	0
Trust Doctors - North	0	0	0	0

Durham				
Trust Doctors - South Durham	0	0	0	0
Total	**0**	**17**	**17**	**0**

Exception reports by Rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services (F2/CT1-3/ GP/ trust doctor)	0	4	4	0
North Durham (F2/ CT1-3/GP/trust)	0	2	2	0
South Durham (F2/ CT1-3/GP/trust)	0	3	3	0
Teesside & Forensic Senior Registrars	0	0	0	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	0	0
DTV CYPS Senior Registrars	0	0	0	0
Total	**0**	**9**	**9**	**0**

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Teesside – 3 exception reports submitted by the same CT2 due to working late on normal working days. 1 exception report submitted by a Trust Doctor due to finishing late on a normal working day.

North Durham –1 exception report submitted by a CT3 due to working late on a normal working and 1 exception report submitted by the same CT3 due to not being able to achieve their break on one occasion.

South Durham – 1 exception report submitted by a CT1 due to working late on normal working day on one occasion. 2 exception reports submitted by the same CT1 due to working late on normal working days.

In addition to the above, 8 exception reports submitted by an F1 doctor working in South Durham. All exception reports were due to late finishes on normal working days. TOIL was agreed on all occasions.

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	0	0	4	0

Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	0	2	0
South Durham Juniors	0	0	11	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	0	0
Total	**0**	**0**	**17**	**0**

Work schedule reviews.

Work schedule reviews by grade	
F1	0
F2	0
CT1-3	0
ST4 - 6	0

Work schedule reviews by locality	
Teesside & Forensics	0
North Durham	0
South Durham	0

Bank Shifts Via Patchwork

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	0	0	0	0	0
	CT1	46	28	0	501.5	336
	CT2			0		
	GP			0		
	CT3	0	0	0	0	0
	Trust Doctor	0	17	0	0	161.5
	Middle Tier (SR/SAS)	9	9	0	136	136
North Durham	F2	0	0	0	0	0
	CT1	38	36	0	340.5	324.5

	CT2			0		
	GP			0		
	CT3	0	0	0	0	0
	Trust Doctor	0	2	0	0	16
	Middle Tier (SR/SAS)	40	40	0	498	498
South Durham	F2	0	1	0	0	12.5
	CT1	31	23	0	262.5	187.5
	CT2			0		
	GP			0		
	CT3	0	0	0	0	0
	Trust Doctor	0	5	0	0	20
	Middle Tier (SR/SAS)	4	4	0	48	48
CAMHS	Middle Tier (SR/SAS)	76	76	0	767	767
Total		**244**	**241**	**0**	**2553.5**	**2507**

The discrepancies in the figures are due to:

- *1 shift on Teesside Resident Rota and 2 shifts for South Durham were not picked up, middle tier had to act down. All 3 shifts were late notification, and the shifts did not get picked by resident doctors.*

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	9	9	0	103	103
Service requirement	13	13	0	94.5	94.5
Sickness	56	53	0	569	522.5
On call cover	153	153	0	1569.5	1569.5
Paternity leave	3	3	0	64	64
Maternity leave	3	3	0	64	64
Special leave	6	6	0	73.5	73.5
Annual Leave	1	1	0	16	16
Total	**244**	**241**	**0**	**2553.5**	**2507**

Vacancies

Vacancies by month

Locality	Grade	Month 1	Month 2	Month 3	Total gaps (average)	Number of shifts uncovered
Teesside & Forensics	F1	0	0	0	0	0
	F2	1	0	0	0.33	16
	CT1	0	0	0	0	0
	CT2					
	CT3					
	ST4 -6	1	3	3	2.33	111
	GP	3 (ITP)	4 (ITP)	4 (ITP)	3.67	174
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2					
	CT3					
	ST4 -6	1	0	0	0.33	16
	GP	2	2 (ITP)	2 (ITP)	2	96
South Durham	F1	0	0	0	0	0
	F2	0	1	1	0.67	32
	CT1	0	0	0	0	0
	CT2					
	CT3					
	ST4 -6	2	3	3	2.67	127
	GP	1	1 (ITP)	1 (ITP)	1	48
Total		**11**	**14**	**14**	**13**	**620**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	0	£00.00
North Durham	0	£00.00
South Durham	0	£00.00
Total	**0**	**£00.00**

There were no fines for quarter 4

Appendix 2
QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING (NYY)

High level data

Number of doctors / dentists in training (total): 91
Number of doctors / dentists in training on 2016 TCS (total): 91
Amount of time available in job plan for guardian to do the role: 1 PA
Admin support provided to the guardian (if any): 4 days per quarter
Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Exception reports (regarding working hours) from 1st January to 31st March 2025

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F2 - Scarborough	0	0	0	0
F2 - York	0	1	1	0
CT1-2 / GP - Northallerton	0	0	0	0
CT1-2 / GP – Harrogate	0	0	0	0
CT1-2 / GP - Scarborough	0	2	2	0
CT1-2 / GP - York	0	3	3	0
CT3 – Northallerton	0	0	0	0
CT3 – Harrogate	0	0	0	0
CT3 – Scarborough	0	1	1	0
CT3 – York	0	0	0	0
ST4-6 - Northallerton	0	0	0	0
ST4-6 - Harrogate	0	0	0	0
ST4-6 - York	0	0	0	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors -	0	0	0	0

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Scarborough				
Trust Doctors - York	0	0	0	0
Total	**0**	**7**	**7**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
NYY (F2/CT1-3/ GP/trust doctor)	0	4	4	0
Scarborough (F2/CT1-3/ GP/trust doctor)	0	3	3	0
NYY middle tier	0	0	0	0
Scarborough middle tier	0	0	0	0
South CYPS middle tier	0	0	0	0
Total	**0**	**7**	**7**	**0**

In Scarborough, 1 exception report submitted by a resident doctor was for a breach of not having 5 continuous hours of rest from 10pm to 7am. 2 exceptions reported were by the same doctor for late finish due to acuity of the ward.

4 exception reports were submitted by NYY resident doctors, 3 out of these were for breach of not having 5 continuous hours of rest from 10pm to 7am and 1 exception was for late finish. The reasons for the exceptions were multiple telephone advice and physical health review.

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
NYY Resident doctors	4	0	0	0
NYY Middle tier	0	0	0	0
Scarborough Resident doctors	2	1	0	0
Scarborough Middle tier	0	0	0	0
Total	**6**	**1**	**0**	**0**

Work Schedule reviews

Work schedule reviews by grade	
F1	0
F2	0
CT1-3	0
ST4 - 6	0

Work schedule reviews by locality	
Northallerton	0
Harrogate	0
Scarborough	0
York	0

Bank Shifts Via Patchwork

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Harrogate, Northallerton, Selby & York	F2	0	8	0	0	102
	CT1/CT2/GP	31	21	0	391.5	198
	CT3	0	1	0	0	4
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	60	61	0	1196	1200
Scarborough	F2	0	3	0	0	72
	CT1/CT2/GP	34	27	0	644	578
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	83	80	0	1437	1398
Total		**208**	**201**	**0**	**3668.5**	**3552**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
On call cover	23	23	0	376	376
Vacancy	171	165	0	3047.5	2944
Sickness	14	13	0	245	232
Increase in workload	0	0	0	0	0
Special leave	0	0	0	0	0

Extra weekend support	0	0	0	0	0
Annual Leave	0	0	0	0	0
Total	**208**	**201**	**0**	**3668.5**	**3552**

** The discrepancies in the figures are due to:*

- *Middle tier doctor picked up 1 CT1/2 shifts in NYY*
- *Consultant picked 7 locum middle tier shifts in Scarborough*
- *Middle tier doctors picked 4 CT1/2 shifts in Scarborough*

