Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS
14 August 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: a. The ordinary board meeting held on 12 June 2025 b. The special board meeting held on 25 June 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 12 August 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	Corporate Risk Register	CN	11.45pm
12	NHS 10 Year Plan summary and implications	EDS&T	11.50am
13	Our Journey to Change - Next Chapter	EDS&T	11.55pm

BREAK 12.00pm – 12.30pm

BAF Risk 1: Safe Staffing

14	Report of the Freedom to Speak up Guardian	FTSU Guardian	12.30pm

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

15	Report of the Chair of the Quality Assurance Committee	Cmt Chair	12.45pm
16	Quarterly Report of the Guardian of Safe Working Hours for Postgraduate Doctors	S Beattie, GOSW	12.50pm
17	Learning from Deaths Report	EMD	1.05pm
18	Leadership walkabouts feedback – June 2025	EDCA&I	1.15pm

BAF Risk 13: Public Confidence

19	Report of the Chair of the Charitable Funds Committee	Cmt Chair	1.20pm
20	Communications update	EDCA&I	1.25pm

Governance

21	Board Assurance Framework (verbal)	Chair	1.35pm

Exclusion of the Public

22	**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	-

CONFIDENTIAL SESSION

Standard Items

23	Minutes of the confidential session of the last board meeting held on 12 June 2025	Chair	1.40pm
24	Board Confidential Action Log	Chair	

Strategic Items

25	Chief Executive's Confidential report	CEO	1.45pm
26	Reportable Issues Log	CN	2.00pm
27	Report of the Chair of Audit & Risk Committee *(for information – verbal report provided 25 June 2025)*	Cmt Chair	-

BREAK 2.10pm – 2.20pm

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

28	Report of the Chair of Resources and Planning Committee *(for information – verbal report provided 12 June 2025)*	Cmt Chair	-
29	Medium Term Financial Planning	EDFE&F EDS&T	2.20pm
30	2025/26 Month 3 Finance Report	EDFE&F	2.55pm
31	Cito update	CIO	3.05pm
32	Report of the Chair of the Roseberry Park Hospital Sub-Group	Chair	3.20pm

Governance

33	Draft Board Assurance Framework - Quarter 1 2025/26	Co Sec	3.25pm

Matters for information:

34	To receive and note the minutes of the meetings of the following committees (for information): a. Charitable Funds Committee, 3 March 2025 b. Quality Assurance Committee, 5 June 2025	Co Sec	-

Evaluation

35	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
8 August 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 THE BOARD OF DIRECTORS HELD AT 10.30AM ON 12 JUNE 2025 AT WEST PARK HOSPITAL, DARLINGTON AND VIA MSTEAMS

Present
J Preston, Non-Executive Director and Senior Independent Director (Chair)
P Scott, Interim Chief Executive
Z Campbell, Executive Managing Director, North Yorkshire, York & Selby Care Group
K Kale, Executive Medical Director
J Maddison, Non-Executive Director
B Murphy, Chief Nurse/Interim Deputy Chief Executive
J Robinson, Non-Executive Director
L Romaniak, Executive Director of Finance, Estates and Facilities
C Wood, Non-Executive Director
A Bridges, Executive Director of Corporate Affairs and Involvement (non-voting)
H Crawford, Executive Director of Therapies (non-voting)
K Ellis, Executive Director of Strategy and Transformation (non-voting)
K North, Joint Executive Director for People and Culture (non-voting)

In attendance
P Bellas, Company Secretary
S Beattie, Guardian of Safe Working
K Christon, Deputy Company Secretary (minutes)
J Todd, DTVF Care Group Director of Transformation and Operations (obo N Lonergan)

42. CHAIRS WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting and placed on record the Board's thanks to D Jennings, who had stepped down as Trust Chair, for his commitment and strong leadership, during a challenging period for the Trust. He also noted the attendance of P Scott in his role as Interim Deputy Chief Executive and the appointment of K Ellis, Interim Director of Strategy and Transformation

Prior to commencing the agenda, he reminded the board that behind every statistic reported at the meeting was a patient, carer or family.

43. APOLOGIES FOR ABSENCE

Apologies for absence were received from B Reilly, Interim Trust Chair, R Barker, Non-Executive Director, N Lonergan, Interim Managing Director, Durham, Tees Valley and Forensic Care Group, S Dexter-Smith, Joint Executive Director for People and Culture (non-voting) and from C Carpenter, Non-Executive Director, who would join the confidential session.

44. DECLARATIONS OF INTEREST

None.

45. MINUTES OF THE BOARD MEETING HELD ON 10 APRIL 2025

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

The Chair recognised the attendance of the Company Secretary and Deputy Company Secretary to ensure good governance and accurate minutes.

46. ACTION LOG

In discussion:

1. It was noted that the transformation programme would be a key topic of discussion at the forthcoming Quality Assurance Committee away day and the action was closed [action 118].
2. L Romaniak advised that several of the estate issues raised in the Governor question would be resolved through the relocation to Hummingbird House. In the interim, a site visit would be held to consider concerns about air conditioning and options to manage the building differently. Staff had received a briefing and further feedback would be provided in advance of the relocation [action 7].

47. INTERIM CHAIRS REPORT

Board received the report from the Interim Trust Chair, following her appointment in May 2025.

The Chair advised that the CEO appointment panel had also included a Non-Executive Director from CNTW with lived experience. He noted the new CEO would start in post mid-September 2025 and P Scott provided assurance on work that had started to ensure there was a smooth transition.

48. QUESTIONS RAISED BY GOVERNORS

None.

49. BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

P Bellas presented the report, which provided information on risks included in the Board Assurance Framework to support discussion at the meeting. He commented on proposals to develop the report to reduce time spent in preparation and improve how it was used and this was supported.

50. CHIEF EXECUTIVE'S REPORT

P Scott and B Murphy presented the report, which briefed the board on topical issues of concern and summarised strategic and operational developments since the previous meeting. Attention was drawn to the confirmation received from NHS England that the Trust had met the criteria to move out of mandated quality oversight and B Murphy reflected on, and thanked staff for, all the work undertaken across care groups and corporate services over the past three years to support the improved position.

In discussion:

1. The Chair acknowledged the progress that had been achieved, as reflected in recent CQC inspections, which demonstrated an upward trajectory whilst recognising there was more to do.

   P Scott also welcomed the position as an important milestone, which recognised the high standards of care provided by staff and would provide assurance to communities and those accessing Trust services.
2. Board discussed the outcome of the government's spending review for the NHS, and whilst the revenue uplift for the NHS was welcomed, a concern was expressed about capital investment that would be required to support system change and funding for social care, to support patients who were clinically ready for discharge.

3. Feedback was provided from a national meeting on job planning, which had suggested that there may be opportunities for additional mental health funding if providers were able to demonstrate clear outcomes. It was acknowledged that patient outcomes was a key focus for commissioners and something that the sector had struggled to achieve.
4. The board noted a report published by NHS Providers that commented on the importance of mental health services in delivery of health and care. Feedback was also provided from the NHS ConfedExpo 2025, where the ability of NHS providers to help influence a reset across the system had been discussed.
5. It was noted that the NHS 10-year plan was not be condition specific and the Trust would continue to work closely with partners to ensure the mental health agenda was aligned to the physical health agenda.
6. The board welcomed the focus given to strategy and transformation through the appointment of an interim executive director and P Scott confirmed that the role was part of the Deputy Chief Executive portfolio and provided additional capacity while he acted as Interim Chief Executive. He suggested the new Chief Executive would review future arrangements once in post.

51. INTEGRATED PERFORMANCE REPORT

K Ellis 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. She also commented on work that would be undertaken to develop the IPR further to support discussion at Board meetings.

Z Campbell and J Todd summarised the reported challenges and improvements for North Yorkshire, York and Selby Care Group (NYYS) and Durham, Tees Valley and Forensic Care Group (DTVF).

In discussion:

1. K Ellis agreed to confirm the response rates for patients reporting a very good or good experience, carers who felt actively involved, and inpatients feeling safe whilst in Trust care **Action: K Ellis**

   P Scott and Z Campbell acknowledged that response rates were not where the Trust wished them to be and advised that care groups monitored rates by team and sought to improve them, with support from Co-creation Boards. External sources, such as Healthwatch, would contribute to service intelligence.
2. Board noted that, whilst bed occupancy remained high, there had been improved availability, which enabled the Trust to support people's needs more quickly and provide care closer to home. B Murphy recognised the support provided by General Managers.
3. Assurance was sought on the level of confidence the Trust had that a reduction in delayed transfers of care would be achieved, when the Trust was reliant on local authorities to provide appropriate care packages and in the context of the limited financial settlement for local government. It was also suggested that the Trust could use its position to advocate for appropriate local authority funding.

   L Romaniak advised that the Trust position was driven by challenges in North Yorkshire, Durham and Stockton-on-Tees and it was agreed that a further discussion should be held at Resources and Planning Committee and Quality Assurance Committee on the cause of delayed transfers of care, reporting into the board. **Action: L Romaniak, B Murphy**

   Z Campbell commented on early community transformation activity to help reduce admissions and she acknowledged particular challenges in North Yorkshire, where a joint

board had been established with the local authority to consider pressure points across mental health and learning disability.

K Ellis reflected on the discussion at Resources and Planning Committee in relation to the importance of visibility of the impact of key streams of work and the involvement of partners - recognising where the Trust was able to influence and where system support was required. K Kale also noted that Quality Assurance Committee had discussed system support with the integrated care board, in the context of an increase in patients clinically ready for discharge, from 60 to 80.

Commenting on the data, L Romaniak noted that the trust had 30 available beds, 60 beds occupied by patients clinically ready for discharge, and historically had upwards of 20 patients placed out of the area. This equated to 110 movement in flow and discharge was now the challenging issue.

P Scott reflected on the sustained progress to reduce bed occupancy and the positive impact of this on the quality of care provided and those working in services. He proposed that community transformation would help to reduce waiting times and caseloads.

4. Board was advised that that Trust was one of the lowest users of prone restraint nationally within a mental health trust, as reported to Quality Assurance Committee via the Positive and Safe Annual Report.
5. Board noted the improvement in mandatory and statutory training compliance and B Murphy acknowledged there remained challenges for face-to-face training, linked to suitable training venues across the estate and attendance due to clinical pressures.
6. Assurance was sought on the keeping in touch and waiting well offer and J Todd provided an outline of the support provided to children, young people and adults while they wait for services in order that their status is maintained and they are ready to engage. He proposed that the impact was variable - some found it helpful and others less so - and he noted that needs-based support in educational settings would be provided irrespective of a diagnosis.
7. The Chair welcomed the opportunity to provide a summary of matters to draw to the attention of the board in the cover report, with the IPR provided for more detailed review and this was supported.

   B Murphy noted a discussion at the Quality Assurance Committee development session on further development of the Trust's Quality Management System, which would support the Board and meetings across the Trust structure to focus on key challenges.

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, recognising there is limited assurance about the quality of impact on those patients who are waiting to access Trust services, which Quality Assurance Committee will continue to monitor.*

52. OUR JOURNEY TO CHANGE DELIVERY PLAN QUARTER 4 2024/25

K Ellis presented the report, which outlined progress against the priorities of the delivery plan and the impact/benefit of work to date, by journey, where that was available and had been realised. In discussion:

1. The board noted the recommendation of Resources and Planning Committee that consideration be given to lessons learnt and the impact on service users, and this would be included in future reports.
2. L Romanik advised the refresh of the Green Plan had been delayed to align with the late issue of national guidance and would be completed by end of July 2025. K Ellis went on

to note overlap between the green plan and delivery of other priorities and proposed that this be drawn out in future reports.

3. N Black advised that the business intelligence system had moved to the cloud in April 2025 and a pilot scheme for devices on inpatient wards was underway, prior to roll out.
4. P Scott welcomed the opportunity to capture progress made on autism priorities and impact and that this be shared with communities and partners.
5. Assurance was sought on progress of the female bed model within NENC secure services provider collaborative and K Ellis and P Scott advised that the Trust was actively involved in conversations with partners to ensure the partnership board met regularly.

53. REPORT OF THE CHAIR OF PEOPLE, CULTURE AND DIVERSITY COMMITTEE

J Robinson presented the report and summarised the key areas of discussion at the committee meeting held on 29 May 2025. She alerted the board to the importance of the freedom to speak up (FTSU) service and risk should a service not be in place and the importance of permanent funding for the Reasonable Adjustments Team. In discussion:

1. K North advised that proposals for a new model of delivery for FTSU would be considered at the next committee meeting and confirmed that Executive Directors Group had agreed permanent funding for the Reasonable Adjustments Team, recognising their positive impact.
2. The Chair noted that the FTSU procurement process had been ongoing for some time and acknowledged the support of the Guardian in continuing to provide the service. He also provided an example of a member of staff who had benefited from support provided by the Reasonable Adjustments Team.

   Z Campbell reflected on the earlier discussion on the spending review and engagement with partners and noted potential for Trust involvement in conversations to re-direct resources towards issues that would support people to remain in work.
3. L Romaniak expressed concern about national misalignment, where the Trust would wish to support the work of the FTSU service and the Reasonable Adjustments Team and had a target to reduce corporate costs. She also noted a misalignment between productivity requirements and the apprenticeship levy, where 500 apprenticeships would be equivalent to 100 WTE less staff at work at any time.

   N Black noted a similar inconsistent message between investment in digital and technology to support efficiency and change and inclusion of the team in corporate targets.
4. K North advised that the Trust had paused gender awareness training to wait for national guidance and to consider how to proceed in a compassionate and supportive way for those involved.

54. GUARDIAN OF SAFE WORKING 2024/25 ANNUAL REPORT

S Beattie, the Guardian of Safe Working, presented the report, which provided assurance that postgraduate doctors were safely rostered and their working hours were safe and in compliance with their terms of conditions of service. In discussion:

1. S Beattie suggested that the reported reduction in fines in quarter 4, may be due to a delay in reporting and advised that the impact of the hybrid model in Scarborough and York was be expected to be reported in quarter 2.
2. The Board noted that junior doctors had voted TEWV as the best Trust for training in the GMC survey, reflecting progress that had been made, and acknowledged that regulators would place emphasis on feedback from learners.
3. S Beattie advised that the junior doctors forum ran well and had a good working relationship with the Trust.

55. REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

J Maddison presented the report and summarised key areas of discussion at the committee meetings held on 1 May 2025 and 5 June 2025. B Murphy drew attention to matters alerted to the board, which included compliance with quality assurance audits and the perinatal service in North Yorkshire, where an approach had been agreed to ensure the quality of care for people accessing the service.

56. LEARNING FROM DEATHS REPORT

K Kale presented the report, which proposed there was good assurance of reporting and learning in line with national guidance.

In discussion A query was raised in relation to the regularity that headings were reported and the detailed consideration that would take place on areas beneath those headings.

K Kale and H Crawford confirmed that a deep dive was completed on any issues raised by a mortality review to ensure that learning had been captured and all measures had been taken in response. Learning would be disseminated through patient safety briefings and staff webinars. The Trust had identified 12 overarching learning themes, which were considered by the Organisational Learning Group and triangulated with information from other sources.

Agreed: *There is a good assurance of reporting and learning in line with national guidance.*

57. REPORT OF THE CHAIR OF MENTAL HEALTH LEGISLATION (MHL) COMMITTEE

K Kale presented the report and summarised the key areas of discussion at the committee meeting held on 12 May 2025. He alerted the board to: ongoing discussions with Middlesbrough Council to address their backlog of Deprivation of Liberty Standards applications and interim support that would be provided by the MHL Team to advise staff in respite services; and the new opt out process for advocacy services and proposals to improve the level of staff awareness and increase referrals.

The board queried the availability of interpreters in areas such as advocacy and K North agreed to confirm following the meeting. **Action: K North**

58. COMMUNICATIONS UPDATE

A Bridges presented the report, which provided an overview of communication activity and delivery of the communications strategy during the period April to May 2025. In discussion:

1. A query was raised on the 2025/26 forecast for vaccinations at 22% and A Bridges confirmed that moving into winter there would be a renewed focus across the system on the vaccination programme. B Murphy advised that the decrease in take-up reflected vaccine hesitancy and lack of interest, which was attributed to the intervention applied during the Covid pandemic. The next programme would have a more personal approach, with local vaccinators based within teams.
2. Board welcomed the success of the You Matter campaign and it was noted that there had been good level of media reporting, with the exception of the Northern Echo.
3. Responding to a query, A Bridges confirmed that there would be a focus on partnership working, integration of mental health and physical health and emphasis on the themes of the 10-year plan.

59. LEADERSHIP WALKABOUTS

A Bridges presented the report, which provided high level feedback from leadership walkabouts that took place in April and May 2025. She noted an improvement to the report to include strengths and achievements.

The board welcomed the opportunity to visit corporate services in the context of concerns about corporate benchmarking targets.

60. 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.

61. REGISTER OF SEALINGS

Noted.

62. EXCLUSION OF THE PUBLIC

Agreed*: that representatives from 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 matters, the meeting finished at 3.35pm.