Vacancies

Locality	Grade	Month 1	Month 2	Month 3	Average no of vacancies	Number of shifts uncovered (days)
Northallerton	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	1	1	0.67	31.83
	ST4 -6	1	0	0	0.33	15.67
	GP	1	1	1	1	47.50
	Trust Doctor	0	0	0	0	0
Harrogate	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	1	1	0.67	31.83
	ST4 -6	0	0	0	0	0
	GP	1	1	1	1	47.50
	Trust Doctor	0	0	0	0	0
Scarborough	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	1	1	0.67	31.83
	ST4 -6	0	1	0	0.67	31.83
	GP	1	2	2	1.67	79.33
	Trust Doctor	0	0	0	0	0
York	F1	0	0	0	0	0
	F2	1	1	1	1	47.50
	CT1-3	0	0	0	0	0
	ST4 -6	0	1	1	0.67	31.83
	GP	1	1	1	1	47.50
	Trust Doctor	0	0	0	0	0
Total		**6**	**11**	**10**	**9**	**444.15**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**

Scarborough	1	£245.88
Harrogate, Northallerton & York	3	£161.59
Total	**4**	**£407.47**

*****_All fines were for breach of not having 5 hours continuous rest_

Appendix 3
ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Annual data summary from 1st April 2024 to 31st March 2025

Vacancies

Locality	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average wte)	Number of shifts uncovered (over the year)
North Durham	F1	0	0	0	0	0	0
	F2	0	0	0	0	0	0
	CT1 CT2 CT3	0	0	0	0	0	0
	ST4 - 6	0	0	0	0.33	0.0825	16
	GP	0	0	2	2	1	191
	Trust Doctor	0	1.6	0	0	0.4	77.6
South Durham	F1	1	0.3	0	0	0.325	30.5
	F2	1	0.3	0	0.67	0.4925	62.5
	CT1 CT2 CT3	0	0	0	0	0	0
	ST4 - 6	0	2	3	2.67	1.9175	367
	GP	0	1	0	1	0.5	96.5
	Trust Doctor	0	0	0	0	0	0
Teesside & Forensics	F1	2	0.6	0	0	0.65	112.1
	F2	1.3	2	2	0.33	1.4075	273
	CT1 CT2 CT3	2	0.6	0	0	0.65	63.1
	ST4 - 6	1	1	1	2.33	1.3325	256.5
	GP	0	2.3	3	3.67	2.2425	428.5
	Trust Doctor	0	0	0	0	0	0
Scarborough	F1	2	1.33	0	0	0.8325	97
	F2	1	0.67	0	0	0.4175	48.5

Locality	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average wte)	Number of shifts uncovered (over the year)
	CT1 CT2 CT3	1	0.67	0	0.67	0.585	31.83
	ST4 - 6	1	0.67	0	0.67	0.585	80.33
	GP	0	0.33	1	1.67	0.75	127.83
	Trust Doctor	0	0	0	0	0	0
NYY	F1	0	0	0	0	0	0
	F2	0	0.33	1	1	0.5825	112.01
	CT1 CT2 CT3	2	1.34	0	1.34	1.17	257.49
	ST4 - 6	4	3	1	1	2.25	451.18
	GP	4	3.67	3	3	3.4175	531.51
	Trust Doctor	0	0	0	0	0	0
Total		**23.3**	**23.71**	**17**	**22.35**	**21.59**	**3711.98**

Fines

Locality	Quarter 1 Number of fines levied	Quarter 2 Number of fines levied	Quarter 3 Number of fines levied	Quarter 4 Number of fines levied	Annual Total
North Durham	0	0	0	0	0
South Durham	0	0	0	0	0
Teesside & Forensics	1	5	0	0	6
Scarborough	1	3	1	1	6
NYY	1	9	9	3	22
Total	**3**	**17**	**10**	**4**	**34**

Locality	Quarter 1 Value of fines levied	Quarter 2 Value of fines levied	Quarter 3 Value of fines levied	Quarter 4 Value of fines levied	Total
North Durham	£0.00	£0.00	£0.00	£0.00	£0.00
South Durham	£0.00	£0.00	£0.00	£0.00	£0.00
Teesside & Forensics	£481.20	£1593.46	£0.00	£0.00	£2074.66

Locality	Quarter 1 Value of fines levied	Quarter 2 Value of fines levied	Quarter 3 Value of fines levied	Quarter 4 Value of fines levied	Total
Scarborough	£447.17	£655.87	£238.5	£245.88	£1587.42
NYY	£55.90	£2148.44	£1602.83	£161.59	£3968.76
Total	**£984.27**	**£4397.77**	**£1841.33**	**£407.47**	**£7630.84**

The following has been spent in the last year:

Spend	Q1	Q2	Q3	Q4	Total
Catering	118	717	290	1,256	**2,381**
Furniture	52	26			**78**
Hot Drinks	107		344	733	**1,184**
Misc	-59		589	164	**695**
Total	**218**	**743**	**1,224**	**2,153**	**4,337**

Appendix 4: Detailed expenditure

Month	Supplier	Value £	Sub-Category
Apr-24	AMAZON.CO.UK	-52	Misc
Apr-24	YORKSHIRE PURCHASING ORGANISATION	-7	Misc
May-24	Amazon Business EU SARL	52	Furniture
Jun-24	Currys PC World Business	107	Hot Drinks
Jun-24	BARCLAYCARD BUSINESS	118	Catering
Aug-24	Amazon Business EU SARL	26	Furniture
Nov-24	Yorkshire Purchasing Organisation	8	Misc
Nov-24	Yorkshire Purchasing Organisation	8	Misc
Nov-24	Yorkshire Purchasing Organisation	64	Misc
Nov-24	Yorkshire Purchasing Organisation	64	Misc
Dec-24	D.P. Supplies (North West) Ltd	63	Hot Drinks
Dec-24	D.P. Supplies (North West) Ltd	54	Hot Drinks
Dec-24	D.P. Supplies (North West) Ltd	63	Hot Drinks
Dec-24	NHS SUPPLY CHAIN	9	Misc
Mar-25	AMAZON.CO.UK	80	Hot Drinks
Mar-25	BFS GROUP T/A BIDFOOD	14	Hot Drinks
Mar-25	Amazon Business EU SARL	72	Hot Drinks
Mar-25	Amazon Business EU SARL	22	Hot Drinks
Mar-25	Amazon Business EU SARL	68	Hot Drinks
Mar-25	BARCLAYCARD BUSINESS	127	Catering
Mar-25	Amazon Business EU SARL	72	Hot Drinks
Mar-25	Amazon Business EU SARL	22	Hot Drinks
Mar-25	Amazon Business EU SARL	68	Hot Drinks

Aug-24	BARCLAYCARD BUSINESS	160	Catering
Aug-24	BARCLAYCARD BUSINESS	110	Catering
Aug-24	BARCLAYCARD BUSINESS	87	Catering
Aug-24	BARCLAYCARD BUSINESS	184	Catering
Sep-24	BARCLAYCARD BUSINESS	110	Catering
Sep-24	BARCLAYCARD BUSINESS	66	Catering
Oct-24	BARCLAYCARD BUSINESS	133	Catering
Oct-24	BARCLAYCARD BUSINESS	28	Catering
Oct-24	Take Me Group Ltd	146	Misc
Nov-24	D.P. Supplies (North West) Ltd	62	Hot Drinks
Nov-24	D.P. Supplies (North West) Ltd	47	Hot Drinks
Nov-24	D.P. Supplies (North West) Ltd	55	Hot Drinks
Nov-24	Take Me Group Ltd	226	Misc
Nov-24	BARCLAYCARD BUSINESS	79	Catering
Nov-24	BARCLAYCARD BUSINESS	50	Catering
Dec-24	Take Me Group Ltd	65	Misc
Jan-25	BARCLAYCARD BUSINESS	133	Catering
Jan-25	BARCLAYCARD BUSINESS	89	Catering
Jan-25	BARCLAYCARD BUSINESS	245	Catering
Jan-25	Bainbridge A	35	Misc
Feb-25	BARCLAYCARD BUSINESS	97	Catering
Feb-25	BARCLAYCARD BUSINESS	184	Catering
Feb-25	BARCLAYCARD BUSINESS	255	Catering
Feb-25	BARCLAYCARD BUSINESS	126	Catering
Mar-25	D.P. Supplies (North West) Ltd	55	Hot Drinks
Mar-25	D.P. Supplies (North West) Ltd	47	Hot Drinks
Mar-25	D.P. Supplies (North West) Ltd	55	Hot Drinks
Mar-25	Take Me Group Ltd	65	Misc
Mar-25	D.P. Supplies (North West) Ltd	55	Hot Drinks
Mar-25	D.P. Supplies (North West) Ltd	47	Hot Drinks
Mar-25	D.P. Supplies (North West) Ltd	55	Hot Drinks
Mar-25	Take Me Group Ltd	65	Misc

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12th June 2025**
Title:	**Learning from Deaths**
Executive Sponsor(s):	**Kedar Kale, Executive Medical Director**
Author(s):	**Amy Taylor, Interim Associate Director of Patient Safety**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
8	**Quality Governance** - There is a risk that our floor to Board quality governance does not provide thorough insights into quality risks caused by the need to further develop and embed our governance and reporting including triangulating a range of quality and performance information resulting in inconsistent understanding of key risks and mitigating actions, leading to variance in standards.	There is a risk that if we fail to embed key learning from deaths, patient safety and quality will be compromised and the people we serve will lose confidence in the services we provide. This paper sets out key processes for mortality reviews and learning from deaths including patient safety incident investigations across the Trust to reduce and mitigate this risk.
10	**Regulatory compliance** - There is a risk that failure to comply with our regulatory duties and obligations, at all times, could result in enforcement action and financial penalties and damage our reputation	

Executive Summary:

Purpose:

The national guidance on learning from deaths requires each Trust to collect and publish specific information. This report covers the period from January to March 2025 (Quarter 4). The Board of Directors is receiving the report for information and assurance of the Trust's approach in line with national guidance.

All NHS Trusts must publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis. These are deaths which are in-scope of the Learning from Deaths policy and have been subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all the deaths categorised as in scope for the Learning from Deaths policy are subject to an initial review before determining if they require further investigation. Further details and the locally agreed criteria for mortality reviews and Structured Judgement Reviews (SJRs) are in Appendix 2.

Proposal:
That the dashboard and the learning points are provided as good assurance of reporting and learning in line with national guidance.

Overview:
In line with National Guidance the Learning from Deaths Dashboard at appendix 1 details Q4 information for the Trust and includes 2023/24 data for comparison.

- During Q4 the Trust received 361 death notifications of patients who had been in contact with our services in the preceding 6 months. The Trust received 19 death notifications of people with a learning disability or autism in the time frame. These figures represent all deaths (including natural expected/unexpected, and unnatural/unexpected) in relation to people who were currently open to the Trust's caseload which is largely community and includes older people and memory services (>70,000).
- 6 inpatient deaths were reported. 3 of these deaths were expected and subject to part 1 reviews. All 3 deaths occurred in Mental Health Services for Older People wards.
- The remaining 3 inpatient deaths occurred in Adult Mental Health wards and have been reported on the national Strategic Executive Information System (StEIS) and are subject to a Patient Safety Incident Investigation (PSII). All 3 deaths were reported as suspected suicide and occurred off the ward. All PSII investigations are in progress.
- 3 unexpected community deaths were reported on StEIS during the reporting period and are being investigated as a PSII.
- Immediate After Action Reviews were conducted for all the above PSII deaths and where appropriate, rapid improvements have been made to improve patient safety.
- 4 Part 2 Structured Judgement Reviews (SJRs) were requested.
- 62 Part 1 reviews and 15 SJRs were completed.
- 5 Serious Incident/Patient Safety Incident Investigations for unexpected deaths were completed.
- All deaths of people with either a learning disability or a diagnosis of autism require reporting to LeDER in line with national requirements over the reporting period. Deaths are reported to LeDER via the clinical teams and the Patient Safety Team have added a prompt to all After Action Review and Mortality Review documents. It has also been built into the InPhase reporting system since 30th October 2023. Any discrepancies in reporting are being followed up by the Patient Safety team. Reasons given for not reporting have been identified as deaths occurring in the Acute Trust or a Care home and it was assumed by the TEWV clinical team that the team providing 24-hour care had submitted the referral. Teams are being asked to confirm this with those providers.

Appendix 3 sets out in detail the specific areas of learning, Trust themes, progress within the Quality Assurance programme and structures to support and embed learning from incident investigations.

8 Patient Safety Briefings were circulated Trust wide during this reporting period, examples included:

- 3 in relation to environmental risks and issues
- 1 in relation Electronic Prescribing & Medicines Administration (EPMA)
- 1 in relation to safe practice managing sharps
- 2 in relation the functionality of CITO (Electronic Care Record system) and recording information.
- 1 to raise awareness of risks associated with breastfeeding a baby in a sling.

To improve learning and measure progress against the Trusts main themes, all learning requires a SMART action plan. To support learning at the earliest opportunity all incidents that are identified as a PSII are subject to an After-Action Review overseen by daily patient safety

huddles.

The transition, to InPhase incident reporting in 2023/24 supports additional benefits in terms of triangulating learning and monitoring of actions as well as greater monitoring of Duty of Candour as it is further embedded and refined. It has also highlighted anomalies in reporting processes and in addition to incident reporting for unexpected deaths we now report expected natural cause deaths as outcomes following guidance from NHS England. Some unexpected deaths, once fact finding has been completed to establish if a patient safety incident has occurred can also be moved into outcomes and the patient safety team are currently reviewing and updating processes to reflect this.

Prior Consideration and Feedback

Updates and assurance aligned to improvement work relating to learning from deaths is reported to the Quality Assurance Committee. This includes regular updates on the Quality Assurance schedule (providing assurance of compliance against key patient safety policies such as leave, clinical record keeping, risk assessment and management, observation and engagement) as well as updates on key areas that sit within our Quality and Clinical journeys that relate to themes from patient safety incidents such as progress following implementation of the patient safety incident response framework (PSIRF). Themes of learning are reported into the Trust wide Organisational learning group to support organisation wide learning.

Implications:

There is a risk that the data published is utilised or interpreted without context as there is no current national benchmarking or methodology within mental health and learning disability services for mortality data.

There are financial and reputational implications associated with poor standards of care. A focus on learning helps the Trust to improve the quality and safety of our care services.

Recommendations:

The Board of Directors is requested to note the content of this report, the dashboard and the learning points as good assurance of reporting and learning in line with national guidance and consider any additional actions to be taken.