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Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF A SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD AT 2PM ON 25 JUNE 2205 VIA MSTEAMS

Present:
B Reilly, Interim Chair
B Murphy, Chief Nurse/Acting Interim Chief Executive
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
J Preston, 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)

Present:
P Bellas, Company Secretary
N Black, Chief Information Officer
J Chapman, Associate Director of Finance (Accounting and Governance)
K Christon, Deputy Company Secretary (minutes)

WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and thanked J Maddison for attending the meeting while on holiday. She went on to place on record the thanks of the Board to all staff involved in preparation of the reports to meet the tight deadlines involved.

APOLOGIES FOR ABSENCE

Apologies for absence were received from P Scott, Interim Chief Executive, C Carpenter, Non-Executive Director, J Robinson, Non-Executive Director, R Barker, Non-Executive Director, Sarah Dexter-Smith, Joint Executive Director for People and Culture (non-voting), and K Ellis, Executive Director for Strategy and Transformation (non-voting).

DECLARATIONS OF INTEREST

None.

REPORT OF THE CHAIR OF AUDIT AND RISK COMMITTEE (VERBAL)

J Maddison, Chair of Audit and Risk Committee, provided a verbal report from the last committee meeting held on 20 June 2025 and noted:

- Completion of the Annual Accounts in line with the deadline and he placed on record thanks to L Romaniak, J Chapman and their team for all their efforts to achieve that.

  There had been late notification from the external auditor that PIPs, the Trust's Wholly Owned Subsidiary, should be consolidated into the annual accounts, as it had met the materiality criteria and this change had led to an increase in the reported surplus. Resources and Planning Committee would consider next steps for PIPs, following

queries raised by the Chair of Quality Assurance Committee. The external auditor would issue their letter that week and no issues were expected to be highlighted.
- The Trust's Annual Report had also been amended to reflect the consolidation of PIPs. Executives would review the timeline for preparation of the 2025/26 Annual Report, with a view to earlier submission of a first draft to Audit and Risk Committee in March 2026, and then to the external auditor.
- The improved 'good' Head of Internal Audit opinion on the Trust's system of internal control, which formed part of the Annual Governance Statement. Audit and Risk Committee had also received the detailed auditor rational for the Opinion rating, which had referenced encouraging analysis of the Trust's position against that of previous years and other NHS Trusts.
- The Quality Account had been considered by Quality Assurance Committee from a quality perspective and Audit and Risk Committee due to statutory reporting requirements.
- Audit and Risk committee recommended the Annual Report and Accounts 2024/25 and Quality Account 2024/25 to the Board for approval.

THE ANNUAL REPORT AND ACCOUNTS 2024/25

B Murphy introduced the report, which sought the board's approval of the Annual Report and Accounts 2024/25, as recommended by Audit and Risk Committee.

L Romaniak noted:

- The external auditor was expected to complete their work by Friday 27 June and, on the basis of substantive work completed to date, a clean audit opinion was expected. The Subject to this, the Annual Report and Accounts would be submitted by the deadline of Monday 30 June and the process would start to lay the accounts before Parliament.
- The value for money assessment included in the draft External Auditor Annual Report, confimred there were no new significant risks. The improvement from that reported in previous years reflected the improvement in the Trust's CQC regulatory position, with both actions closed following re-inspection.
- The Annual Accounts for 2024/25 demonstrated that the Trust had met its financial targets and the external auditor had confirmed there were no unadjusted misstatements.

In discussion:

1. It was noted that, with the exception of the Interim Trust Chair, all Non-Executive Directors were members of Audit and Risk Committee and had received a detailed briefing on the annual accounts. The Chair confirmed she also had the opportunity to discuss the report and related queries in advance of the meeting.
2. The board welcomed the improved audited position on value for money and work undertaken by staff to achieve that.

Recommendations – AGREED

Agreed: *that board –*

i. Approve the Annual Report and Annual Accounts 2024/25
ii. Approve the Letter of Representation
iii. Authorise the signing of
- *The Annual Report*
- *The Performance Report*
- *The Accountability Report*
- *The Remuneration Report*

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

iv. Authorise the submission of the signed Annual Report and Accounts, and related documentation, to NHS England and Parliament

THE QUALITY ACCOUNT 2024/25

B Murphy, in her capacity as Chief Nurse, confirmed that the Quality Account had followed a full governance process – with positive feedback received from a range of stakeholders including local overview and scrutiny committees and consideration by Quality Assurance Committee and Audit and Risk Committee – and she recommended it for approval.

There was no longer the requirement to produce a Quality Report, which External Auditors had previously then audited.

The Chair confirmed that, as Chair of Quality Assurance Committee during 2024/25, the committee had had the opportunity to review the Quality Account on a number of occasions.

Agreed: *that board -*

i. Approves the Quality Account 2024/25
ii. Authorises its submission to the Department of Health and Social Care and publication on the Trust's website.

REGISTRATION OF CONFLICTS OF INTEREST

P Bellas presented the report, which provided the Register of Interests of the Board of Directors as at June 2025. He went on to note the legislative requirements and invited board members to continue to register any conflict of interest throughout the year.

In discussion:

1. B Murphy proposed an amendment to the register to include that she was a member of the National Nursing Advisory Forum and confirmed there was no financial interest or conflict with the Trust.
2. Responding to a query, P Bellas confirmed that the Trust produced four registers in line with NHS England guidance, which included: A Register of Gifts and Hospitality; A Register of Conflicts of Interest for Governors, which was reviewed each year on completion of the election process; and a Register of Interests of Decision Making Staff at bands 8b and above and at band 7 for staff working in the areas of IT, finance, estates, facilities management and medical consultants. Some data quality issues had been raised in relation to the staff register and the Trust would centralise that submission process in July through use of ESR.

Agreed: *the Board notes the Register of Interests of the Board of Directors as at June 2025, subject to amendment proposed by B Murphy.*

EXCLUSION OF THE PUBLIC

P Bellas advised that the report on the Data Security and Protection Toolkit was determined not to be confidential and the board was not therefore required to go into private session.

Agreed: *the board would not exclude the public from the remainder of the meeting.*

DATA SECURITY AND PROTECTION TOOLKIT

N Black presented the report, which proposed the Trust submit an 'approaching standards' level submission, supported by an action plan that identified delivery by December 2025, as considered by Audit and Risk Committee.

In discussion:

1. N Black advised that the report reflected a significant change to the toolkit requirements from the previous year and most NHS providers would now report at the 'approaching standards' level. He also provided assurance that the position had been reflected in the Board Assurance Framework (BAF).

   L Romaniak went on to note that the new framework required the support from colleagues beyond the Digital and Data Team and advised that Audit and Risk Committee had considered the report as it related to key systems of internal governance and control.
2. The Board noted that delivery of the plan would be monitored via Resources and Planning Committee, who oversaw the related BAF risk, and Audit and Risk Committee, from a controls perspective. It was agreed that until the board was able to be assured on progress against the action plan, the report would be taken with reasonable assurance.

Agreed: *the board accepts the report with reasonable assurance and supports the submission of an approaching standards toolkit submission with a supporting action plan.*

The meeting concluded at 2.29pm

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	Closed	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: 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. **This was agreed.**
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: L Romaniak advised that several of the estate issues raised in the Governor question would be resolved through the relocation to Hummingbird House. In the interim, a site visit would be held to consider concerns about air conditioning and options to manage the building differently. Staff had received a briefing and further feedback would be provided in advance of the relocation **July 25: Estates visited site on 13 June 25 and undertook some immediate minor works in the Early Intervention in Psychosis and Crisis (children and young people) team offices, including to remove restricted window openers / fit window glazing film to reduce sun/heat penetration. Quotes were being progressed for external fencing to allow external doors to remain open (protect privacy). Whilst a quote to extend existing air conditioning was being sought, the value for money of this will necessarily be considered separately. A review of planned preventative maintenance checks was requested by the Director of Estates to ensure air ventilation is running free and clear.**
12/06/2025	**51 (1)**	**IPR - response rates**	**K Ellis agreed to confirm the response rates for patients reporting a very good or good experience, carers to felt actively involved and patients feeling safe whilst in Trust care.**	**K Ellis**	**Aug-25**	Closed	**Written response provided by A Bridges.**
12/06/2025	**51 (3)**	**IPR - clinically ready for discharge**	**Resources and Planning Committee and Quality Assurance Committee to discuss delayed transfers of care and report into the board**	**L Romaniak C Carpenter B Murphy J Maddison**	**Oct-25**		
12/06/2025	**57**	**Advocacy**	**K North to confirm the availability of interpreters in areas such as advocacy**	**K North**	**Aug-25**	Closed	**July 25: The Trust would provide an interpreter for advocacy in connection with our services if required, this would be booked through Everyday Language Solutions. The Mental Health Legislation team or the service involved could arrange this.**

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Interim Chair Report

August 2025

Fit for the Future: 10 Year Health Plan for England

There has been a significant amount of activity associated with the publication of the 10 Year Health Plan for England which was published by the Government on 3rd July 2025. Whilst lengthy, it sets out a clear strategy to transform the NHS with the backbone being three major shifts:

1. From hospital to community
2. From analogue to digital
3. From sickness to prevention

What does this mean for us? The plan includes key focus on improved access to crisis care via NHS 111(2), developing community-based crisis alternatives and providing more support for children and young people. The plan also focuses on integrating mental and physical healthcare with specific initiatives for severe mental ill health and early intervention psychosis.

In considering the plan, I have been part of a number of national and regional calls with Chairs and Chief Executives. It is very clear that we must focus on transformation, which has already significantly informed Our Journey to Change (part 2).

New NHS Oversight Framework Segmentation

The new NHS Oversight Framework sets out how NHS England will assess providers and Integrated Care Boards (not assessed until 2026/7) alongside a range of agreed metrics. Following assessment, organisations are placed into segmentations ranging from

1. The organisation is consistently high performing across all domains, delivering against plans.
2. The organisation has good performance across most domains. Specific issues exist.
3. The organisation and/wider system are off track in a range of domains or are in financial deficit.
4. The organisation is significantly off track in a range of domains.

We have been placed in segment 2. Work is already underway to maintain and improve our position at our next assessment.

External Meetings

As previously mentioned, there has been a lot of focus on considering the plan, however I am grateful to have had the opportunity to meet again with Fiona Edwards, the Regional Director, North East and Yorkshire, NHS England and discuss our progress on

improvement. I have also met with Jason Stamp, the Acting Chair of Humber and North Yorkshire Integrated Care Board and attended a meeting with fellow Chairs with Sir Liam Donaldson, Chair and Sam Allen, CEO of North East and North Cumbria Integrated Care Board. It is incredibly important that we engage positively with our strategic partners during a significant period of change in the NHS. I have met with Darren Best, Chair of Cumbria, North East and Wearside NHS FT. We are both clear that both TEWV and CNTW will play a significant part in delivery of the plan, and we will work together appropriately.

Internal Meetings

It has been a very busy 8 weeks for us all. I have had several welcome meetings with staff and a regular catch up with our Lead Governor Gary Emmerson. I have chaired:

- Board Nomination and Renumeration Committee
- Extra Ordinary Board Meeting to agree the Annual Report, Accounts and the Quality Account
- Council of Governors Meetings (Note 14th July Jules Preston kindly stepped in at very short notice)
- Roseberry Park Subgroup
- NEDs and Chair monthly meetings
- Council of Governors Nomination and Renumeration Committee (part)

Items of Interest

We have had a number of Board Seminars as part of our learning and development. On the 26th June, I was delighted to welcome colleagues from Nottinghamshire Healthcare NHS FT who talked us through their learning and experience following the devastating attacks in June 2023. It was one of the most powerful and thought-provoking seminars we have ever had.

On the 10th July the Board have also had very insightful health and safety training, a very timely update on the 10-year plan and *A review of patient safety across the health and care landscape* by Dr Penny Dash, Chair of NHS England. I have also attended my Level 2 Autism training.

I was delighted to attend the new Governors Induction session on 24th July. I am really looking forward to getting to know new faces and welcome back familiar colleagues.

The Interim CEO and I met with Dewi Williams, our FTSU Guardian. Dewi talked us through oversight of his current caseload and provided us with great insight into our overall position.

I was privileged to Chair the recruitment panels for consultants. It is a great part of this role and one that I learn from and very much enjoy. Congratulations to our two new

colleagues. A Consultant for CAMHS (community)in North Yorkshire, York and Selby Care Group and a MHSOP (community) Consultant in our Durham, Darlington, Teesside a Forensics Care Group.

Leadership Walkabouts

It was an absolute pleasure to meet with staff from our CAMHS Team in Stockton. Huge thanks to Gemma Sharpe and colleagues for hosting us and helping us to learn. Thanks also to staff on Birch Ward at West Park who allowed me to pop in and have a look around.

Our New Chief Executive Alison Smith

As you would expect, I have been in regular contact with Alison, our incoming Chief Executive. Alson starts her employment with us on the 8th September. She has spent time with us on site and has had several introduction meetings with colleagues and stakeholders. We look forward to a very warm welcome here at Team TEWV.

Bev Reilly

Interim Chair

August 2025

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Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14 August 2025**
Title:	**BAF Summary Report**
Executive Sponsor(s):	**Beverley Murphy, Acting Interim Chief Executive**
Report Author(s):	**Phil Bellas, Company Secretary**

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

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

1: We will co-create high quality care	✓
2: We will be a great employer	✓
3: We will be a trusted partner	✓

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
10	Regulatory Compliance	Under its Provider Licence, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the Licence, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

EXECUTIVE SUMMARY:

Purpose:

The purpose of this report is to support discussions at the meeting by providing information on the risks included in the Board Assurance Framework (BAF).

Proposal:

Board Members are asked to take the strategic risks, included in the BAF, into account during discussions at the meeting.

Overview:

The BAF brings together all relevant information about risks to the delivery of the

Trust's strategic goals.

A summary of the BAF is attached. It seeks to provide information on:

(a) The strategic risks together with positive and negative assurances relating to key controls which have been identified since the last Board meeting

(b) Any new, emerging or increasing risks identified

The Board will recognise that it receives a number of reports at each meeting that are pertinent to the BAF risks, including:

- Integrated Performance Report
- Chief Executive's Report
- Board Committee Reports
- Monthly Finance Report (confidential)
- Reportable Issues Log (confidential)

In regard to progress on managing the BAF risks (as at Quarter 1, 2025/26):

(1) The three lines of defence are articulated for each control identified in the BAF with the exception of:
   - BAF 2 (Demand) – Establishment Reviews – 3rd line
   - BAF 14 (Health Inequalities – Draft) – all controls

(2) Changes have been made to the scores of the following risks:
   - The present risk scores have reduced for the following risks:
     - BAF 4 (Quality of Care)
     - BAF 8 (Quality Governance)
   - The target risk score of BAF 13 (Public Confidence) has increased

(3) The following risks have achieved their target risk scores:
   - BAF 4 (Quality of Care)
   - BAF 6 (Estate/Physical Infrastructure)
   - BAF 8 (Quality Governance)
   - BAF 10 (Regulatory Compliance)

(4) Those risks with the greatest variance between their "present" and "target" risk scores are as follows:
   BAF 1 (Safe Staffing) – 10 point difference
   BAF 5 (Digital - Supporting Change) – 10 point difference
   BAF 7 (Digital – Data Security and Protection) – 10 point difference

(5) Those risks with the greatest variance between their present score and tolerance (the acceptable upper threshold for day to day risk fluctuation) are as follows:
   - BAF 1 (Safe Staffing) – 11 point difference
   - BAF 13 (Public Confidence) – 11 point difference*
   - BAF 5 (Digital – Supporting Change) – 8 point difference
   - BAF 7 (Digital Security and Protection) – 8 point difference
   - BAF 12 (Financial Sustainability) – 8 point difference*
   - BAF 2 (Demand) – 7 point difference
   - BAF 14 (Health Inequalities) – 7 point difference

   *(*Note: cannot, at present, be mitigated to tolerance and therefore provides the greatest longer-term risk)*

Prior Consideration and Feedback:

Not applicable to this report

Implications:

None relating to this report

Recommendations:

The Board is asked to take the strategic risks into account during its discussions at the meeting.