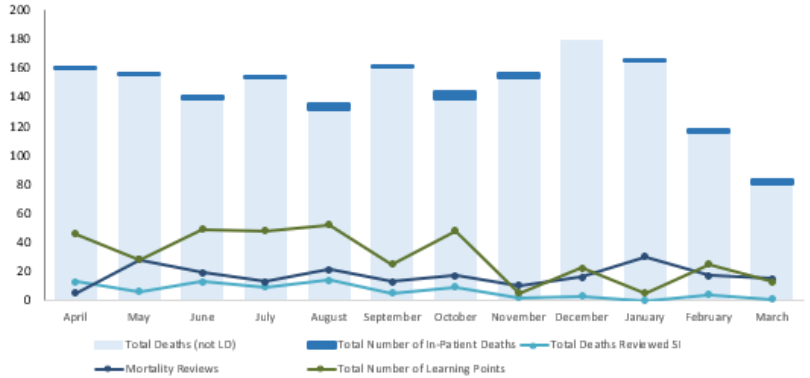
Appendix 1: Learning from Deaths Dashboard Q4 2024/25

Learning from Deaths Dashboard - Data Taken from Paris
Reporting Period - Q4 2024-25

Summary of total number of deaths and total number of cases reviewed under the SI Framework/Patient Safety Incident Response Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

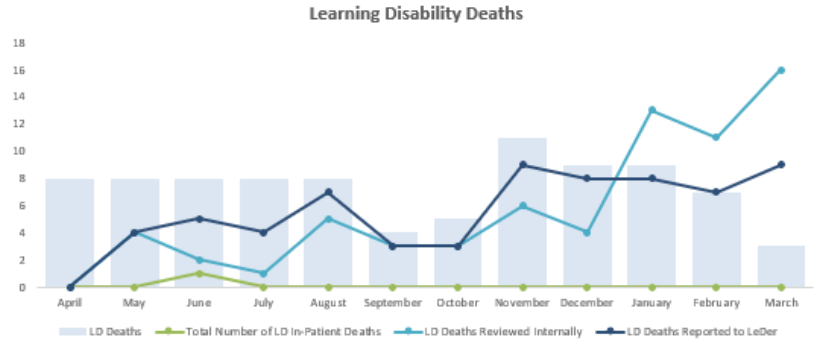
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
Q1	453	↘ 511	5	↗ 4	32	↗ 13	52	↘ 175	123	↗ 38
Q2	444	↗ 437	7	↘ 8	28	↘ 41	47	↔ 47	125	↘ 159
Q3	471	↘ 531	8	↘ 9	14	↘ 48	43	↗ 38	75	↘ 169
Q4	361	↘ 536	6	↔ 6	5	↘ 55	62	↗ 17	43	↘ 221
YTD	1729	↘ 2015	26	↘ 27	79	↘ 157	204	↘ 277	366	↘ 587



Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI Framework/Patient Safety Incident Response Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
Q1	24	↘ 26	1	↗ 0	6	↘ 12	9	↔ 9
Q2	20	↗ 18	0	↔ 0	9	↗ 7	14	↗ 7
Q3	25	↘ 38	0	↔ 0	13	↗ 8	20	↗ 5
Q4	19	↘ 26	0	↔ 0	40	↗ 11	24	↗ 10
YTD	88	↘ 108	1	↗ 0	68	↗ 38	67	↗ 31



Appendix 2

Mortality Reviews 2024/2025

Mortality reviews are completed in-line with guidance from the Royal College of Psychiatrist and peer organisations across the region.
The mortality review tool used consists of a Part 1 and Part 2 review.
Part 1 is a review of the care records, if any red flags or concerns are noted a Part 2 (Structured Judgement Review) will be considered and completed if required.

The “red flags” to be considered during the Part 1 review are as follows:

- Family, carers, or staff have raised concerns about the care provided
- Diagnosis of psychosis or eating disorders during the last episode of care
- Psychiatric in-patient at the time of death, or discharged from care within the last month (where the death does not fit into the category of a Serious Incident)
- Under Crisis Resolution and Home Treatment Team at the time of death (where the death does not fit into the category of a Serious Incident)
- Random Selection
- Specific area of interest to the Trust (e.g., Clozapine)

This criterion allows for greater learning from a more suitable selection of cases reviewed. To prioritise the most significant cases for learning from unexpected and expected physical health deaths, the following actions have been taken for those deaths reported via inphase.

- All in-patient deaths, not subject to a Patient Safety Incident Investigation (PSII) have either had a Part 1 completed or are in the process of having one completed.
- All LD deaths of those open to TEWV have either been reviewed or are being reviewed under Part 1 of the mortality review process. Where any concerns are identified, a Structured Judgement Review has been or will be requested. All these cases are to be reported to LeDER for review. The LeDER referral will not necessarily be completed by TEWV if the individual is receiving their main care from another provider.
- All community deaths for patients aged 64 and under have been or are being reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested.
- 20% of community deaths for patients aged between 65 and 74 have been reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested. This 20% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.
- 10% of community deaths for patients aged 75 onwards have been reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review has been requested. This 10% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.

Appendix 3

1. Mortality Reviews and Learning

Mortality Review 2024/2025

15 structured judgement reviews were discussed and reviewed by the Mortality Review Panel during Q4.

A number of actionable learning points were identified in relation to:

- Record Keeping/Care Documents
- Medicines Management
- Physical Healthcare

Learning from actions/assurance

- Findings from SJRs are fed back to the clinical networks, where appropriate, to ensure that learning feeds into existing improvement work. Outcomes are captured in minutes at the following mortality review panel. These are fed into the re-established Organisational Learning Group for future quarters.
- Where the learning identified is related to the work of a specific professional group, for example Pharmacy, the relevant mortality review panel member ensures this is actioned and shared Trust-wide. Good examples of assurance can be evidenced from the workstreams related to Clozapine, Lithium and Depot Injections.
- Learning for individuals is shared with operational teams where appropriate and addressed via supervision and local governance processes.

Learning from mortality reviews often demonstrate similar themes identified during Serious Incident reviews / Patient Safety Incident Investigations. The themes from mortality reviews are triangulated with learning from serious incidents reviews to establish any new themes occurring.

1.2 Learning from deaths and patient safety incidents

Within Quarter 4 there were a total of 43 learning points from both Patient Safety Incident Investigations and mortality reviews. In addition, there were 118 learning points from After Action Reviews undertaken following patient deaths. The most frequent actionable learning theme identified related to record keeping and documentation, followed by processes and communication. Another theme related to the lack of handover from local acute trusts when patients from TEWV inpatient wards have been under their care for a period of time.

1.3 Structures to support and embed learning

1.3.1 Fundamental standards group

Practice Development Practitioners are now integrated into the Care Group Fundamental Standards meetings where wider learning and good practice can be shared to facilitate improvements Trust-wide.

1.3.2 Organisational Learning

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group (OLG). Any significant issues identified by the OLG are escalated to the Executive Directors Group – Quality and Performance for further discussion

and or actions. The OLG now has a 12 month workplan based on the recurring themes identified.

1.3.3 Patient Safety Incident Management/Investigation

The Trust has a continued focus on improving the quality of incident reporting, investigation, and identification of key actionable learning. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring they are compliant with the requirements of the National NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF).

The Patient Safety Programme Board provides oversight on the Risk management system procurement, and the embedding of the Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE). The Programme Board reports into the Transformation Delivery Board.

1.3.4 The Environmental Risk Group

This group receives information where environmental factors may have contributed to harm, as well as progression of initiatives to reduce harm. Any urgent learning identified through this group is distributed Trust-wide via Patient Safety Briefings. The annual Environmental survey programme with a multi professional input from estates, health and safety and clinical services continue. The ligature reduction programme is monitored through this group with assurance provided through the Trusts quality governance structures. Significant investment has been dedicated to assistive technology in the form of Oxehealth and door sensors to make wards safer.

1.3.5 Recruitment and Retention/staffing establishment reviews

When looking at patient safety incidents through a systems and human factors lens, it can be seen that workforce pressures and capacity including community caseloads can impact on the quality of care delivered. Significant work is being undertaken to ensure that we have a suitably skilled and resourced workforce who can carry out their duties in a safe and compassionate way. Further details can be seen within the safe staffing and establishment review papers.