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
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.	DoP&C	PCDC	**High 20** (C5 xL4)	**Moderate 10** (C5 x L2) **Q3, 25/26**	**Q1, 25/26** Workforce plans in place for all services (-1L)	**Good**	Knowing which staff we need and where	▪ Daily operational processes in care groups ▪ Monthly e-roster reviews re fill rates etc ▪ Safe staffing reports re shifts over 13 hours, missing RN, missed breaks	**Positive** **IPR:** ▪ Compliance with ALL mandatory and statutory training (metric 20) - *increased performance assurance* ▪ Staff in post with a current appraisal (metric 21) - *increased performance assurance* **GoSW Report:** GOSW satisfied that all exception reports submitted by doctors on the 2016 contract have been actioned by Medical Staffing **FTSU Report:** Good assurance that the FTSU service being provided to employees is safe and provides good governance to Board through the various mechanisms in place to ensure independence and oversight **Negative** -	-	**Public Agenda Item 14** – Report of the Freedom to Speak Up Guardian (FTSUG) **Public Agenda Item 16 –** Report of the Guardian of Safe Working (GOSW)
											Ensuring that staff are recruited to and safely deployed to the right places	▪ Rosters for inpatient services ▪ Daily management huddles/ staffing calls ▪ Daily safety huddles on wards			
											Staff are appropriately trained to support people using our services	▪ Daily safety huddles on wards ▪ Increasing number of development JDs in place to ensure people are safely developed into more senior roles ▪ Individual and manager compliance reports available weekly			
											Staff are supported to maintain their wellbeing, feel they belong and choose to stay and work here.	▪ Quarterly reviews and annual appraisals support staff ▪ Supervision – managerial and clinical ▪ OH provision ▪ Multiple H&W interventions including comprehensive support and psychological services – all with outcome measures			
											Ensuring that local leaders and managers are equipped to lead and maintain safe staffing	▪ Recruitment processes inc LE panel members ▪ 3 year leadership programme and quarterly leadership events for service management level and above			
											Early understanding of when things go wrong	▪ Operational escalation processes ▪ Links from services to ePCD increasingly strengthening ▪ Thinking about leaving interviews ▪ 'Working in TEWV' monthly online meetings			
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.	**Mng Dir**	**QuAC**	**High 16** (C4 xL4)	**Moderate 12** (C4 xL3) Q4 25/26	**Q4 25/26** Implement transformational developments (-1L)	**Good**	Partnership Arrangements	▪ Weekly operational interface meetings with Local Authority partners to support flow within inpatient services	**Positive** **QuAC (3/7/25):** Good assurance from specialist services across a range of indicators for example the responsiveness of the perinatal with increased access and significant reductions in	-	-
											Demand Modelling	▪ Associate Director of Strategic Planning and Programmes – Lead for demand modelling in the Trust			
											Operational Escalation Arrangements	▪ Inpatient wards – Management of admissions through PIPA process and the operational daily escalation calls ▪ Bed Management Team – Responsible for the oversight and management of the use of			

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3									beds ▪ On-call arrangements – Agreement of actions in response escalation ▪ Freedom to Speak Up Guardian – Point of contact for staff with concerns about quality e.g. the impact of demand ▪ Daily Lean Management Processes – to understand and escalate risks associated with operational delivery are in place across inpatient and community services	waiting lists, particularly in Persistent Physical Symptoms service **Negative** -		
											Integrated Performance Reporting	▪ Operational delivery of performance standards by wards and teams ▪ Performance Department – Management of the IPR including validation of data, oversight of data quality and reporting to the various tiers of the governance structure			
											Establishment Reviews	▪ Safe Nursing Workforce Staffing Standards Team – Responsible for managing and delivering the establishment review process. This is based on: ▪ Acuity dependency assessments for each ward using the MHOST tool and professional judgements ▪ General Management reviews, including discussions with Matrons, on the ward assessments ▪ Assessments of a range of data including benchmarking, patient outcomes, staffing information e.g. use of temp staff and overtime ▪ Care Group Boards – Review the outcomes of the establishment reviews and development of proposals (included in the Establishment Review reports to the BoD) ▪ Finance Department – Reviews of affordability of the outcome of establishment reviews *(Reports to the FSB/EDG)*			
											Strengthen voice of Lived Experience	▪ Role of peer workers. ▪ Expanding opportunities of lived experience roles, including lived experience facilitators and senior lived experience roles/peers ▪ Service level service user and carer user groups ▪ Triangle of care ▪ Patient Experience reporting ▪ Understanding our complaints themes and impact on services ▪ Patient Safety Partners - PSIRF ▪ Partnership with clinicals networks – cocreation of clinical care initiatives and models ▪ Commissioning VCS lived in core services to meet identified needs			

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
3	✓	✓	✓	**Co-creation** **There is a risk** that if we do not fully embed co-creation **caused by** issues related to structure, time, approaches to co-creation and power **resulting in** fragmented approaches to involvement and a missed opportunity to fully achieve OJTC	DoCAI	QuAC	**Moderate 8** (C4xL2)	**Low 4** (C4 x L1) **Q3 2025/26**	**Q3 2025/26** Delivery of key mitigations (1L)	**Good** ↑	Further develop the co-creation infrastructure	▪ Director of Corporate Affairs and Involvement – Responsible for the delivery of the Cocreation priorities set out in Our Journey to Change (OTJC), and associated Delivery Plan ▪ Head of Co-creation ▪ Lived Experience Directors ▪ Involvement & Engagement (I&E) team ▪ Patient Experience team ▪ Peer Support team ▪ Clinical Leaders ▪ Service Managers	**Positive** - **Negative** -	-	-
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.	CN	QuAC	**Moderate 9** (C3 x L3) ↓	**Moderate 9** (C3 x L3) Target Achieved	Target Achieved	**Good**	Complaints Policy	▪ Chief Executive – Overall accountability for ensuring that the Complaints Policy meets the statutory requirements. ▪ Director of Corporate Affairs and Involvement – Responsible for the development, implementation and monitoring of the complaints policy ▪ Head of Patient Experience - Responsible for facilitating the effective reporting, investigation, and communication of all complaint activity ▪ Complaints Team Manager – Responsible for managing the complaints' function including the central database for complaints and producing statistical data. ▪ Trust Organisational Learning Group – triangulation between all sources of intelligence to identify and act on service improvements. ▪ General Managers/Service Managers – ▪ Responding to concerns and complaints within their areas of responsibility. ▪ Ensuring timely approval of complaints. ▪ Ensuring learning and actions from complaints are identified and reported upon. ▪ Ward/Team Managers/Modern Matrons – ▪ Ensuring information is available on how to raise concerns and complaints. ▪ Responding to concerns raised locally (Local Issue Resolution). ▪ Capturing Local Issue Resolution (LIR) and monitoring using the InPhase solution. ▪ Providing feedback to complaints upon request. ▪ Implementation of actions/learning ▪ Complaints Team - Responsible for ▪ Managing complaints ▪ Ensuring complaints are investigated in line with the complaints policy.	**Positive** **QuAC (3/7/25):** Good assurance from specialist services across a range of indicators for example the responsiveness of the perinatal with increased access and significant reductions in waiting lists, particularly in Persistent Physical Symptoms service **IPR:** ▪ Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for (metric 2) - *increased performance assurance* ▪ CYP showing measurable improvement following treatment - patient reported (metric 4) - *increased performance assurance* ▪ Restrictive Intervention Incidents Used (metric 12) -	-	-

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
												▪ Ensuring the accurate and timely recording of data using the InPhase Solution. ▪ Ensuring written responses include any identified learning/actions. ▪ Ensuring that responses are compassionate and have a restorative approach. ▪ Obtain feedback from those that have experience of the service to inform future service improvement.	*increased performance assurance* **Negative** **QuAC (3/7/25):** Reasonable assurance following review of the May 2025 Quality Dashboard and the Quality Risks to the Quality Assurance Schedule **IPR:** ▪ Inpatients reporting that they feel safe whilst in our care (metric 3) - *reduced controls assurance* ▪ Medication Errors with a severity of moderate harm and above (metric 13) - *reduced performance assurance*		
											Friends and Family/Patient Experience Survey	▪ Director of Corporate Affairs and Involvement – Overall accountability for ensuring that the patient experience data and reporting of such, meets the statutory requirements ▪ Head of Patient Experience ▪ Patient and Carer Experience Team – Responsible for the orgGooanisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated Performance Approach including the patient experience metric (based on FFT data)			
											Our Quality and Safety Strategic Journey	▪ Chief Nurse – Responsible for the development of Our Quality and Safety Journey ▪ Workstreams and key performance indicators have been developed for each of the Journey's four priorities ▪ The professional structure with the care groups have day to day oversight of the quality and safety of care ▪ Integrated Performance Dashboard is utilised to identify variance in care delivery ▪ Learning from serious incidents and near misses			
											Incident management policies and procedures	▪ Chief Nurse ▪ Responsible for ensuring the systems for incident reporting, identification of patient safety issues and reporting appropriate incidents through correct procedures is in place ▪ Clinical and operational Managers medical Staff, modern matrons responsible for the operational implementation of the policy and associated guidelines. ▪ MDT in teams ensure effective after action reviews.			
											Governance arrangements at corporate, directorate and specialty levels	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolios including: ▪ ERQ (CN) – Responsibilities include oversight of Serious Untoward Incident/Never Event management processes and receive lessons learnt for sharing across the Trust as appropriate			

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
												▪ CGBs (Mgt Dirs) – Responsibilities include Oversight of the day to day management of an effective system of integrated governance, risk management and internal control across the whole Care Group's activities			
											Performance Management of Serious Incident Review	▪ Patient Safety Team - ▪ Responsible for ensuring all reportable serious incidents are reviewed within the agreed timescales following an internal governance process ▪ Daily patient safety huddles to review incidents of moderate harm and above to identify areas of immediate action and learning and support timely dissemination of information to mitigate risks ▪ Implementation of PSIRF Jan 24			
											Organisational Learning Group ↑	▪ PSIRF Policy ▪ PSIRF Implementation plan			
5	✓	✓	✓	**Digital – Supporting Change** There is a risk of failure to deliver OJTC goals, organisational and clinical safety improvements, caused by the inability to fully deploy, utilise, and adopt digital and data systems	**CEO (CIO)**	**RPC**	**High 20** (C5xL4)	**Moderate 10** (C5 x L2) Q4 2026/27	**30/6/2026** EPR deployment and optimisation programme control moves to substantial assurance Significant issues with Cito stability, leading to improvement work to mitigate clinical risk. (-1L)	**Good**	Embedded Digital Strategy and Delivery Plan	▪ Digital Management Meeting ▪ Digital Programme Board (DPB) ▪ Digital Programme Assurance Group (DPAG)	**Positive** **Cito Update Report:** Good assurance regarding the oversight provided on the Cito Stabilisation and Simplification project, the EPR Procurement and the ICO correspondence **Negative** **Cito Update Report:** Reasonable assurance on progress towards delivery of the milestones for Cito and associated mitigations	-	**Confidential Agenda Item 31** – Cito Update
											EPR deployment and optimisation programme:	▪ Executive Strategy & Resources Group (ESRG) ▪ Cito Improvement Group (CIG) ▪ Clinical Advisory Group (CAG) ▪ Transformation & Strategy Board			
											Integrated Information Centre optimisation programme:	▪ Digital Programme Board (DPB) ▪ Digital Programme Assurance Group (DPAG)			
											Digital and Data Delivery Plan (new control)	▪ Digital Management Meeting ▪ Digital Programme Board (DPB) ▪ Digital Programme Assurance Group (DPAG)			
6	✓	✓	✓	**Estate / Physical Infrastructure** **There is a risk** of delayed or reduced essential investment	**DoFE**	**RPC**	**Moderate 12** (C4 x L3)	**Moderate 12** (C4 x L3)	Due to uncertain national financial position, and given regional CDEL pressures / in absence	**Good**	NENC Infrastructure board	▪ Executive Director of Finance and Estates/Facilities and Director of Estates, Facilities & Capital (or their deputies) represent the Trust at NENC	**Positive** -	-	-

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
				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.					of CSR to not project reduction in score before 2028/29			Capital Collaborative and Infrastructure Board meetings	**Negative** -		
											Estates Master Plan	▪ EFM Directorate – Responsible for the preparation / delivery of the EMP in conjunction with the Care Groups based on an established prioritisation framework ▪ Finance Department – Responsible for the preparation of the annual capital and revenue financial plans for Board approval			
											CIG & CPSG	▪ Estates, Facilities, Capital and Finance teams work closely to ensure engagement across the Trust to collate capital investment priorities, risk / impact assess these and support agreement of final annual capital plan and medium term capital requirements			
											Estates, Facilities & Capital Directorate Management Team Meeting	▪ All of the directorate's functions provide monthly assurance reports to this meeting which is chaired by the Director of Estates, Facilities and Capital			
											ERIC, PLACE and PAM national annual reporting / benchmarks submission and monitoring	▪ EFM Directorate responsible for: ▪ **PLACE** ▪ Organising (with CA&I) the PLACE assessment visits ▪ Compiling the information ▪ Submission of the information to NHSE ▪ Preparation of the Action Plan ▪ **ERIC** Compiling and submitting ERIC submission to NHSE and considering actions taken in response to benchmarked outputs ▪ **PAM** Self-assessment against the questions included in the PAM and on the delivery of resultant action plans, processes in train to ensure timely submission			
											Environmental Risk Group	▪ Director of Estates, Facilities and Capital ensures aligned CPSG and ERG agendas, including close collaboration with Chief Nurse / MD DTVF joint chairs ▪ Directors of Operations / Operational teams support identification of environmental issues ▪ Service desk tracks levels of maintenance issues			
7	✓	✓	✓	**Data Security and Protection** There is a risk of data breach or loss of access to systems, caused by successful cyber-attack, inadequate data management, specialist resource gaps, and low levels of digital literacy resulting in compromised patient safety, impacts on business continuity, systems and	**CEO (CIO)**	**RPC**	**High 20** (C5 x L4)	**Moderate 10** (C5xL2) **2025/26 Q4**	**30/06/2026** Internal Audit assurance on 2024/25 DSPT with submission of Meets Standards; and control moves to substantial assurance (-1 L)	**Good**	Digital, Data & Technology (DDAT) Skills and Knowledge	▪ Digital and Data Management Meeting (DDMM) ▪ Digital Programme Assurance Group (DPAG) ▪ Digital Programme Board (DPB)	**Positive** - **Negative** -	-	-
											Secure IT infrastructure and asset management.	▪ DPAG			

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3	information integrity, reputational damage and loss of confidence in the organisation.							Cyber Security and Incident Management	▪ DPAG			
											Data Security and Protection Toolkit (DSPT) and Information Risk Management fully operational	▪ DPAG			
											Robust Clinical Safety and Change Control	▪ DPAG ▪ DPB ▪ Digital Change Assurance Board			
											Digital service delivery monitoring	▪ Digital Programme Assurance Group (DPAG)			
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.	**CN**	**QuAC**	**Moderate 9** (C3 x L3) ↓	**Moderate 9** (C3 x L3) **Target Achieved**	**Target Achieved**	**Good**	Open and transparent culture working to organisational values steered by Our Journey to Change	▪ Cohesive Board ▪ Engaged and visible Executive ▪ High Quality Care Group Directors ▪ Substantive recruitment of service leadership and clinical teams	**Positive** **QUAC (3/7/25):** ▪ Good assurance that all 14 CQC improvement actions within the Integrated Oversight Plan are progressing ▪ Good assurance that learning in the Health Services Safety Investigations Body (HSSIB) reports has been considered ▪ Good assurance on awareness of the EQIA pipeline and workstreams ▪ Good assurance that the risks to quality are understood and are being managed appropriately **Learning from Deaths Report** Good assurance of reporting and learning in line with national guidance **Negative**	-	**Public Agenda Item 17** – Learning from Deaths Report
											Executive and Operational Organisational Leadership and Governance Structure	▪ Chief Executive – Responsible for the Operational Leadership and Governance Structure ▪ Executive Directors – Responsible for the delivery of key elements of the Leadership and Governance Structure within their portfolios ▪ Co Sec – Responsible for the provision of secretariat services within the governance structure ▪ Care group clinical leaders responsible for the oversight of care delivery			
											Quality Management System	▪ The QI team is well established and embedded into services. ▪ There is an operational, clinical and professional leadership structure. ▪ There are Improvement plans for incidents, complaints and inspections. ▪ The IPD tracks performance monthly. ▪ The Care Group Board oversees delivery of services.			
											Oversight / Insight / Foresight	▪ Performance team are responsible for measuring and reporting performance ▪ Chief Nurse leads the nursing and quality directorate who have responsibility to measure and report out on - patient safety - quality governance -audit - infection, prevention and control - safeguarding - risk -Use of Force ▪ Chief Nurse lead the executive review of quality reporting to QuAC ▪ Medical Director leads on a number of patient safety priorities including Mortality review and Sexual Safety ▪ Care groups have dedicated clinical leaders at director			

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	1	2	3									delivery levels with a role to assess delivery of care standards	**QuAC (3/7/25):** Limited assurance on progress with the timely completion of after-action reviews (AAR's) and part one mortality review		
9			✓	**Revised** **Partnerships and System Working** There is a risk that failure to engage effectively in partnerships across our Integrated Care Systems, Provider Collaboratives, 'places' and 'neighbourhoods' will compromise our ability to effect service improvement, transformation and population health of the communities we serve	**DCEO**	**RPC**	**High 16 (C4 x L4)**	**Moderate 12 (C=4 x L=3) Dec 25**	**Dec 25** Cumulative impact of: ▪ Refresh of our strategic framework and priorities in consideration of emerging national, regional and local priorities (including 10 Year Plan). Our Journey to Change 'Next Chapter' to August Board, further development of priorities and detailed plans end Q3 ▪ Board seminar in September 2025 on sustainability and Trust offer, to inform future business and medium-term financial planning ▪ Review of Trust engagement during Q2-Q3 in formal Collaboratives and collaborative working at ICB, and regional level ▪ Mapping exercise of attendance at Collaborative and place based sub-committees and other key	**Good**	Active engagement in Collaborative forum at regional, ICB and local level to help shape system strategic planning and delivery	▪ Engagement in a wide range of partnership functions and committees/ groups across each place, in line with individual place governance structures ▪ Joint work / operational processes with local authorities and other partners including PCNs ▪ Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future	**Positive** - **Negative** -	-	-
											Strategic Framework	▪ Visibility of Strategic Framework through internal / external comms (so that it is widely known what our strategic Goals and Objectives are)			