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Tees, Esk and Wear Valleys
NHS Foundation Trust

Mental Health Legislation Committee (MHLC): Key Issues Report to the Board of Directors		
Report Date:	13 June 2025	
Date of last meeting:	12 May 2025 – committee was quorate	
1	**Agenda: The Committee considered the following agenda items during the meeting** • CQC Mental Health Act Monitoring Activity • Discharges from Detention • Section 136 - Police emergency powers to take a patient to a place of safety • Section 132b – Information to detained patients including reading of rights • Section 18 – absent without leave (AWOL) • Positive and Safe Care Quarter 3 and Mental Health Units Use of Force Act • NYYS and DTVF Multi Agency Mental Health Legislation Operational Groups • Internal Mental Health Legislation Operational Groups (DTVF/NYYS) • Mental Capacity Act/Deprivation of Liberty Safeguards • Section 17 leave and time away from the ward • Individual Case Study • Revised policies: ➢ Deprivation of liberty Safeguards Procedure. ➢ Deprivation of Liberty Policy. ➢ Providing Information to Patients and Relatives. • MHLC Workplan 2024/25 - noted	
2a	**Alert: The Committee alerts members of the Board to the following:** **Deprivation of Liberty Safeguards (DoLS)** Discussions continue between Middlesbrough Local Authority and DAC Beachcroft to work collaboratively to address the backlogs of applications made. DoLS Activity for December 2024 – March 2025, there were currently 47 active cases with standard authorisations in place within respite settings. **Advocacy:** Regular meetings are in place between the Trust and two of the main advocacy services, We Are People First and Cloverleaf. TEWV operates an 'opt out' process for Independent Mental Health Advocacy (IMHA), so all patients are automatically referred unless they specifically decline. This ensures they are aware of and have access to advocacy support as part of their care. In January 2024, the data was indicative of a low referral rate, therefore the MHL department put several internal action plans in place to increase awareness and knowledge around advocacy services. Pilot work has been completed recently at Roseberry Park involving teaching sessions being delivered by an advocate, which were co-delivered with someone who has received advocacy services. There is work to do to address barriers, such as cultural, organizational and systemic, as there is inconsistent implementation of advocacy services across the Trust.	
2b	**Assurance: The Committee assures members of the Board on the following:** **CQC MHA Monitoring Activity** There is good assurance related to the system oversight and delivery of actions that result from MHA inspection activity, compliance with the Mental Health Act 1983 and adherence to the five guiding principles, as set out in the Mental Health Act Code of Practice. The main themes raised during the four CQC inspections from January to April 2025 include wi fi, food and drink, communication/induction to the ward/timeliness of a second opinion doctor (SOAD) request and the understanding of the Independent Mental Health Advocacy (IMHA) role.	

	A new Mental Health Act Bill was introduced on 6 November 2024 by the Government to reform the Mental Health Act 1983, which is still being debated in parliament. The Associate Director of Mental Health Legislation will give a presentation on the implications to the Strategic Quality Standards Group in July 2025. Committee will be updated in September 2025. Committee are interested in the provision of wi fi for patients to be able to keep in touch with family and friends as there is some assurance about the work to improve wi fi, however uncertainty about the outcome. **Discharge from detention** There is good assurance that the number of times detained patients are discharged by the tribunal or hospital mangers is within normal range. Manual records are being kept by the MHL team due to technical issues with IIC. There were no discharges by Hospital Managers in quarter 3. The tribunal discharged 14 patients from 230 meetings. There were seven discharges from 195 meetings, which represents a 2.5% increase in discharge rate. **Section 136** There is good assurance relating to the accurate recording of data for the use of section 136 suites and that legal requirements are being met for those individuals placed on a section 136. There were ten occasions when it had not been recorded that a patient had been given their rights. One patient was recorded as going past 24 hours, when they had been taken to the acute hospital first and transferred to TEWV at 24 hours and then in care for three hours. Section 136 is also monitored via the Quality Assurance Committee, where assurance is sought on the impact of quality care. **Section 132b –** There is good assurance that patients are being given their rights when first detained and a robust escalation process is in place for any patients who have not had their rights within three days of detention. The level of assurance has reduced from substantial in the last quarter due to staffing resource issues in the MHL team. There were 989 new detentions (946 in the last period) and the escalation process was used 142 times, 14%, (153 times previously last quarter). Six patients were discharged without their rights being read on or before day three of detention. The longest a patient was detained without evidence of rights being read was 12 days, which had not been escalated due to the staffing issues within the MHL team. **Section 18, Absent without Leave (AWOL)** There is substantial assurance that compliance with the legislative requirements to inform the CQC of any patient absent without leave is being met. The operational detail behind the numbers is a matter that will be explored further by the two internal mental health operational groups in DTVF and NYYS care groups. **Mental Capacity Act Training** Overall compliance for MCA training throughout the Trust is at 86%. **Positive and Safe Strategy** There is good assurance from quarter three that satisfactory progress is being made with the Trust wide Positive and Safe strategy, including the changes the organisation must make to comply with the Mental Health Units use of Force Act.
2c	**Advise: The Committee advises the Board on the following:** **Compliance with section 17 leave and time away from the ward** Assurance can be provided from DTVF (limited) and NYYS (reasonable) care groups on the actions in place to address the audit findings from Section 17 leave and time away from the ward. This is a cross-cutting theme also reported to the Quality Assurance Committee. Rather than presenting

	duplicate reports at both Committee meetings, a short, combined summary report will be provided going forward. **Internal Mental Health Legislation Operational Groups** Plans are being made for the two groups, one for NYYS and DTVF care group board to meet on the same day as the external MH Operational Groups from July 2025. The internal group will look at the operational data behind the numbers and information before reporting into MHL Committee. The external group is held with joint stakeholders, including Police and ambulance services to look at issues and themes across the patch. Consideration is being given to taking a short summary report, following the outcome of the internal/external meetings to Executive Directors Group/Care Group Boards and then to the MHL Committee. This will allow the key issues, matters of escalation and assurance to be given adequate scrutiny, check and challenge in the governance layers below Board Committee level. The next MHL Committee meeting is in September, which will allow sufficient time for the new reporting mechanisms to flow from ward to Board. **Case Study** A case study detailed the care of an 89-year-old lady with a diagnosis of Charles Bonnet syndrome and registered blind who was managed in the community and had a tribunal hearing on a Friday, where she was discharged as a manageable risk. There were some concerns about having the right care plan in place and this was arranged quickly with the crisis and home based treatment team. Care started the following Monday. This was in keeping with least restrictive practice under the principles of the Mental Health Act. The following policies/procedures were approved: • Deprivation of liberty Safeguards Procedure. • Deprivation of Liberty Policy. • Providing Information to Patients and Relatives.	
2d	**Review of Risks**	No additional risks were identified.
Recommendation: The Committee proposes that the Board of Directors: *i) Note the report and confirm the levels of assurance provided across reporting.*		
3	**Actions to be considered by the Board:** There are no actions for the Board to consider.	
4	**Report prepared by***: Jules Preston Acting Chair of Committee/Non-Executive Director, Kedar Kale, Executive Medical Director and Donna Keeping, Corporate Governance Manager*	