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	1	2	3												
									governance meetings, ensuring appropriate attendees, effective engagement and internal communication and governance to optimise our approach ▪ Active engagement with each ICB on the implications of national policy direction, ICB blueprint and developing thinking about functions at ICB, provider and Regional level (-1L)						
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	**CEO**	**Board**	**Moderate 8** (C4 x L3)	**Moderate 8** (C4 x L2) **31/03/25**	31/3/25 Delivery of CQC Improvement Plan (-1L)	**Good**	Statutory Reporting	▪ Reporting requirements and timetables developed by the Company Secretary ▪ Information provided by designated leads ▪ Reports produced by Corporate Affairs and Communications based on submissions received. ▪ Annual Accounts timetable drafted by Head of Accounting and Governance ▪ Annual Accounts (and related TAC submissions) undertaken by the Finance Staff ▪ Head of Financial Accounting and Governance considers and coordinates annual training needs for annual accounts team ▪ Accounting ledger and accounts payable entries reviewed including to ensure accurate coding to support reporting as well as VAT recovery	**Positive** **ARC (20/6/25):** ▪ Good assurance provided by the Head of Internal Audit for 2024/25 on the overall adequacy and effectiveness of the Trust's systems of internal control ▪ Good assurance from the matters surrounding the management of risks **QuAC (3/7/25):** ▪ Good assurance that all 14 CQC Improvement actions within the Integrated Oversight Plan are progressing ▪ Good assurance on the	-	-
											Provider Licence	▪ Board certification processes undertaken by the Company Secretary ▪ Delivery of related by policies by operational and corporate departments ▪ Commissioning of external governance reviews, preparation of evidence for and support by the ACE and Co Sec ▪ Delivery of improvement plans by designated leads			
											Environmental Sustainability	▪ The Estates, Facilities and Capital Team are maintaining day to day BAU ▪ Estates & Facilities DMT maintain routine operational oversight			

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	1	2	3								**Statutory Financial Duties**	▪ Processes overseen by the Head of Financial Management including annual budget holder sign off of budgets / establishments following agreement of annual budget setting processes ▪ Annual budget prepared by DoFEF ▪ Monthly financial reports and refreshed forecast outturn positions prepared by Finance Department to support agreement with Care Groups / Directorates and returns for submission to NHSE ▪ Budget holder management of individual budgets ▪ Accountability Framework sets out responsibilities for financial management	management of the strategic risks assigned to the Committee ▪ Good assurance that the risks to quality are understood and are being managed appropriately **RPC (11/6/25):** ▪ Good assurance on the process and oversight of corporate risks ▪ Good assurance that the process for producing the National Cost Collection was in line with national costing standards and on time, as required by the NHS Provider Licence **Negative** **ARC (20/6/25):** Reasonable assurance on the registration of conflicts of interest, gifts and hospitality **RPC (11/6/25):** Reasonable assurance on the oversight of risks relevant to the committee		
											Compliance with the CQCs Fundamental Standards of Quality and Safety ↑	▪ Day to day delivery of the fundamental standards by ward and team staff ▪ Responsibility for delivery of each element of the CQC Action Plan designated to lead Directors ▪ Chief Nurse is the lead Executive for relationship management with the CQC			
											Compliance with Mental Health Legislation (MHL)	▪ Delivery of the requirements of MHL by ward and team staff			
											Equality, Diversity, Inclusion and Human Rights	▪ The Director of People and Culture has operational responsibility for Equality, Diversity, Inclusion and Human Rights throughout the Trust in both Employment and Service Delivery ▪ EDIHR Lead and officers: ▪ Provision of support for inclusion networks ▪ Compilation of Equality Act 2010 data ▪ Compilation of evidence and consultation on the EDS ▪ Support for the development of the Trust's equality objectives ▪ Designated managers/leads: ▪ Completion of equality analyses ▪ Delivery of actions under the EDS ▪ All staff are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision ▪ Public Health Consultant engaged to develop the Trust's approach to tackling health inequalities			
											Risk Management Arrangements	▪ Care Group Managing Directors, General Management Tier and Service Management Tier – ▪ Consider capture and maintain risks raised by staff in local risk registers ▪ Develop and implement			

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	1	2	3									action plans to ensure risks identified are appropriately treated ▪ Ensure that appropriate and effective risk management processes are in place and that all staff are made aware of the risks within their work environment ▪ Other Executive Directors - Responsible for ensuring effective systems for risk management, are in place within their directorate ▪ Head of Risk Management – Day to day management of the Trust Risk Register			
											Health Safety and Security (HSS)	▪ The Trust has a Health, Safety and Security Team who manage the day-to-day Health and Safety requirements in line with all relevant parliamentary acts ▪ Reporting system is in place for the reporting of incidents which fall under the requirements of Reporting of Incidents of Disease and Dangerous Occurrences regulation (RIDDOR) ▪ Provision of HSS information for new employees at Trust induction. ▪ HSS awareness training forming part of all staff mandatory package. ▪ HSS online tool kit available for all services, wards and departments across the trust. ▪ Regular workplace audits undertaken by the HSS team. ▪ Incidents recorded on 'InPhase' are shared with relevant service leads, including HSS. This enables investigation of incidents to identify trends and flag any remedial actions			
											Executive and Care Group Leadership, management and governance arrangements	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolio ▪ Individual staff compliance with the range of policies relating to regulatory compliance e.g. health and safety			
											Inquests and Coroners	▪ Inquest Team - Management of the Inquest process from a Trust perspective including: ▪ Arranging and compiling witness statements and submission to Coroner ▪ Instruction of Solicitors ▪ Co-ordination and compilation of information ▪ Provision of support for staff ▪ Preparation of responses to Regulation 28 Reports by staff nominated by the CEO			
11	✓	✓	✓	**Roseberry Park** **There is a risk that** the necessary Programme of rectification works at Roseberry Park and impacted by	**DoFE**	**Board**	**High 16 (C4xL4)**	**Moderate (12) (-1L)**	TBC Rectification date for works – subject to access to national capital (uncertain)	**Good**	Roseberry Park Rectification Programme	▪ Programme Director and Programme Manager – Responsible for managing the RPRP including key risks and issues log (Assurance to weekly huddle)	**Positive** **RPC (11/6/25**) Good assurance on robustness of the	-	-

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	1	2	3	limited access to capital funding **could adversely affect** our service quality, safety, financial, and regulatory standing.					and Trust cash position / scope of works		Capital Programme	▪ Trust CPSG overseeing agreement of priorities for capital investment / impact assessment ▪ Environmental Risk Group assuring inpatient standards for wards ▪ DMT overseeing detailed milestone capital project planning ▪ NENC Infrastructure Board (ICS Estates & Finance Directors)	RPH Phase 2 Business case and the procurement process **Negative** -		
											External Audit				
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	**DoFE**	**RPC**	**High 20** (C5 x L4)	**High 20** (C5 x L4) -	**2028/29** The following are expected to impact on the risk: ▪ HMT / DHSC to confirm national and ICB medium term funding allocations to inform ICB and Trust financial risk assessment ▪ NENC ICB to develop organisationally owned medium term financial plan including funding assumptions pending a longer term NHS settlement. Guidance anticipated October 2025 ▪ Trust to develop medium term financial plan including funding assumptions consistent with ICS MTFP pending a longer term NHS settlement and actions to secure financially sustainable service. Guidance anticipated October 2025 ▪ Trust to deliver medium term financial plan outcomes (recurrent financial position)	**Good**	ICB Financial Governance including Mental Health LDA Arrangements and CEO Leadership and DoF financial planning groups and sub groups	▪ DoFE member of ICS DoF/CFO group ▪ DoFE member of ICS Resource Allocation Steering Group ▪ CEO member of NENC CEO provider collaborative group ▪ CEO connected to HNY provider collaborative work for MHLDA ▪ DCEO / CNTW COO leading Provider collaborative work to assess implications for beds / pathways and clinical models	**Positive** **IPR:** Agency price cap compliance (metric 25b) - *increased controls assurance* **Negative** **IPR:** ▪ Surplus/Deficit (metric 24) - *reduced performance assurance* ▪ Financial Plan: Agency expenditure compared to agency (metric 25a) - *reduced controls assurance* ▪ Capital Expenditure (Capital Allocation) (metric 29) - *reduced performance & controls assurance*		**Confidential Agenda Item 29** – Medium Term Financial Planning
											Executive Directors Group (Financial Sustainability Focus	▪ Financial reporting using intelligence from Care Groups, Directorates and costing transformation programme to inform management of underlying financial position			
											Business Planning and Budget Setting Framework and in Year Financial Forecasting & Recovery Arrangements	▪ DCEO -Responsible for the delivery of the Business Planning Framework ▪ DoFEF and EDG – Responsible for arrangements to develop the Financial Plan including tracking the recurrent and non-recurrent implications and underlying financial position and cost drivers ▪ Managing Directors (for Care Groups) and other Execs (for their Directorates) responsible for management of costs with budgets and/or agreed forecasts and informing assumptions to underpin financial planning using business planning processes. (Reporting into FSB and EDG with assurances into P&PC and Board)			

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	1	2	3												
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	**DoCAI**	**Board**	**High 20** (C5 x L4)	**High 20** (C5 x L4) ↑	Risk score unlikely t0 change in the medium term	Reasonable	Communications Strategy	▪ Director of Corporate Affairs and Involvement ▪ Head of Communications ▪ Communications team	**Positive** - **Negative** **Our Journey to Change – Next Chapter Report:** Reasonable assurance that the Trust is continuing its work to communicate the implementation of Our Journey to Change – the Next Chapter	-	**Public Agenda Item 13** – Our Journey to Change – Next Chapter
											Stakeholder Communications and Engagement Strategy	▪ Trust Board ▪ Director of Corporate Affairs and Involvement ▪ Care Group Board Directors ▪ Head of communications ▪ Corporate Affairs and Stakeholder Engagement Lead ▪ Communications team			
											Social Media Policy	▪ Director of Corporate Affairs and Involvement – responsible for the development, implementation and monitoring of the social media policy ▪ Head of communications ▪ Comms team – responsible for ongoing monitoring of social media ▪ General Managers/Service Managers – ▪ Ward/Team Managers/Modern Matrons – as above ▪ Complaints team ▪ Patient experience team ▪ Clinical leaders ▪ Service managers ▪ People and Culture			
14	✓	✓	✓	DRAFT **Health Inequalities** There is a risk that health inequalities are exacerbated/opportunities to reduce health inequalities are not realised c Caused by differential opportunities for equitable access, excellent experience and optimal outcomes. In particular for people living in areas of high deprivation, those from Black, Asian and minority ethnic communities and those from inclusion health groups Resulting in lack of service reach into underserved communities, increased risk of late/crisis presentation, higher acuity, disengagement, suboptimal outcomes and experience in health inclusion groups.	**DCEO**	**QuAC**	**High 16** **(C4 x L4)**	**Moderate 12** (C=4 x L=3) **TBC**	**TBC** (-1L)	Limited	Build public health capability and capacity		**Positive** - **Negative** -		-
											Use of Data, insight, evidence and evaluation				
											Strategic leadership & accountability				
											System Partnerships				

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	1	2	3												
15			✓	DRAFT Transformation There is a risk that failure to ensure we have the capacity and capability to scope and deliver a Trust-wide programme of transformation, realise and evidence anticipated benefits, will mean we do not deliver on the Trust ambition to impact positively on the mental health and wellbeing of our local populations	**EDTS**	**RPC**	**High 16 (C4 x L4)**	**Moderate 12 (C=4 x L=3) Dec 25**	**Dec 25** Cumulative impact of: ▪ Review of delivery impact of transformation workstreams in the past year ▪ Review of Transformation Governance (Transformation Delivery Board, programme reporting) ▪ Review and development of future transformation portfolio, linked to medium term financial plan ▪ Review of capacity and capability requirements to deliver transformation portfolio (-1L)	**Good**	Review of Trust-wide transformation portfolio (content, governance, delivery/impact) Development of future Trust-wide transformation portfolio ▪ Development of transformation portfolio ▪ Assessment of capacity and capability required to deliver the above	Engagement with Operational and Corporate teams to review Transformation workstream delivery ▪ Engagement and horizon scanning activities of national policy, guidance and transformation expectations ▪ Assessment of capacity and capability to deliver necessary transformation alongside development of the above	**Positive** **NHS 10 Year Plan Report** Assurance that Executive Directors: ▪ Have commenced work to fully understand the implications, pursue opportunities and mitigate risks ▪ Have instigated a planning approach which will integrate transformation and financial / workforce sustainability and which will be structured around the 3 shifts and a fourth "how we do things" group of actions which will improve how we work as an organisation (including aspects such as culture, improvement, transformation and productivity) **Negative** **RPC (11/6/25):** Reasonable assurance on the Trust's approach to transformational change **Our Journey to Change – Next Chapter Report:** Reasonable assurance that the Trust is continuing its work to communicate the implementation of Our Journey to Change – the Next Chapter	-	**Public Agenda Item 12** – NHS 10 Year Plan summary and implications **Public Agenda Item 13** – Our Journey to Change – Next Chapter **Confidential Agenda Item 29** – Medium Term Financial Planning

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14 August 2025**
Title:	**Chief Executives Public Report**
Executive Sponsor(s):	**Beverley Murphy, Interim Chief Executive**
Report Author(s):	**Beverley Murphy, Interim Chief Executive**

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

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

1: We will co-create high quality care	✔
2: We will be a great employer	✔
3: We will be a trusted partner	✔

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
	Not applicable to this report	

EXECUTIVE SUMMARY:

Purpose:
A briefing to the Board of strategic and topical issues that are of importance.

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

Overview:
A range of national and local of topics to inform the Board of Directors of.

The Board can take assurance that the Executive are sighted on issues of importance when delivering their responsibilities.

Prior Consideration and Feedback:
The issues are wide ranging and as such have been considered across the TEWV governance structure.

Implications:
Various in line with the range of issues referenced.

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

Matters of strategic importance

Fit for the Future: 10 Year Health Plan for England

In July 2024 the Secretary of State for Health and Social Care commissioned Lord Darzi to conduct an independent investigation of the NHS. Lord Darzi's report was published September 2024 and concluded that the NHS was in a 'critical condition'. As a response to the Darzi report, both the Prime Minister and the Secretary of State for Health and Social care, Wes Streeting, pledged to use the findings to develop a plan for the future of the NHS, this is the origin of the 10 Year Health Plan for England.

The Secretary of State, Wes Streeting shared his view that 'we can take a new course and reimagine the NHS through transformational change that will guarantee its sustainability for generations to come.' He went on to say that the NHS plan will be a break with the past.

The 10 Year Health Plan for England (the NHS Plan) was published on 3 July 2025, it can found here.

The NHS Plan is built around three core principles to drive transformation:

- hospital to community
- analogue to digital
- sickness to prevention.

The NHS Plan goes on to set out the foundation for the transformation as:

- a new operating model
- a new era of transparency
- creating a new workforce model with staff genuinely aligned with the future direction of reform.
- a reshaped innovation strategy
- a different approach to NHS finances.

The Secretary of State, Wes Streeting, and the Chief Executive of the NHS, Sir James Mackey, supported by senior NHS England leaders have actively engaged with NHS providers and Integrated Care Boards making clear the direction and the need for pace in working together, across the system, to plan for and deliver the necessary transformation. TEWV leaders have been a part of this engagement.

TEWV leaders have also engaged actively with both the Humber and North Yorkshire and North East and North Cumbria Integrated Care Systems. We are committed to working in partnership and being a part of developing the transformation for the communities that we serve.

We welcome the plan as an opportunity to work into neighbourhoods, with our partners to transform services. The key driver for us is the recognition that working in a much more localised way gives us a real opportunity to use our resources to support the population health of come of the most deprived areas in the country.

There follows a substantive item on this Board about the 10 Year Plan where our - engagement with the plan is further articulated.

Review of patient safety across the health and care landscape

Dr Penny Dash's review of patient safety across the health and care landscape in England, commissioned by the Department of Health and Social Care was published 7 July 2025.

The report looked at 6 bodies:

- The Care Quality Commission
- The National Guardian's Office
- Healthwatch England and the Local Healthwatch network
- The Health Services Safety Investigations Body
- The Patient Safety Commissioner
- NHS Resolution

Dr Dash made 9 recommendations which in summary recognised the need to streamline and have greater positive impact on the quality of care as an outcome from Health and Social Care regulation and investigation.

The five principal conclusions are:

1. Action is needed to address gaps in functions. In particular, a strategic approach to improvement and innovation in quality of care (including safety) is needed that:

- considers allocation of resources to maximise health outcomes
- co-ordinates and prioritises the many recommendations and 'asks' of providers

2. There is a need to streamline, simplify and consolidate functions where considerable duplication and overlap currently exist - specifically when it comes to:

- user, patient or community engagement
- capturing and learning from user or patient experience, or the 'voice of the user'
- investigations

3. Too many functions sit outside of the commissioners and providers of care who are responsible for improving quality (including safety). This results in limited impact from the very many inquiries, reviews, investigations and resulting recommendations that are made.

4. Within commissioners and providers, there needs to be a far greater focus on:

- building skills and capabilities
- effective governance structures
- clearer accountability for quality (including safety) of care

5. CQC was established as the independent regulator of health and care. It needs to rebuild public, professional and political confidence, and should also house functions where independence is required.

The full report can be found here.

The next steps are linked to the delivery of the 10 Year Plan. The report recognises that primary and secondary legislation would need to be changed to deliver some of the

recommendations. The report also recommends that the DHSC needs to continue to explore the options in relation to the duplication, gaps and opportunities for transformation in relation to its wider arms length body landscape.

We will use the report and consider the learning for TEWV, many of the principal points have resonance.

NHS Oversight Framework 2025/26
The new framework has been implemented to provide consistent and transparent approach to assessing the performance and quality of Integrated Care Boards (ICBs) and NHS Trusts and Foundation Trusts. The framework provides a foundation for how NHS England works with systems and providers to support improvement. The framework sets out a range of agreed metrics, promoting improvement and enabling the identification of organisations that may require support.

The framework will be reviewed in 2026/27 in line with the implementation of the ICB operating model. The framework will be further developed in line with the 10 Year Plan for the NHS.

The framework gives a consistent approach for the assessment of NHS providers and concludes by placing a provider in a segment in line with a score. The framework also describes the approach when a provider's performance falls below an acceptable standard and/or has governance concerns that may lead NHS England to use regulatory powers to step in and secure improvement. ICBs will not be placed in a segment in 2025/6, due to the years of significant change for ICBs ahead, ICBs will transform in line with the Model ICB Blueprint to focus on strategic commissioning and implement plans to meet the running cost reductions.

Segment descriptions

Segment	Description
1	The organisation is consistently high performing across all domains, delivering against plans.
2	The organisation has good performance across most domains. Specific issues exist.
3	The organisation and/or wider system are off-track in a range of domains or are in financial deficit.
4	The organisation is significantly off-track in a range of domains.
5	The organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve. or The organisation is a challenged provider where NHS England has identified significant concerns.

The full framework can be found here

On the 8th July 2025 we were notified by Fiona Edwards, Regional Director (North East and Yorkshire) that TEWV has been placed in Segment 2 with a provisional ranking of 28 out of 61 mental health / community providers. It is anticipated that the league table ranking Trusts will be made available later in 25/26.

The measures used to determine the overall segmentation demonstrate that we benchmark well in our inpatient length of stay, the experience of our community services (National CQC survey), our response to urgent referrals to the Crisis team within 24 hours and the financial

measures. We are carefully considering the scores attributed to other measures including the percentage of young people accessing services, our sickness absence rate, specific staff survey criteria, the use of restrictive interventions and the CQC rating in the Safe domain.

Whilst we are delighted that the segmentation recognises strong performance in a number of key areas we will use the information to support our commitment to continues improvement across all services in line with Our Journey to Change.

National Neighbourhood Improvement Programme
On the 9th July 2025 NHS England published an invitation for organisations to be involved in the national Neighbourhood Health Implementation Programme. The programme is central to the Government's ambition to shift care from hospitals to community, analogue to digital and delivering sustainable health and care services, moving from sickness to prevention.

The initial focus for creating Neighbourhood Health systems and processes is for adults with multiple long-term conditions with a risk that care may progress to hospital admission.

Applications to lead the development of a Neighbourhood Health system needed to be a collaborative and collective process amongst the different provider organisations in a particular geography. TEWV is a key partner to several applications made across the Trust footprint, we have actively discussed with partners the importance of mental health care in addressing long term health conditions.

Submissions were made on the 8th August 2025, we keenly await the outcome and, in the meantime, we continue to engage with strategic partners to maximise the opportunities of having an impact in the emerging network of neighbourhoods. Partners have reflected that the application process has galvanised organisations and that even where applications are not supported the process has promoted a way of working that we will continue to act on.

Leading the NHS: proposals to regulate NHS managers consultation response
The 10 Year Health Plan recognised the central role of leadership in the delivery of high-quality health care. A consultation about NHS leadership was launched in November 24 and received more than 4000 contributions. The majority (92%) of responses supported regulation of NHS managers. The new proposals were developed following this public consultation.

On 21st July 2025 the DHSC, NHS England and the Secretary for State for Health and Social Care published new proposals to prevent any leader who silences whistle-blowers or behaves unacceptably from returning to a health service position.

The Government's view is that a statutory barring system for board-level directors and their direct reports within NHS bodies is the most proportionate and effective regulatory approach for NHS managers and leaders and that the Health and Care Professions Council (HCPC) is best placed to take on this role. Legislative work that will provide the HCPC with the statutory powers to disbar NHS leaders in senior roles who have committed serious misconduct from holding such roles is being taken forward.

Timetable for the future of manager regulation
There are several further actions that will need to be taken to develop the framework to enable the regulation of managers. This includes:

- a statutory 3-month consultation on the draft legislation to confer on HCPC the powers to bring managers into regulation dependent on the legislative vehicle.

- following consultation, and analysis and, subject to further amendments, the draft order will be finalised.
- the finalised order will then be laid before both houses of Parliament alongside a report on the outcome of this consultation. It is anticipated that this will take place in the second half of 2026.
- once debated, the legislation will either be approved or rejected.
- if approved, His Majesty in Council may then make the order.
- the HCPC will then develop, consult on, make its rules and put in place the processes needed to hold a barring list for NHS managers with a view to commencing regulation within 12 months of the legislation being made.

We welcome the opportunity this brings to further professionalise NHS managers who play an essential part in the safe delivery of NHS services.

TEWV matters of importance

NHS England Getting it Right First Time visit the Crisis Assessment Suite, Roseberry Park Hospital, Middlesbrough

We were delighted to host a visit for the NHS England Getting it Right First Time Team (GIRFT) on 31st July 2025, Dr David Somerfield, Dr Neeraj Berry and Suzanne Davies. The team wanted to see how the Crisis Assessment Suite (CAS) links with the other elements of the urgent care pathway and specifically how we have achieved a pathway that is able to meet people's needs without delay at a time of Crisis whilst also taking pressure off the local Emergency Department.

I was grateful and very impressed by our colleagues Dr Ranjeet Shah, Shaun McKenna, Sarah Kuster and Andrea Card, to name a few, when hearing them talk about how they have worked in partnership across TEWV teams, the local police and the VCSE to deliver high quality care to those in crisis.

The GIRFT team fed back to us that it was particularly helpful to understand how the clinical and operational focus of the CAS and associated mental health urgent and emergency care pathways has developed. They also noted the effectiveness of pathways with James Cook University Hospital. The positive impact on patient experience and delays spent in the local emergency department were recognised. The visiting team stated, *'These achievements have clearly been a significant challenge met, maintained and continually improved by a team of skilled and impressive clinicians and managers.'*

I am delighted that the work of our colleagues has been recognised by national leaders. We are working to replicate this model across other parts of our geography, allowing for necessary variance of approach.

Winter planning 25/25
The national Urgent and Emergency Care (UEC) delivery plan requires all NHS providers to make robust preparations for winter. We are currently working through the development of a formal winter plan. The plan seeks assurance against a number of key standards with regard to patient flow through our hospitals, maximising staff vaccination rates against influenza and maintaining effective support for those needing mental health care within emergency departments.

As part of preparations, we have submitted returns, alongside acute care colleagues, to our respective ICBs to inform the National return and provide assurance of our internal preparations. Once our finalised winter plan is confirmed, we will be required to participate in a NEY Regional EPPR and preparedness event to stress test arrangements across the system. It's likely this event will take place September 3rd.

The Board will be asked to sign off the final plan prior to submission, this may require delegation to the CEO/nominated assurance committee.

We will also be required to complete a Board Assurance Framework specific to winter, the template can be found here

BMA Resident Doctor Industrial Action
From 25th - 30th July 2025 the BMA Resident Doctors strike took place.

NHS England provided guidance and implemented sit reps and reporting requirements during this time. Dr Kedar Kale, Executive Medical Director worked closely with TEWV Emergency Planning to ensure that we both met the NHSE requirements and that we had good plans in place to manage the potential impact on services and care delivery. We did not experience any harm to patients as a result of the strike action.

NHS England reports that the NHS maintained 93% of planned care. Sir James Mackey, NHS Chief Executive and Secretary for State for Health and Social Care, Wes Streeting engaged directly with CEOs about the strikes and also offered thanks for the running of services during this time.

The BMA has a 6-month mandate meaning that they have a legal right to announce more strikes until 6th January 2026. Negotiations continue.

General Medical Council (GMC) Survey 2025
The annual survey of trainee results show we ranked 1st for both North-East and Yorkshire Humber. Nationally we ranked 6th out of 226 Trusts which is an improvement from 9th place last year.

Nationally we ranked 9th out of 220 Trusts which is an improvement from 30th last year.

I wish to extend my thanks to the medical education faculty and colleagues involved in teaching and training, our clinical teams, trainees, supervisors, and all people across our services who support the training and development of trainee doctors.

Chief Executive Officer
It is with great pleasure that I can share with the Board that meetings between Alison Smith, our incoming Chief Executive Officer, and members of the Executive have been taking place in recent weeks. I have personally welcomed the opportunity to meet with Alison a number of times.

We have worked collaboratively as a team and with Alison to develop a robust induction to support Alison to take up her responsibilities with our full support.

It has been a privilege in the interim to lead the TEWV Executive team as the interim Chief Executive. I wish to express my grateful thanks to the Executive team and to our interim Chair, Bev Reilly, for supporting me and for continuing to lead our organisation during this transitional period.

Mutually Agreed Resignation Scheme (MARS)
MARS is part of the national Agenda for Change Terms and Conditions. It provides a very clear framework for organisations to offer staff a settlement payment, based on numbers of years in the NHS, with a clear set of parameters about return to the NHS and payback processes if people do return within that time frame. Applications closed at the end of July, and we received slightly over 300 applications. Discussions with services and directors are now taking place, ahead of formal executive panels through August. A final business case will then come to EDG outlining the implications of all the proposed decisions for quality/ safety, colleague wellbeing and finance. Individual applicants will receive formal notification of the decision about their application in September, with particular emphasis on the limitations of return to the NHS for those who were successful and offers of space to think through future options for those who were not successful. Applicants can withdraw at any point until they sign the settlement agreement.

Conclusions:
The strategic landscape of the NHS has developed rapidly over the early summer months, the Executive and senior leaders are engaged across both ICBs to ensure that our thinking, the transformation of services and the delivery of care remains aligned with the strategic direction.
Although we are committed to the continuous improvement of our services and learning where care is not as it should be, this report details just a few examples, of many, of where we can demonstrate high quality care and the development of our most important asset – our workforce.

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14th August 2025**
Title:	**Board Integrated Performance Report as 30th June 2025**
Executive Sponsor(s):	**Kathryn Ellis, Interim Executive Director of Transformation & Strategy** **Naomi Lonergan, Interim Managing Director, Durham, Tees Valley & Forensic Care Group** **Brian Cranna, Director of Operations, North Yorkshire, York & Selby Care Group**
Report 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: We will co-create high quality care	✓
2: We will be a great employer	✓
3: We will be a trusted partner	✓

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
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.
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
- **Reasonable performance assurance** (previously good) regarding the Integrated Performance Dashboard (IPD)
- **Good performance assurance** (previously reasonable) regarding the National Quality Requirements and Mental Health Priorities
- **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.

There are change in the levels of control and performance assurance this month (as shown above); however, Board is asked to note the positive changes outlined in the report below.

Overview:

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.

Performance Assurance

Integrated Performance Dashboard (IPD)

The overall reasonable level of **performance assurance** for the IPD has been underpinned by the Performance and Controls Assurance Framework, which demonstrates **18** measures (58%) with good or substantial assurance (previously 21).

Key changes this month:

Increased performance assurance (from good to substantial)	• Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for • The number of Restrictive Intervention Incidents • Percentage compliance with ALL mandatory and statutory training • Percentage of staff in post with a current appraisal
Increased performance assurance (from reasonable to substantial)	• Percentage of CYP showing measurable improvement following treatment - patient reported
Reduced performance assurance (from good to reasonable)	• Financial Plan: SOCI - Final Accounts - Surplus/Deficit • Capital Expenditure (Capital Allocation)

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
- Compliance with ALL mandatory and statutory training
- Staff in post with a current appraisal
- Cash Releasing Efficiency Savings (CRES) Performance – Non-Recurrent

In June, work was undertaken on the **CYP Outcome measure (PROM)** as it had been identified that a number of paired ROMs were recorded on Cito as showing improvement yet were not showing within the measure. Whilst there remains no significant change, the work has resulted in a significant increase in the number of patients showing measurable improvement and the measure is now achieving standard.

There are a small number of measures, we are advising continue to be a focus for improvement.

- **Outcomes:** The Trust-wide Clinical Outcomes Improvement Plan continues to progress. A review has taken place of opportunity to expedite improvements to enhance outcome reporting that are not dependent on planned Cito developments. This has identified 6 improvements that can be made and following approval at the June EDG to extend the deadlines for 2 actions, all remain on track for delivery. The next quarterly update will go to EDG in September. Further analysis confirms that collection rates for current caseloads are continuing to increase; 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).

- **Bed Occupancy** – Whilst special cause improvement is being demonstrated we are still exceeding the commissioned and funded level of 85%. The main area of concern is DTVFCG MHSOP which is linked to patients that are clinically ready for discharge (*see below*).

- **Agency Price Cap Compliance** - Most price cap breaches relate to medical locum or prison mental health nursing cover for hard to fill vacancies. Restrictions on who can fill the post means we will continue to see some breaches until we have completed recruitment. There has been a Performance Improvement Plan in place to reduce the use of Agency staff, which has 2 outstanding actions due for completion in September 2025. Whilst the PIP has had some impact to date EDG have reviewed the position and decided that it is now the right time for the PIP to be stood down, and for the EDG Temporary Staffing Sub-Group to take on the leadership and oversight of this work, continuing the positive progress it has made.

We have also identified this month, that we need to identify improvement actions in relation to **Sickness Absence.** Whilst this is not currently identified as an area of concern (there is no significant change), we continue to exceed our internal standard, and our benchmarking position is not where we would want it to be. It was agreed at EDG in July that People & Culture would facilitate trust-wide improvement work, which will be reported back to Quality & Performance EDG in August 2025.

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.** In the new supporting measure we have developed, there is special cause concern in AMH in both Care Groups and in MHSOP within NYYSCG. Whilst there is no significant change in MHSOP in DTVFCG, there is a direct correlation to occupancy levels. At Trust level, patients classified as clinically ready for discharge in June, equated to an average of 80.7 beds (50.7 Adult and 30.0 Older Adult beds), with an associated direct cost of c.£1.59m (including £0.028m independent sector bed costs). Of the

cost, c.£0.87m relates to Adult and c.£0.72m relates to Older Adult. In DTVFCG AMH and MHSOP specialities to come together to review how they work with partners to progress patients who are clinically ready for discharge. Within NYYSCG the senior leadership team have been working closely with system partners to progress patients who are clinically ready for discharge and resolve challenges. A workshop is planned with North Yorkshire Local Authority and in City of York, an initial "Framework for excellence in discharge planning" event was held in July involving all system partners.

- **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. From the 14 courses currently below the standard; 9 are showing an improved position compared to the previous month, 3 are showing a reduced position and 2 are included for the first time. Overall, we have an improved position (compared to January 25) with only 1 course just below 70%. A detailed report on corporate directorates and service lines, including correlation with wasted spaces was discussed at the July EDG People Meeting. It was agreed at the Quality & Performance EDG in July that the Workforce Development Lead would work with the Care Group Business Managers to identify SMART actions, which would be brought back to the Quality & Performance EDG in August. The Training and Education Task Group are reviewing the courses that appear in the mandatory and statutory framework to understand the issues driving lower compliance and support the development of an action plan which will be reported back to EDG in August. 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.

- **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, identify 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. It was agreed at the Quality & Performance EDG in July that the Head of Performance would support the Acting Interim Chief Executive to revise the PIP to support the level loading of annual leave across Trust services.

- **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 co-ordinates and collates trackers for each scheme, receive exception reports, signpost/support on those schemes at risk, and in turn report into EDG. 2025/26 initial plans in train have "plans on a page" and QEIA are being progressed. New schemes, and those coming on-line later in the year, will have plans in place by July 31*st*. Overperformance on non-recurrent schemes is mitigating the recurrent schemes under-performance. A Trust-wide event held in early July reviewed CRES plans and mitigating actions, and opportunities for delivery of longer-term transformational changes that will support sustainability. Suggestions on mitigating actions and short-term reduction in spend are being worked up.