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Communications Dashboard

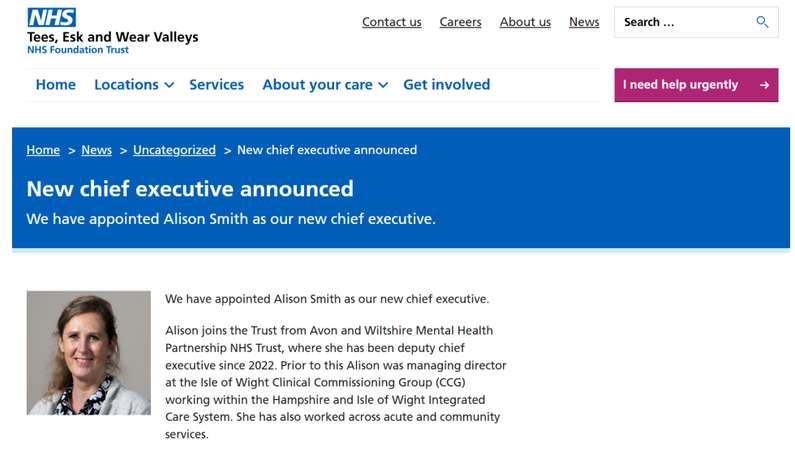
April - May 2025

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Highlights

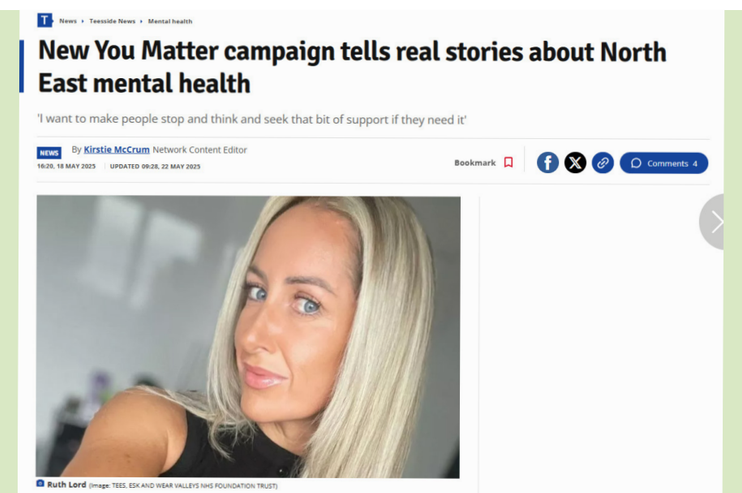
Carol Knaggs, our receptionist lead at Foss Park got a bus in York named after her for winning the 'Nominate Your Hero' competition

Our second annual TEWV 10k saw over 300 hundred people run, jog and walk around the Knavesmire in York Racecourse



We shared news of the appointment of Alison Smith as our new chief executive, both internally and externally

Rowan Lea ward received a collection of handmade hearts from local community group Untangled Threads, to help inspire and support our patients and visitors



We gained press coverage of our newly launched You Matter campaign, highlighting stories of lived experience

We shared photos of how our Trust celebrated Mental Health Awareness Week, including a visit from Daisy the therapy dog at Roseberry Park's festival

Communications Objectives

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

We take a strategic approach to our communications which underpins Our Journey to Change and delivers the following communications objectives:

Objectives	Key pieces of our work that support our objectives	
Increase public confidence	• Communications delivery planning for 2025-26 • Our Journey To Change strategy communications planning • Campaign launch for You Matter as part of Mental Health Awareness Week	• New CEO communications plan
Enhance staff engagement	• Developing Chris's Voice video with the family of Chris Irish • Sharing stories of lived experience as part of our You Matter campaign • Media planning for STOMP video launch with people with learning disabilities	• New co-creation page on staff intranet and website • Celebrating the work of peer support workers
Strengthen partnerships	• Annual report • Governor elections • Quality account • Meeting with CNTW communications colleagues	• Primary care communications – supporting our GP education and liaison colleagues • Meeting with GP federation CEO (Hartlepool and Stockton Health) • Support for Overview and Scrutiny Committee (OSC) meetings
Support a culture of co-creation	• Annual staff survey results • TEWV 10k event • Personalised care planning communications • Star awards planning	
Provide accessible and timely information	• Chair stepping down communications plan • Briefings following the Secretary of State meeting with families • Google analytics training • Staff personas work	• Cyber safety training with Cleveland Police • 0800 crisis line deactivation comms planning

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

12
Media enquiries handled by the team

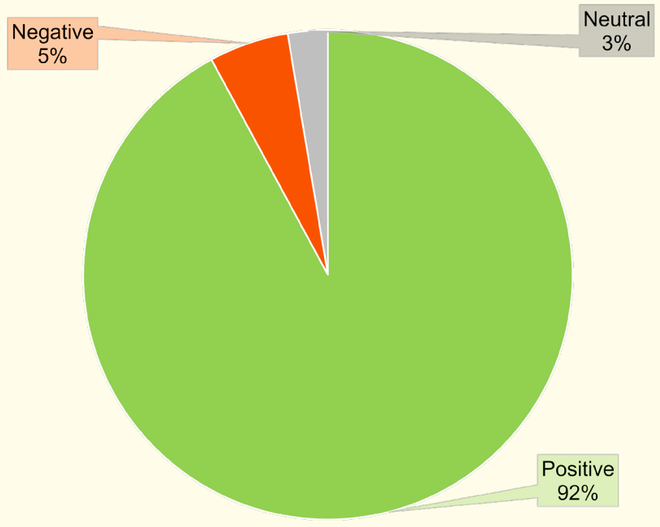
35
Media releases issued

76
Total pieces of coverage across online news, TV, and radio

Some of our news stories

- **Project to assess NHS employment advisors' effectiveness –** *York Press*
- **New outdoor space helps children and young people bloom –** *Scarborough News*
- **York: NHS Trust stages annual 10k run in Knavesmire –** *York Press*
- **Lanchester Road Hospital patients develop crafting skills –** *Northern Echo*
- **North Yorkshire man speaks out on "life-changing" journey to recovery –** *Yorkshire Post*
- **New You Matter campaign tells real stories about North East mental health –** *Teesside Live*
- **Woman opens up on bipolar disorder struggles before 'turning her life around'** - *Chronicle Live*
- **Trust appoints new chief executive** – *Yorkshire Post*
- **Man diagnosed with dementia at 46 after 'watching Mum go through it' now helping others** – *Teesside Live*

Media sentiment



Our website

85,631
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

116,892
page views

Top staff intranet news stories

1. TEWV 10k
2. Untangled Threads craft kits at Rowan Lea ward
3. Hospital receptionist gets a bus named after her

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

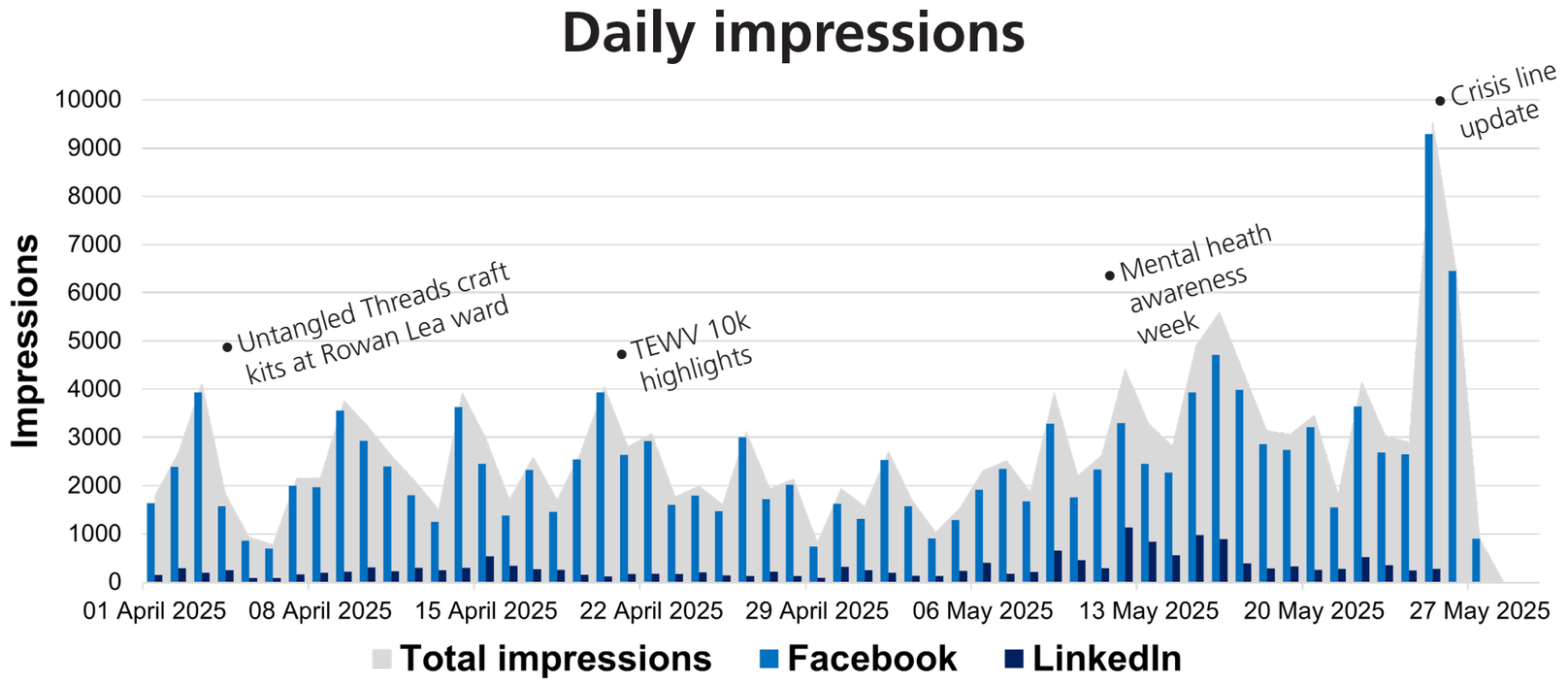
Our audience

28,413
Total followers

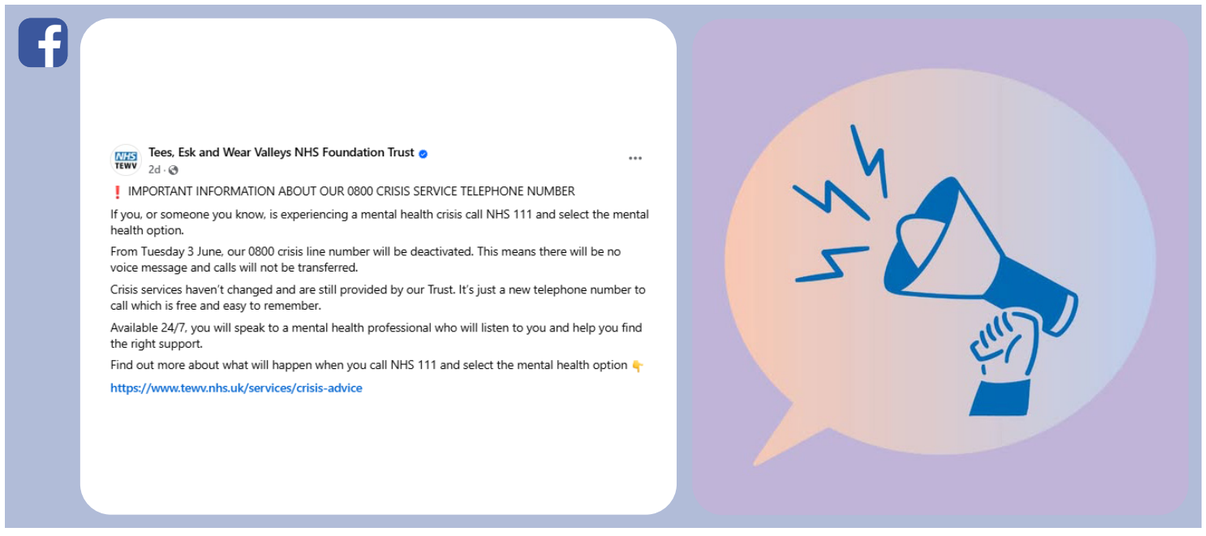
271
New followers

153,746
People who saw our content - impressions

85
Total posts



Top posts



Impressions 13,203 - Engagement 976

Impressions 1,766 - Engagement 121

Our work

Tees, Esk and Wear Valleys
NHS Foundation Trust

Our ongoing work

Communications:

- Campaign planning
- Monthly CEO all staff webinar
- Agreed awareness weeks/days
- Ongoing PR campaign/ good news stories
- Social media content and monitoring
- Responding to media enquiries
- Patient and carer information
- Horizon scanning
- Cito communications

Corporate affairs and stakeholder engagement:

- Policies
- Freedom Of Information (FOI)
- Governor engagement
- Internal MP briefings
- Monthly partner newsletter
- Quality board communications cell - monthly meetings and ongoing liaison
- NHSE NEY communications network meeting
- NENC ICB comms directors' meetings

Intranet news
44
stories posted
~5.5 a week

Email enquires
1,474
email requests
~37 a day

Team TEWV
staff Facebook group
340 posts
925 comments
2,489
total members
90 new members

All staff emails
39
sent
~4.8 a week

Patient information
7
updated

Policies
104 total policies
276 total procedures and guidelines
20 consultations open
32 revised and published

Freedom of Information requests
80 received
~10 a week
52 responded to
~6.5 a week

MP briefings
4

Partner newsletter
22
stories shared

What we're working on

You Matter

We are using the words and voices of people with lived experience in a new mental health campaign giving the message that even if you don't feel it yourself, you matter.

On 12 May we launched our You Matter campaign, which highlights the importance of getting help early if you are struggling with your mental health.

It signposts to a range of easily accessible help and support including self-help guides, Recovery College Online, community wellbeing hubs and support centres, mental health support in GP surgeries and Talking Therapies.

You Matter was created alongside people who have lived experience of mental illness and uses their own words throughout the campaign.

Positive media coverage was secured in Scarborough News, Yorkshire Post, Greatest Hits Radio, Teesside Live, Chronicle Live and involvement member Ruth will be interviewed on BBC Radio Tees.

Ruth Lord, who helped develop the campaign

Insights

Each month our team develops an 'insights' case study on a project we've worked on and evaluated. This demonstrates the impact of that project and enables us to continuously reflect, celebrate successes and improve.

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This month's focus

2024/25 flu vaccination campaign.

From 1 October 2024 to 31 January 2025, we ran a campaign to connect with our colleagues in a meaningful way, to help spread the message that getting a flu vaccine is an easy, important step toward a healthier workplace. The message was simple - by helping to prevent the spread of flu within our trust, we can ensure that our teams remain healthy and ready to provide the essential care our patients need.

Campaign objectives

- **Impressions** – ensure at least 90% of 9,442 staff were exposed to flu-jab messaging at least once during the campaign window
- **Awareness** – achieve over 95% spontaneous recall of the flu campaign in the post-campaign pulse check
- **Engagement** – achieve an average digital engagement rate of more than 4% across all intranet, email and social content
- **Reach** – achieve reach of over 1,000 across digital streams
- **Clarity** – Over 85% of colleagues to say they received "enough information" to make a decision about vaccination

How the campaign landed:

- **2923** colleagues vaccinated
- 18 intranet articles, 36 Facebook posts and more than 80 cascade emails gave us an average **reach of 1,100 colleagues**
- Digital engagement rate **4.6%** – comfortably above the 4% target
- **98%** of survey respondents knew about the flu campaign; **89%** felt they had all the information they needed
- **Winners** – More than eight fantastic prizes given out to lucky winners who'd had the vaccine

Barriers we uncovered

- Competing priorities with workload and vaccine 'fatigue'
- Shift workers struggled with static 9-5 clinics
- Message/campaign saturation in October meant some messages slipped through the net. Staff Survey, Black History Month, Star Awards, Nursing Conference, Admin Conference etc.