National Quality Requirements and Mental Health Priorities

The overall **good** level of **performance assurance** for the National Quality Requirements and Mental Health Priorities has been underpinned by Statistical Process Control Charts, which demonstrates **71%** of measures are achieving standard (improved position, 70% last month). 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/plan) in relation to the following measures:

- 72-hour follow up
- EIP Waiting Times

- Talking Therapies waiting times (6 and 18 weeks)
- Active OAPs (inappropriate)
- Average length of stay for Adult Acute Beds

The actual areas of concern are as follows:

- **Talking Therapies Reliable Improvement** (County Durham & Tees Valley) The Trust-wide action plan was approved in May and will be monitored through the Trust-wide Talking Therapies Group which will be relaunched in July, sharing quarterly updates with Care Group and Executive Directors Group commencing in August. There are 15 actions which are due to be completed by end of Quarter 3 (December 25) and, following review at EDG the General Manager is currently revising the plan, ensuring the actions are SMART. The opt in process for assessment and treatment is now complete, with a reduction of 20% noted overall. This may have an initial impact on the recovery measure with patients opting out, however this should recover longer term with people remaining in the service who want to engage.

- **Specialist Community Perinatal Mental Health Services** (York) – The Perinatal team is continuing to be supported with a service recovery plan. New vacancies and maternity leave cover are being progressed through the recruitment process and in the interim, the service are trying to recruit agency staff however, there have been no suitable candidates. An options appraisal paper was presented to the June EDG and a preferred option has been identified pending a quality impact assessment. In the interim, operational support from wider Trust services is being explored. 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 York place remains below the target, there is special cause improvement indicated in the SPC chart.

- **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 has undertaken further analysis of re-referrals and findings will be shared with the General Manager early August to support the identification of improvement actions.

<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.

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. Within AMH in York how people access services and are supported whilst awaiting intervention from trust services is included within the development of the community mental health hub model.

The actual areas of concern are:

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

  Durham and Tees Valley

  The Trust is continuing discussions with CNTW and the ICB on actions to reduce demand and longer waiters A regional clinical model for neurodevelopmental services is to be progressed and 2 clinical prioritisation events will take place in July 2025 to develop the short and medium approach to reducing demand and improving access for assessments for both adults and children.

  CYPS – ten actions within the recovery plan are progressing. These are due for completion by the end of March 2026; however, demand currently continues to outweigh capacity. Phase 2 testing on dual assessments continues in Darlington; however, this has been impacted by staff vacancies and leave. A meeting took place in June with the Service Manager and Senior Leadership to review progress, and it was agreed that the evaluation of the clinical protocol would be extended to the end of October. 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 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. In addition, whilst 4 additional staff were to be recruited to support the delivery of extra assessments, only 2 have been appointed. The General Manager is undertaking further analysis to better understand the increase in the waiting list in April and is working to identify improvements within community services with a view to increasing assessments from September 2025.

  North Yorkshire & York

  Humber and North Yorkshire Health and Care Partnership Mental Health, Learning Disabilities and Autism Collaborative Programme Executive Strategic Leadership Group received a paper: “Age Autism and ADHD: Managing Risk and Potential Options” in June. This paper proposed several options including promotion of Right to Choose for everyone or £12m in new funding; none of which were approved as they are financially un-viable. Work therefore continues across the system regarding a pathway re-design. There is currently no date for completion.

  CYPS - Within Selby and York, work has been completed to explore the impact of the proposed model for the assessment and treatment of neurodevelopmental conditions, and the option to share resources to improve the patient journey which has concluded is not viable. A report with recommendations for York and Selby teams to manage their neuro waiters has been completed and will be shared with the Specialty Improvement Group in July 25.

  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 July 2025 (previously June) and shared through governance meetings by end of August 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 action plan was approved in May and will be monitored through the Trust-wide Talking Therapies Group which will be relaunched in July, sharing quarterly updates with Care Group and Executive Directors Group commencing in August. There are 15 actions which are due to be completed by end of Quarter 3 (December 25) and the General Manager is currently revising the plan,

ensuring the actions are SMART. Within NYYSCG one post has been recruited to; however, further recruitment is currently on hold pending the qualification of the current PWP cohort. Overtime continues to be offered however uptake is minimal.

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
- 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. It was agreed at EDG in June that an action plan would be developed to describe the Cito impact on the IPR, with actions being taken and timescales. This will be reported to EDG on a quarterly basis. In addition, a “CITO Clinical Specialist” will start attending key care group meetings from August where data quality is routinely discussed to support operational and clinical staff.

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:

- note the step down of Agency Reduction PIP and the proposal that continued improvement will be managed within the Temporary Staffing and Overtime Group.
- 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.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

For the period ending 30th June 2025

Report produced by: Nicola Slee, Performance Lead, and Ashleigh Lyons, Head of Performance
Date the report was produced: 25th July 2025

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

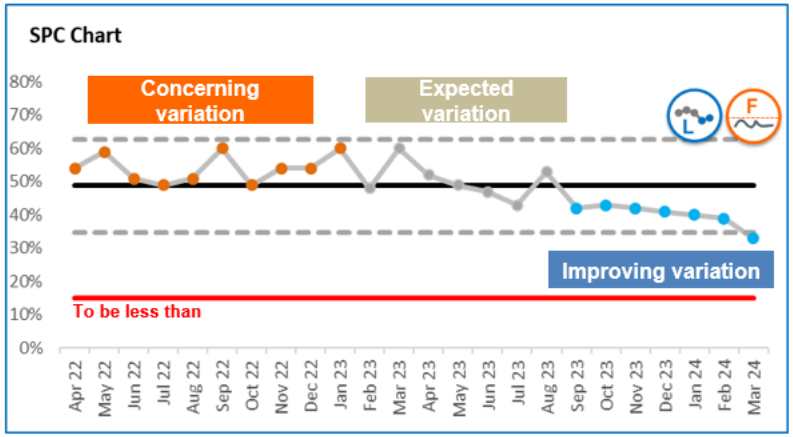
CONTENTS

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS Foundation Trust

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

NHS
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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 has been completed in quarter 1 2025/26 and was approved by Executive Directors Group in July. Scores will be included in the next report.

	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
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
IPD	Integrated Performance Dashboard
IPS	Individual Placement Support
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
PICU	Psychiatric Intensive Care Unit
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
RPIW	Rapid Process Improvement Workshop
SIS	Secure Inpatient Services
SMART	Specific, Measurable, Achievable, Relevant, & Time-bound
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 June 2025

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC		?	92.00%	93.93%
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%	75.90%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC		?	75.00%	83.07%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC		P	35.00%	52.01%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC		F	55.00%	47.08%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	?	50.00%	59.94%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	H	F	30.00%	26.35%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	L	F	85.00%	93.84%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	L			0
10)	The number of Patient Safety Incident Investigations reported on STEIS	QAC	L			3
11)	The number of Incidents of moderate or severe harm	QAC	L			78
12)	The number of Restrictive Interventions Used	QAC				2,614
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				1
15)	The number of uses of the Mental Health Act	MHLC				986

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
16)	Percentage of staff recommending the Trust as a place to work	PC&D				55.90% (Apr - 2025)
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				62.51% (Apr - 2025)
18)	Staff Leaver Rate	PC&D	L	?	11.00%	9.73%
19)	Percentage Sickness Absence Rate (month behind)	PC&D		?	5.50%	5.70%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	H	P	85.00%	90.46%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	H	?	85.00%	88.84%

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				23,353	
23)	Unique Caseload (snapshot)	S&RC				64,088	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	2,783,000	1,894,305
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	2,085,000	2,182,790
25b)	Agency price cap compliance	S&RC	67.00%	54.50%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	3,582,000	2,092,000
28)	CRES Performance - Non-Recurrent	S&RC	1,092,000	2,239,000
29)	Capital Expenditure (CDEL)	S&RC	3,030,000	2,269,729
30)	Cash against plan	S&RC	42,883,000	50,597,924

Board Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

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

- **Outcomes:** in CYP there is no significant change for the PROM and special cause improvement for the CROM; we are above standard in both measures. 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 measures. Whilst 2 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 3 of the 4 measures.

- **Bed Pressures:** whilst there is special cause improvement for bed occupancy and for inappropriate out of area bed days, there is special cause concern for patients clinically ready for discharge (supporting measure). There were no active OAPs as at the end of June 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 was one unexpected inpatient unnatural death reported on STEIS during June.

- **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 above 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, which assumes delivery of a challenging 5.35% £27.41m Cash Releasing Efficiency Schemes (CRES) requirement. The financial position to 30th June 2025 is a deficit of £1.894m, which is £0.889m better than planned for the period. CRES delivery to month 3 was £4.331m against a target for the first quarter of £4.674m, and therefore £343k below plan for the period (an improvement compared to month 2; which was £489k below plan).

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience –** there is no significant change in all patient experience measures, however, achieving the standard for all measures. There is no significant change in the responses received for patients rating their experience as good or very good, however, improvement noted in the number of responses received for carer involvement and patients feeling safe.
- **Outcomes –** there is special cause improvement for CYP for the PROM and CROM and above standard. There is no significant change in the number of patients discharged with a paired outcome measure. Within 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 –** there is special cause improvement in bed occupancy and inappropriate out of area bed days.
- **Patient Safety** – there is special cause Improvement for patient safety incident investigations and incidents of moderate or severe harm. No significant change in the number of restrictive interventions used, the number of medication errors and for unexpected inpatient unnatural deaths.
- **Uses of Mental Health Act –** there is no significant change.
- **People –** there is special cause Improvement in staff leaver rate, mandatory and statutory training and appraisals. Whilst we are achieving the standard for mandatory training, face to face training compliance remains below the 85% standard. There is no significant change in sickness.
- **Demand –** there is no significant change in referrals and unique caseload.
- **Finance** The Care Group, planned to spend £67.9m as at M3, and actual spend was £69.5m, which is £1.661m more than planned with CRES delivery £0.203m below plan. The forecast for reductions in medic agency spend 25/26 now complete with predicted savings of approximately £537k and 26/27 of approximately £1.3m.

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

•Inappropriate OAP bed days
•Outcomes (CYP)
•Use of Restrictive Interventions,
•People (Leaver rate, Appraisals)

Risks / Issues*

- Outcomes
- Financial Plan

Mitigations

Outcomes: CYP and Adults & Older Persons PROMs The Trust-wide Clinical Outcomes improvement Plan continues to progress. Six improvements are currently being progressed and following approval at the June EDG to extend the deadlines for 2 actions, all remain on track for delivery.

Three actions are due for delivery in September 2025:
1. Migration of historical outcomes data from PARIS into Cito
2. CYP PROM (GBO) to flow from Cito into IIC
3. CYP PROM (including parent ratings) requires Reliable Change Index for a small number of measures (EDEQ/EDEA/Gaslight).

The next quarterly detailed report on the Outcomes Improvement Plan will be considered at EDG on 23rd September 2025..

Finance - Financial plan
Actions in place include:
- The Care Group General Managers need to progress delivery of CRES actions including previously unallocated schemes, together with focus on eliminating unfunded posts and reductions in bank and agency spend.

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, and we are not achieving standard ALD – patient experience very good or good, AMH – carers feeling actively involved and patients feeling safe whilst in our care.
- **Outcomes:** In CYP, there is special cause improvement for CROM and no significant change for PROM, both are above standard. There is no significant change at care group level and we are below standard. For PROM, AMH is reporting no significant change and MHSOP reporting special cause improvement although remains concern due to being under standard. For 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 special cause improvement (decrease) for bed occupancy. AMH reports special cause improvement. Concern continues to be reported for clinically ready for discharge 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 clinically ready for discharge patients. We are reporting special cause improvement for the number of inappropriate OAP bed days.
- **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 concern (increase) in the number of medication errors are care group level and AMH. There were 1 unexpected Inpatient unnatural deaths reported on STEIS during June.
- **Uses of Mental Health Act:** no significant change is reported at Care Group, AMH CYP and MHSOP. ALD is reporting special cause variation of an increasing nature where up is not necessarily and improving or concerning nature.
- **People:** There is special cause improvement 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 except Management which is reporting special cause concern, above the standard. There is special cause improvement for mandatory training, and above the standard except management which remains below standard; 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 MHSOP, however Management is on a downward trend for the last 6 data points and CYP is reporting no significant change and below the standard; both have trajectories for end of August 25 in place.
- **Demand:** There is no significant change in referrals; AMH is reporting special cause variation of an increasing nature where up is not necessarily improving nor concerning and Children and Young People are reporting special cause variation of a downward nature where down is not necessarily improving or concerning. Caseload is reporting no significant change at Care Group level, with special cause improvement for Adult Learning Disabilities and Adult Mental Health, with Children reporting concern, however, the service has confirmed this is not an actual concern., 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:** Ongoing pressure on government department spending in 2025/26, therefore aiming to manage 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
- Bed Occupancy
- OAP bed days
- People (Appraisals)

Risks / Issues

- Outcomes for AMH & Older People - PROM & CROM
- Finance (Financial Plan, Agency expenditure, Surplus/Deficit, Agency price cap compliance)

Mitigations

Outcomes

The Trustwide Clinical Outcomes Improvement plan is progressing; six actions are achievable and following approval at the June EDG to extend the deadlines for 2 actions, all remain on track for delivery. Three actions are due for delivery in September 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.

The Care Group General Managers are preparing action plans to mitigate where safe to do so, the key hot spot overspending areas. These action plans will be reported via the Care Group Board.

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 • Compliance with ALL mandatory and statutory training ***increased performance assurance*** • Staff in post with a current appraisal ***increased performance assurance***	• Adults and Older Persons showing measurable improvement following treatment - clinician reported • Bed Occupancy (AMH & MHSOP A & T Wards) • Staff Leaver Rate		
Neutral	• Patients surveyed reporting their recent experience as very good or good • Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for ***increased performance assurance*** • Inpatients reporting that they feel safe whilst in our care- ***reduced controls assurance*** • CYP showing measurable improvement following treatment - patient reported ***increased performance assurance*** • Restrictive Intervention Incidents Used - ***increased performance assurance*** • Uses of the Mental Health Act	• New unique patients referred • CRES Performance – Non-Recurrent	• Adults and Older Persons showing measurable improvement following treatment - patient reported • Medication Errors with a severity of moderate harm and above ***reduced performance assurance*** • Unexpected Inpatient unnatural deaths reported on STEIS • 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 • Agency price cap compliance ***increased controls assurance*** • Use of Resources Rating - overall	
Negative		• Cash balances (actual compared to plan)	• Financial Plan: SOCI - Final Accounts - Surplus/Deficit ***reduced performance assurance*** • Financial Plan: Agency expenditure compared to agency ***reduced controls assurance*** • Capital Expenditure (Capital Allocation) ***reduced performance & controls assurance***	• CRES Performance - Recurrent

NOTES:
1 *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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

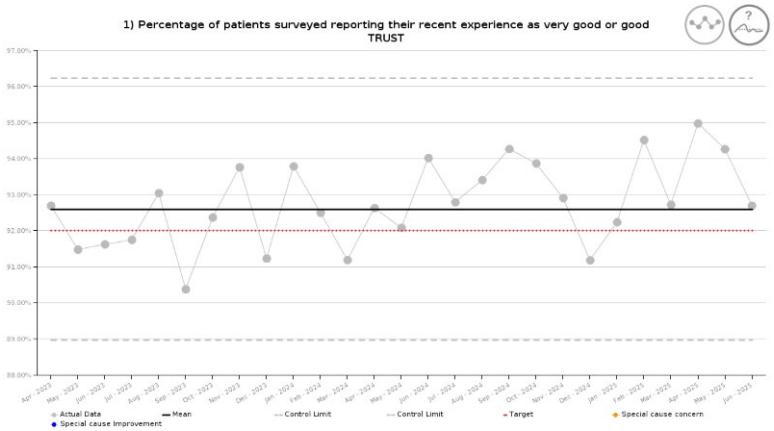
What does the chart show/context:
During June **1492** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **1383 (92.69%)** scored "very good" or "good".

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.

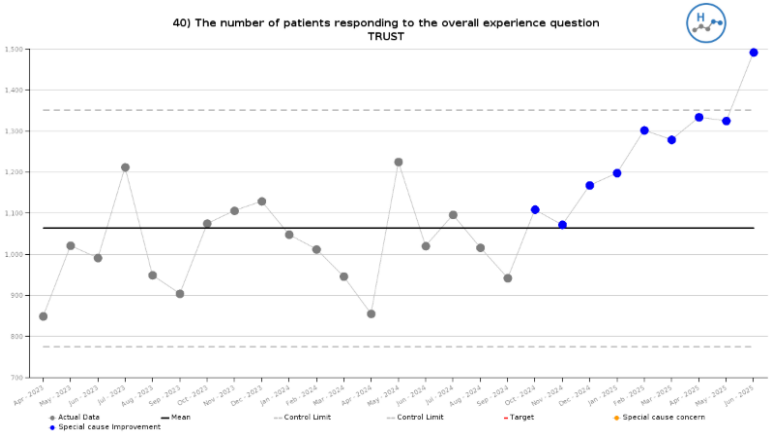
The latest National Benchmarking data (May 2025) shows the England average (including Independent Sector Providers) was **88**% and we were ranked **10** out of 64 trusts (1 being the best with the highest ratings), we were also ranked highest for total number of responses received.

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

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.

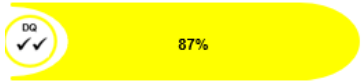
What does the chart show/context:
During June, **648** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **498 (76.85%)** scored "yes, always".