Key insights for next season

- **Channel mix matters:** emails still drive clicks, but roaming teams plus Facebook reminders triggered the biggest late-season spikes in uptake. Still can't discount digital exclusion. A significant portion of colleagues we'd consider digitally excluded, by device access or log-in frequency
- **Hyper-local comms work:** posters/banner boards produced a 14% higher clinic footfall on those wards
- **Story-led content beats stats:** posts featuring clinicians' personal reasons for vaccination generated 4× more comments than infographic posts
- **No booking pop-up clinics:** colleagues feel as though not needing to book an appointment slot and operating 'drop in' clinics is a far more effective way to deliver the static site clinics.
- **Forecasting is key:** Prior years' vaccination targets have been around 75% uptake. Uptake, nationally and regionally, has been on a consistent downward trajectory from 2022. If the national, regional and mental health trust trajectory follows the same pattern as the previous four years, the forecast for 2025/26 should be 22% uptake for our trust.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**10 April 2025**
Title:	**Leadership Walkabouts Feedback – April & May 2025**
Executive Author(s):	**Ann Bridges, Exec Director of Corp Affairs & Involvement** **Ann Bridges**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
All		Visible leadership in our services contribute to the Board's understanding of strategic risks, quality of services and the operation of key controls.

Executive Summary:

Purpose: The purpose of this report is to provide the Board with high-level feedback from leadership walkabouts that took place in April and May 2025.

Overview:

1 **Background**

1.1 The Trust undertakes a monthly programme of regular leadership walkabouts to services. These visits are not inspections however offer an opportunity for teams to have conversations directly with Board members and Governors to raise any matters of importance.

1.2 Walkabouts provide an opportunity for Board to meet with teams to really understand the strengths of the service and consider the more challenging areas, and how we can work together to resolve these and co-create any potential solutions. Full feedback reports and actions reported and monitored via Management Group.

2 **Speciality areas visited**

2.1 Leadership walkabouts took place on 28 April and 19 May 2025 across a range of corporate services including patient safety, people and culture, company secretary's office, complaints and estates, as well as Street Triage in Durham, HMP Old Elvet, Adult Learning Disabilities North Tees, and Stockton Adult Early Intervention in Psychosis (EIP).

3 Summary of feedback

Feedback has been summarised slightly different over these two months given that several, different corporate teams, and services were visited. All visits included discussions on team strengths, challenges, and potential areas for improvement.

HR Operations, People and Culture

- **Strengths / achievements:** team prides itself on strong support among colleagues, extensive expertise with many members having decades of experience, and flexibility in meeting the Trust's needs.
- **Maximising strengths**: enhance service effectiveness, importance of communication regarding HR roles, managing workloads efficiently, and streamlining processes.
- **Challenges**: accountability issues among managers, high workload demands, and staffing shortages, which have persisted for about 12 months.
- **Support needed**: sought consistent accountability from managers, additional support during recruitment phases, and updated job plans to clarify roles and expectations.

Patient Safety

- **Strengths / achievements:** team prides itself on resilience, improved training for clinical teams, and adaptability to changes in national frameworks, enhancing their responsiveness to incidents.
- **Challenges**: Key challenges include the quality of incident reporting, lack of timely responses from other teams, and the negative public perception of the organisation impacting staff and families.
- **Support needed**: enhancing support for quality improvement in incident reporting, promoting a culture of learning rather than blame, and reinforcing communication on the importance of engaging with families in incident reviews.
- **Future focus**: team encouraged to continue developing measures to evaluate the impact of their training and enhance family engagement in the aftermath of incidents.

Company Secretary's Office

- **Strengths / achievements**: team prides itself on teamwork, adaptability to high workloads, and a collective knowledge of governance processes. They emphasised the importance of their role in ensuring good governance, an area which is often misunderstood by others.
- **Challenges**: lack of communication between meeting chairs and report authors, preparation for meetings, and a lack of administrative support.
- **Support needed**: improved IT support, timely communication from report authors, recruitment to alleviate workload pressures.

Finance

- **Strengths / achievements**: team demonstrated resilience during challenging times post-Covid, focusing on efficiency and compassion in their operations. They have successfully adapted to changes and have improved staff wellbeing, with notable recognition as the NE Accounts Team of the Year.
- **Challenges**: pressures on the team, inadequate training for new staff, and the need for better integration of financial management in operational discussions
- **Support needed**: support for training, and discussions about definitive plans / future objectives to deliver operational and financial goals.

Complaints

- **Strengths / achievements**: team has undergone significant changes, including a comprehensive review of their approach and the development and introduction of a new trust-wide system. They have shown incredible resilience and have improved local complaint handling, achieving a 69% compliance rate with timeframes.
- **Maximising strengths**: team have developed action plans for learning, and keen to ensure learning is shared and embedded to affect positive change.
- **Challenges**: challenges regarding ownership and responsibility for complaints, as well as compliance with national standards.
- **Support needed**: support from leadership and IT to improve processes and ensure timely responses to complaints.

Estates and Facilities Management

- **Strengths / achievements**: pride in strong teamwork, positive feedback on service delivery, and building relationships with service users across our sites.
- **Challenges**: include access to wards, staff recruitment and retention, and bureaucracy.
- **Support needed**: improvements involve better communication with clinical services and support from clinical teams, along with a review of pay bands and simplification of procedures.

HMP, Old Elvet, Durham

- **Strengths / achievements:** creating a supportive environment, building strong team relationships, and supporting people in recovery to develop skills.
- **Challenges**: managing risks related to deaths and safety, handling documentation and high caseloads, balancing time management with a heavy workload and limited time**.**
- **Support needed**: Addressing environmental factors and increasing access to more laptops. Also overcoming the challenge of quickly onboarding staff.

Street Triage, Lanchester Road, Durham

- **Strengths / achievements:** team demonstrated strong support for crisis teams during business continuity planning and maintained a positive relationship with the police.
- **Challenges**: ongoing recruitment and retention of registered staff.
- **Support needed**: low referral numbers impacting service delivery.

Adult Learning Disabilities North Tees Community

- **Strengths / achievements:** proud of their person-centred approaches, skilled staff, and welcoming environment that promotes professional curiosity and support.
- **Maximising strengths**: improve collaboration with commissioners to ensure safety and quality in placements, advocating for shared responsibilities in case management.
- **Challenges**: inadequate support from unskilled teams, lack of involvement in commissioning discussions, and increasing complexity in service users' needs.
- Support needed: need for clarity and support in commissioning processes to effectively support complex individuals.

Stockton Adult Early Intervention in Psychosis (EIP)

- **Strengths / achievements:** pride in family intervention and support, adventure therapy and voyage to recovery, and effective EIP interventions, and positive patient and family feedback.
- **Challenges**: timely referrals, funding issues for the ARMS service, and the need for a designated medic.
- **Support** needed: involve educating the medical team on early referrals and securing funding for services.

Recommendations: The Board is asked to:

- Receive and note the summary of feedback as outlined.
- Consider any key issues, risks or matters of concern arising from the visits.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: **Board of Directors**

Date: **12 June 2025**

Title: **Register of Sealing**

Executive Sponsor(s): **Patrick Scott, Interim Chief Executive**

Report Author: **Phil Bellas, Company Secretary**

Report for:

Assurance		***Decision***	
Consultation		***Information***	✓

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
10	Regulatory Compliance	Under its Provider Licence, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the Licence, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Executive Summary:

Purpose: To advise the Board of the use of the Trust's seal in accordance with Standing Order 15.2.

Proposal: The Board is asked to receive and note this report.

Overview: The Trust's seal has been used as follows:

Ref	Document	Sealing Officers
443	Deed of variation relating to Transfer of land at Escomb Road, Bishop Auckland DL14 6HT	Patrick Scott, Interim Chief Executive Phil Bellas, Company Secretary
444	Deed of variation relating to Block 15, Roseberry Park	Kathryn Ellis, Interim Executive Director of Transformation and Strategy

		Phil Bellas, Company Secretary

Prior Consideration and Feedback None relating to this report.

Implications: None relating to this report.

Recommendations: The Board is asked to note this report.