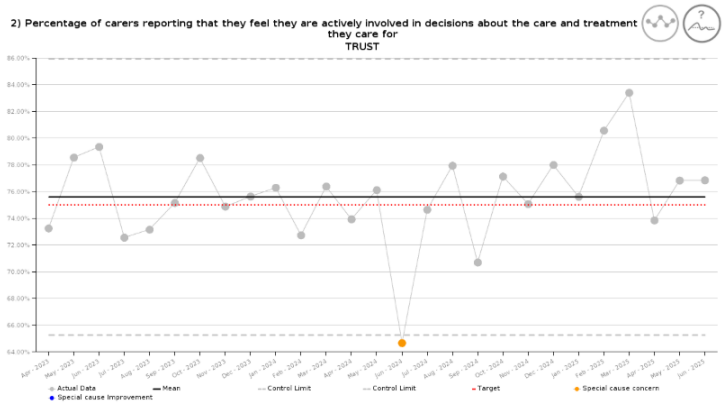
There is no significant change at Trust and Care Group level in the reporting period. There is special cause improvement at Trust and Care Group level in the number of patients who have responded to this question. There is special cause improvement for DTVFCG for Adult Learning Disabilities in relation 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

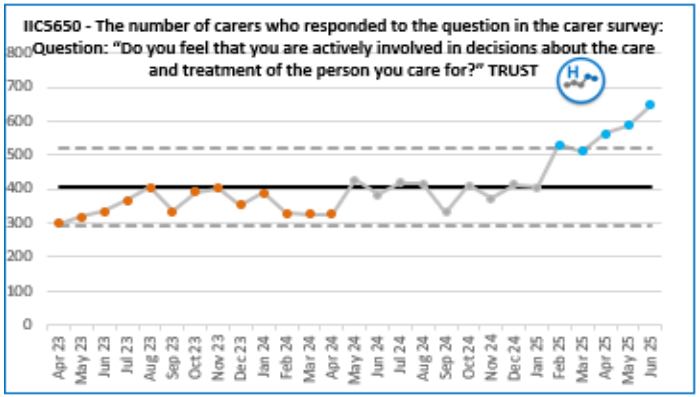
Underlying issues:
- A lack of awareness of the Triangle of Care within Trust Services.

Actions:
- A standard agenda item is now in place for the Trust-wide Strategic Quality Standard group to discuss the Triangle of Care principles and importance. Actions will be monitored, and good practice shared monthly.
- Patient & Carer Experience Team to present the Triangle of Care Annual Report to the Care Group Quality Assurance & Improvement Groups in July 2025.
- Patient & Carer Experience Team and Carer Involvement members to provide training from September 2025 to enable the Carer Champions to deliver Carer Awareness Training within services.





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.

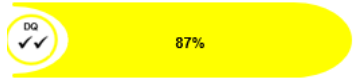
What does the chart show/context:
During June, **285** patients responded to the overall experience question in the patient survey: “During your stay, did you feel safe?”. Of those, **239 (83.86%)** scored “yes, always“ and “quite a lot”.

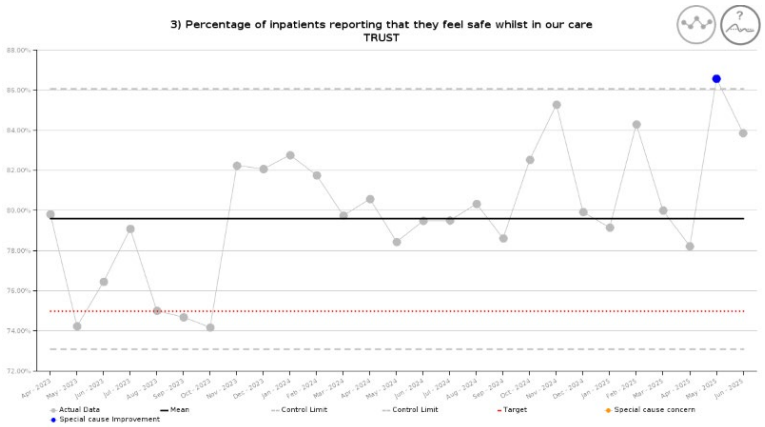
There is no significant change at Trust and Care Group level in the reporting period; however, there is special cause improvement in the number of patients who have responded to this question at Trust level and for Durham, Tees Valley & Forensic Care Group.

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.

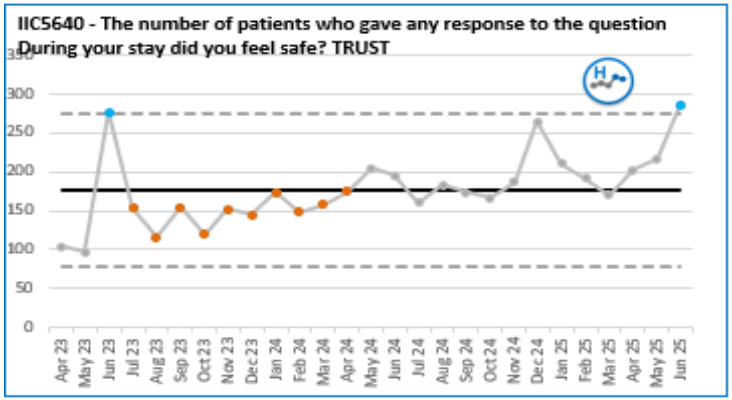
Underlying issues:
There are no underlying issues to report.

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.



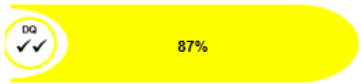


The below chart represents the number of patients that responded to the safety question.



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.

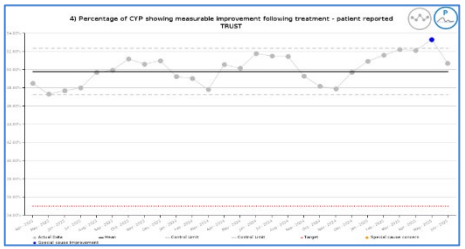
- Further analysis confirms that collection rates for current caseloads are continuing to increase; however, as some patients remain under our care/treatment for longer periods of time, improvements in paired rates will not be visible until the point of discharge (approximately 70% of patients will be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

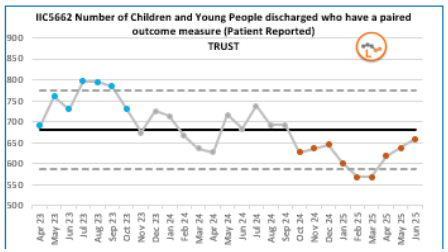
Actions:
The Trust-wide Clinical Outcomes improvement Plan continues to progress. A review has taken place of opportunity to expedite improvements to enhance outcome reporting that are not dependent on planned Cito developments. This has identified 6 improvements that can be made and following approval at the June EDG to extend the deadlines for 2 actions, all remain on track for delivery. Three actions are due for delivery in September 2025:

1. Migration of historical outcomes data from PARIS into Cito
2. CYP PROM (GBO) to flow from Cito into IIC
3. CYP PROM (including parent ratings) requires Reliable Change Index for a small number of measures (EDEQ/EDEA/Gaslight)

The next quarterly detailed report on the Outcomes Improvement Plan will be considered at EDG on 23rd September 2025.

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





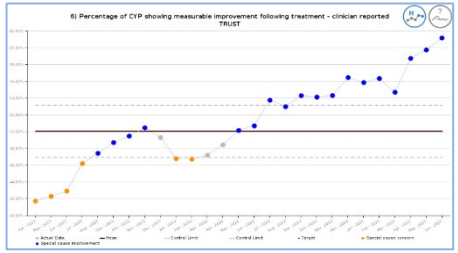
Background / standard description:
We are aiming for 35% of CYP showing measurable improvement following treatment - patient reported

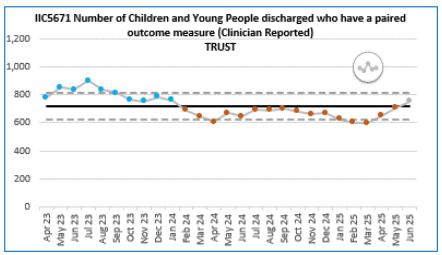
What does the chart show/context:
For the 3-month rolling period ending June, **659** patients were discharged from our CYP service with a patient rated paired outcome score. Of those, **334 (50.68%)** made a measurable improvement.

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

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 June, **752** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those, **460 (61.17%)** 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 no significant change at Trust level and for DTVFCG in the number of patients discharged with a paired outcome measure; there is special cause concern for NYYSCG.

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)

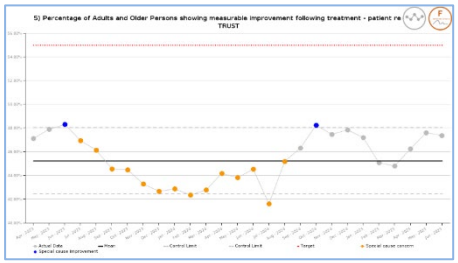
Underlying issues:

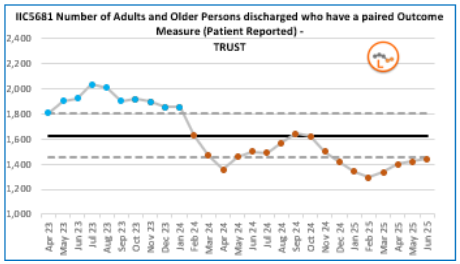
- **PROM only -** this measure currently does not report the full suite of patient-related outcomes as a number of measures do not have a reliable change index, which includes GBO.
- Patients who transition from CYP to AMH are not counted in these measures until they are discharged from TEWV

Actions:

- 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 was to collaborate with the IIC team to address the issue of those paired outcomes demonstrating improvement that were not showing in the measure by the end of June 25. **(Complete)** A significant increase in the number of patients showing measurable improvement within the PROM is visible (approximately 100% increase in the last 3 months).

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





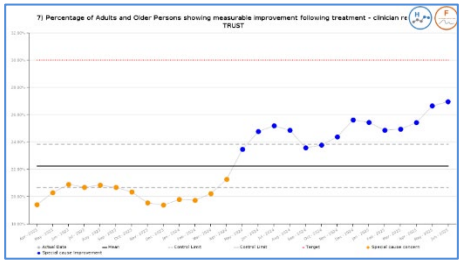
Background / standard description:
We are aiming for 55% of Adults and Older Persons showing measurable improvement following treatment - patient reported

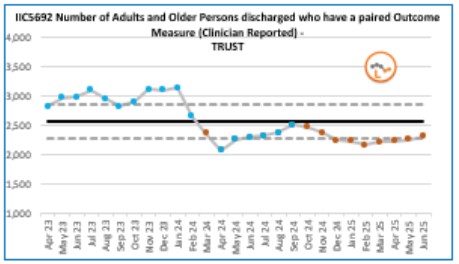
What does the chart show/context:
For the 3-month rolling period ending June **1,442** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 683 (47.36%)** made a measurable improvement.

There is no significant change at Trust level and for North Yorkshire & York Care Group. There is special cause improvement for Durham, Tees Valley & Forensic Care Group and for Mental Health Services for Older People in both Care Groups. 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 June **2,311** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 623 (26.96%)** made a measurable improvement.

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

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 (less than 1% of records).

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 has been added to the Trust-wide Outcomes Improvement Plan to formally govern the progress of the issue). **Update**: The approach agreed by the organisation to prioritise the stabilisation of CITO means that the required system change to rectify the SWEMWBS issue is currently on hold. (*See Outcomes update on page 18)*

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)

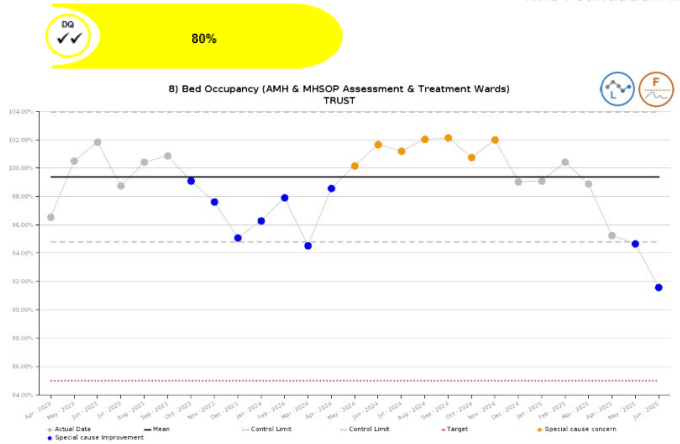
What does the chart show/context:
During June, **10,500** daily beds were available for patients; of those, **9,616 (91.58%)** were occupied. Overall occupancy <u>including</u> independent sector beds was **91.58%.**

There is special cause improvement at Trust and Care Group level in the reporting period, and for Adult Mental Health in both Care Groups; however, performance remains above standard.

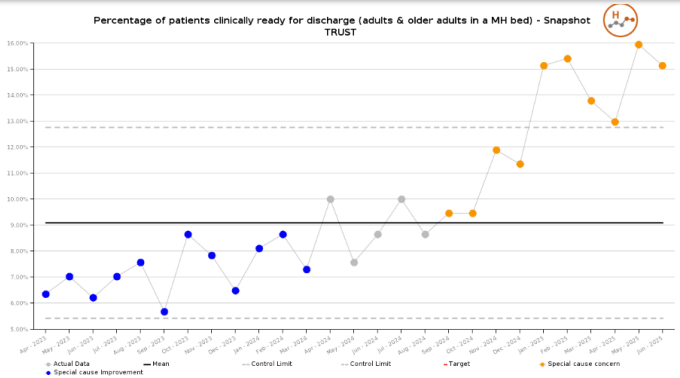
Quality Assurance Committee are fully sighted on bed occupancy and focussed on the potential impact on quality.

Underlying issues:
- Patients clinically ready for discharge are having a significant impact on occupancy *(see bottom right of page)*, as is the availability of specialist packages of care and specialist placements.
- Ministry of Justice (MoJ) patients

Actions:
- The proposed development of Safe Havens in North Yorkshire & York Care Group is pending ICB investment.
- Durham and Tees Valley Care Group has agreed investment with the ICB for a Crisis House as part of our admission avoidance work. The Business Case and Specification for this new service has been developed in Q1 2025/26; however, it will now be presented to EDG in August (previously July).
- There is a proposed development of a discharge hub in Tees Valley in conjunction with the Local Authority as part of the transforming mental health discharge stream. The Business Case will go to System Directors Meeting in June for consideration. **(Not Complete)** the paper will be presented in July.



Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed) (Snapshot)



What does the chart show/context:
There is special cause concern in the percentage of patients clinically ready for discharge at Trust and Care Group level and for Adult Mental Health (both Care Groups) and Mental Health Services for Older People (North Yorkshire, York & Selby Care Group).
**Please note this also includes PICU*

Please Note: At Trust level, patients classified as clinically ready for discharge in June, equated to an average of 80.7 beds (50.7 Adult and 30.0 Older Adult beds), with an associated direct cost of c.£1.59m (including £0.028m independent sector bed costs). Of the cost, c.£0.87m relates to Adult and c.£0.72m relates to Older Adult.

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 June, **0** days were spent by patients in beds away from their closest hospital.

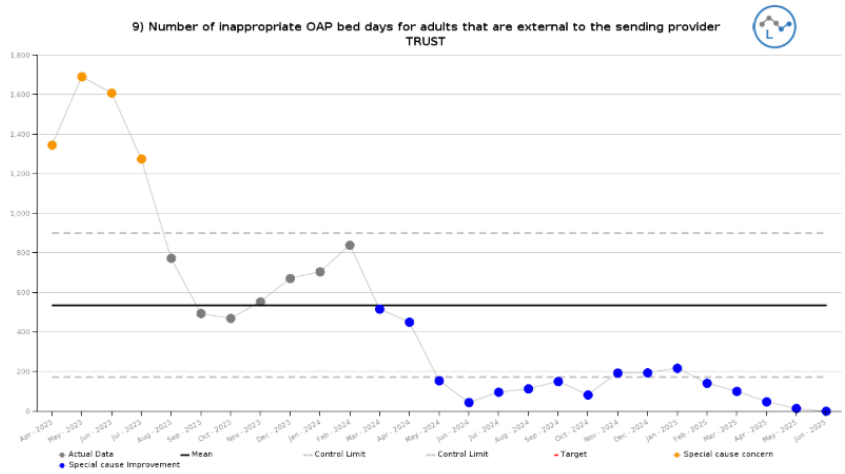
There is special cause improvement at Trust and Care Group level in the reporting period.

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required however this will continue to be monitored through care group governance.

DQ ✓✓ 73%



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

ive 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-2
Trust	Plan	0	0	0									
	Actual	0	0	0									

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

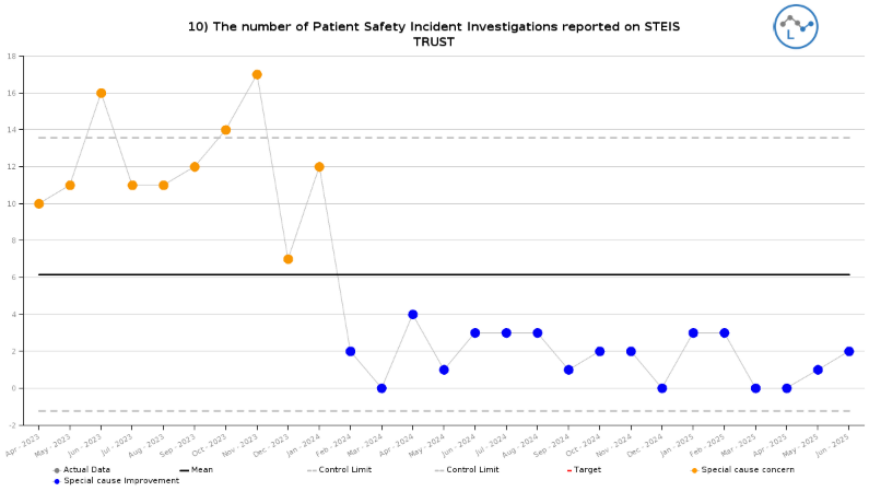
Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is special cause improvement at Trust and Care Group level in the reporting period and for most 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*.
- The management of AARs has now transferred to Inphase. Central Overview reporting was developed to provide more robust oversight from ward to board by the end of June 2025. **(Complete)**



11) The number of Incidents of moderate or severe harm

Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is a reduction (not necessarily an improvement as indicated in the SPC chart) at Trust and in Durham Tees Valley & Forensic Care Group. There is no significant change in North Yorkshire & York Care Group in the reporting period.

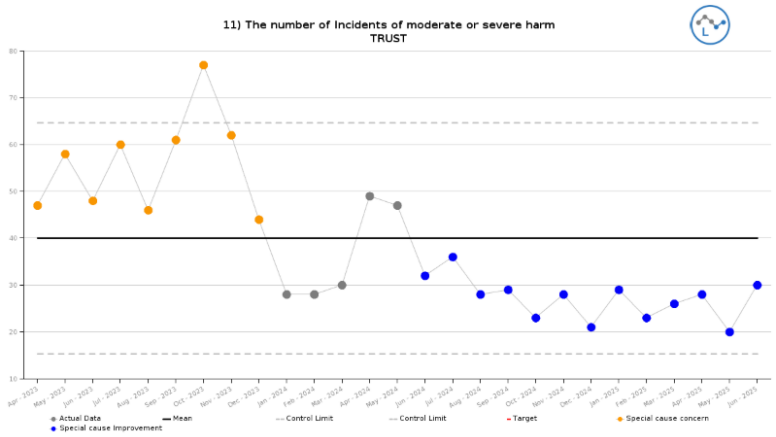
Each incident is subject to a multi-disciplinary after-action review by services. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

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

Underlying issues:
As at the 10th July 2025, there were 365 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. Following a number of workshops, new ways of working are currently being piloted within identified CYP teams and regular reviews of progress and feedback are taking place. A further MHSOP workshop is planned; date to be confirmed.

DQ ✓✓ 87%



12) The number of Restrictive Intervention Used

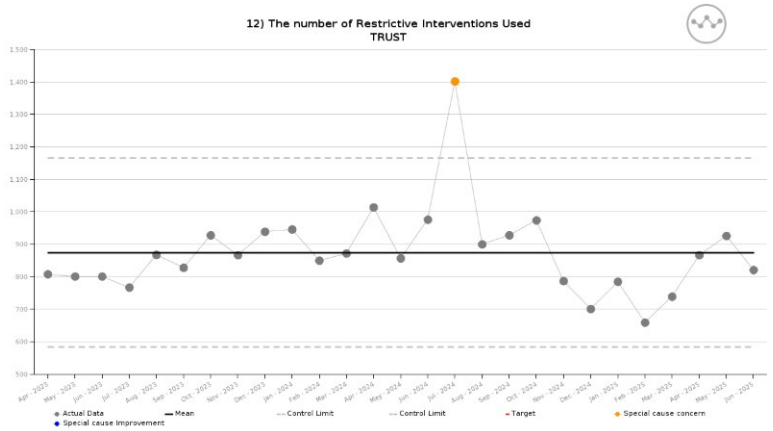
Tees, Esk and Wear Valleys NHS Foundation Trust

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

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

Underlying issues:
- Concerns remain in DTVFCG ALD and SIS 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.
- CCTV reviews within ALD 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 ALD staff nurses to implement Positive Behaviour Support plans.
- The Service, supported by Education and Training has revisited Rapid tranquilisation training for staff nurses and rolled this out as part of Positive and Safe Level 2 training by the end of June 25. **(Complete)**
- DTVFCG SIS are receiving support on Ivy/Clover Ward from the Associate Nurse Consultant for Behaviours that Challenge, both for staff and with 2 Patients when required, and additional support from the Positive Behaviour Support Practitioner within the Secure Outreach & Transitions Team.



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

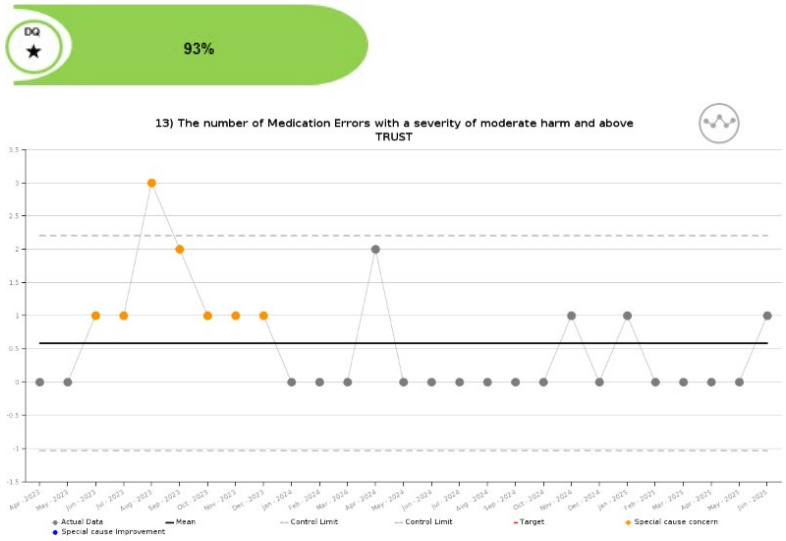
What does the chart show/context:
1 medication error was recorded with a severity of moderate harm during June.

There is no significant change at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period. Whilst there is special cause concern for North Yorkshire, York & Selby Care Group, no issues have been identified at this stage as the After Action Review is currently underway. There is special cause improvement for Adult Learning Disabilities and Adult Mental Health in Durham, Tees Valley & Forensic Care Group and Mental Health Services for Older People in both Care Groups. There is special cause concern for Adult Mental Health in North Yorkshire, York & Selby Care.

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

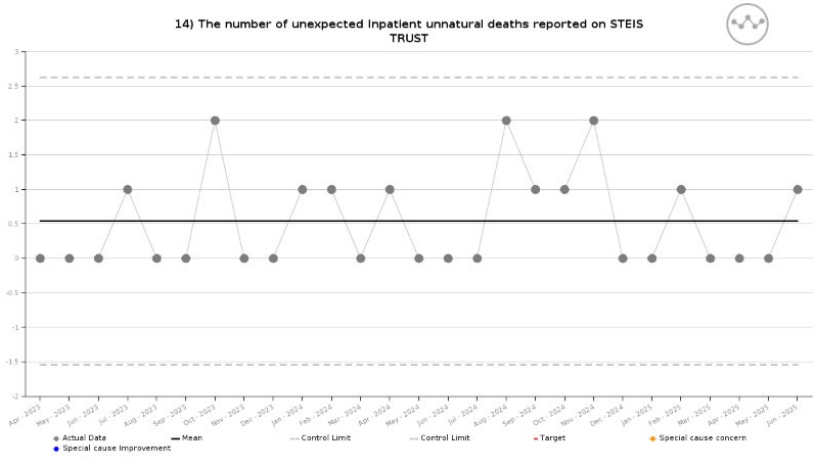
What does the chart show/context:
1 unexpected inpatient unnatural death on an inpatient ward (whilst on leave) was reported on the Strategic Executive Information System (STEIS) during June.

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:
A comprehensive multi-disciplinary after-action review is underway and in line with the National Patient Safety Incident Framework, a full Patient Safety Incident Investigation will be completed; a Family Liaison Officer is supporting the family.

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 **319** uses of the Mental Health Act during June.

There is no significant change at Trust and Care Group level in the reporting period. However, there is an unexpected low shift of referrals for Adult Learning Disabilities within North Yorkshire York & Selby Care Group; the service has confirmed there are no issues at this time.

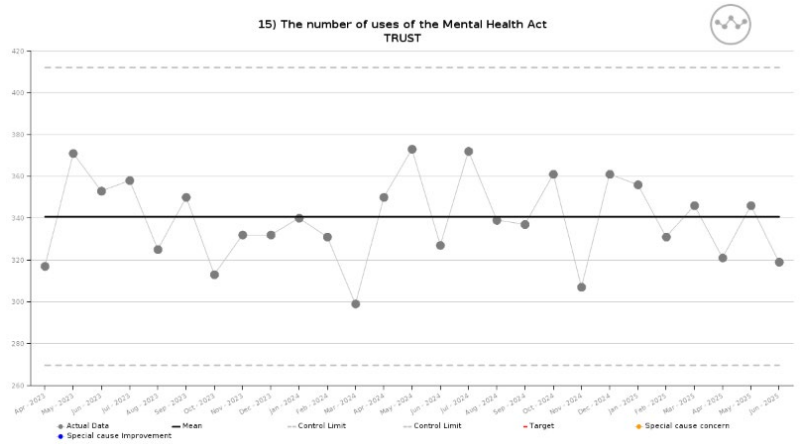
The latest national Mental Health Act data (2023/24) produced by NHS Digital has been analysed by Business Intelligence. Expected rates of detention by gender and ethnicity showed that Trust followed the same trend as the national rate of the higher the level of deprivation, the higher the rate of detention.

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.

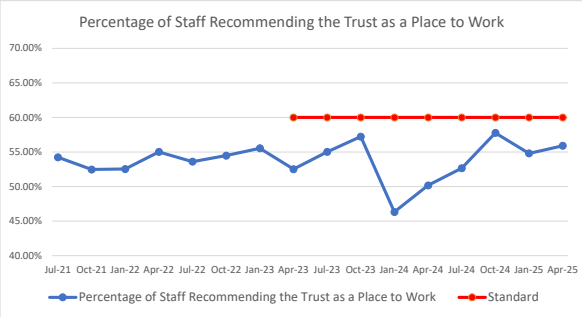
Underlying issues:
Analysis of the latest national Mental Health Act data (2023/24) shows some areas of inequality in our detention rates.

Actions:
The analysis will be taken to the Mental Health Legislation Committee in September 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. *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). **(Not complete)** These will now be presented at the September Trust leadership Events**.** The development of these plans will be supported by Organisational Development and the People Partners.
- Leaders were asked at the June Leadership Time Out meetings to consider how best to engage their teams in discussing the staff survey qualitative analysis (alongside the quantitative data) and for services to offer feedback at the September meetings of the impact this had in finding customised solutions and additional actions needed within their teams in response to the themes identified in the analysis.
- 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 2025.
- It was agreed at EDG in July that People & Culture would facilitate some trust-wide improvement work, progress and future timescales to be reported back to the next Quality & Performance EDG.

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 **7338.32** staff in post, **714.26 (9.73%)** had left the Trust in the 12-month period ending June 2025.

There is special cause improvement at Trust level and for most Directorates in the reporting period. However, there is special cause concern for Estates & Facilities Management, Therapies, Management and Secure Inpatient Services in Durham Tees Valley & Forensic Care Group and Children & Young Peoples Services in North Yorkshire, York & Selby Care Group. The directorates have confirmed there is no actual concern at this stage.

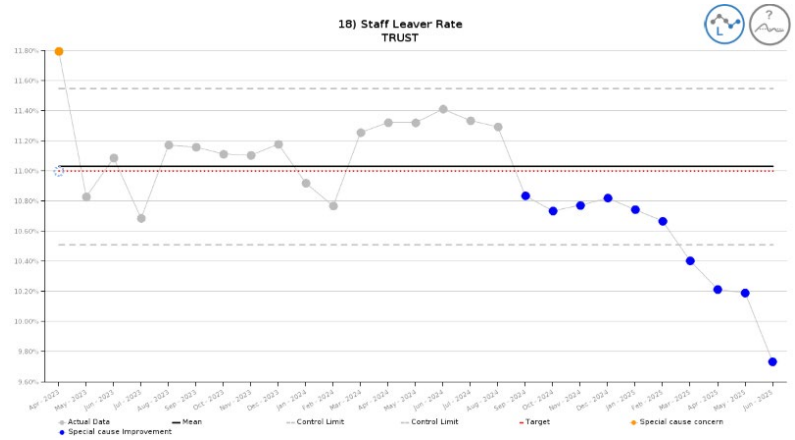
There is no new national benchmarking data available at the time of this report.

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)

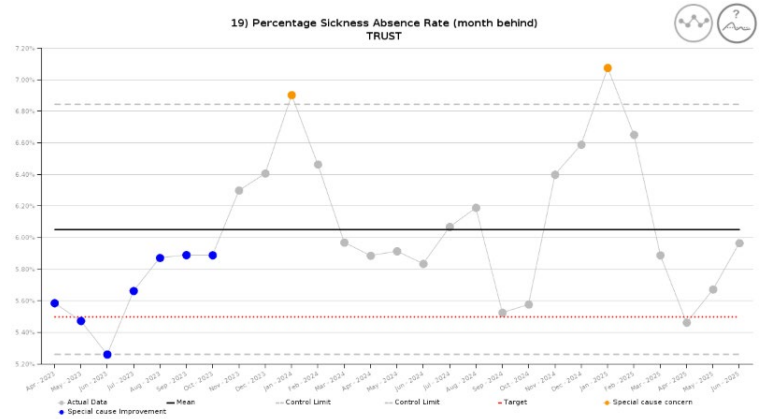
What does the chart show/context:
There were **234,904** working days available for all staff during June 2025 (reported month behind); of those, **14,011 (5.96%)** days were lost due to sickness.

There is no significant change at Trust and for most Directorates in the reporting period. There is special cause concern for Estates & Facilities Management, Nursing & Governance, People & Culture and Management within North Yorkshire, York & Selby Care Group; however, the directorates have confirmed there is no actual concern at this stage.

National Benchmarking for NHS Sickness Absence Rates published 26th June 2025 (data ending February 2025) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.65**%** compared to the Trust mean of **6.14%**, with the Trust ranked 32 of 47 Mental health Trusts (1 being the best with the lowest sickness rate).

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

Actions:
- A review of the Attendance Management procedure has been undertaken and will be signed off at Joint Consultative Committee (JCC) meeting in July.
- A People Management Bitesize Training module has been developed to support Managers when working with staff through the procedure. Roll out dates are to be confirmed.
- It was agreed at EDG in July that People & Culture would facilitate Trust-wide improvement work', progress against which will be reported back to the Quality & Performance EDG in August 2025.



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:
162,143 training courses were due to be completed for all staff in post by the end of June. Of those, **146,669 (90.46%)** were completed.

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

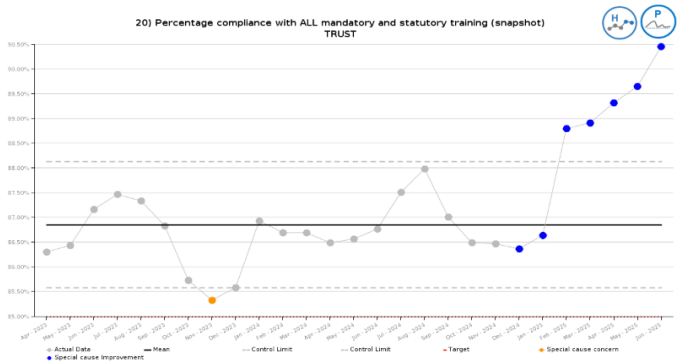
As at the 30th June 2025, by exception compliance levels below 85% are as follows.

Directorate	Numerator	Denominator	Percentage
CHIEF EXECUTIVE OFFICE	88	105	83.81%

Underlying issues:
- The volume of courses that staff have to complete is extremely time consuming and above the current headroom calculation.
- There is a number of staff incorrectly allocated to the Chief Executive Office on the Electronic Staff Record.

Actions:
- Temporary Staffing Manager was to ensure the outstanding Information Governance training for Bank Staff was undertaken by the end of June 2025 (previously December 2024). (Complete)
- Strategic Lead Workforce Information and Resourcing Systems to work with Finance to ensure all staff allocated to the Chief Executive Office are correct. Progress and future timescales to be reported back to the next Quality & Performance EDG.
- The shortfall in performance for the Chief Executive Office also relates to two new Non-Executive Directors. These colleagues will complete their training by end of September (previously April 2025).

DQ ★ 93%



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 June 2025 there has been an average of 41% wasted spaces (including 14% DNAs) across the mandatory face to face training courses.

Actions:
- Workforce Training are removing Autism Tier 2 mandatory training from corporate none patient facing staff and working with the ICB to launch a shorter mandatory Tier 1 training for this cohort of staff. This will release additional tier 2 places for those staff who need to complete this course. Tier 1 training to commence by the end of June 25. **(Complete)**
- Detailed report on corporate directorates and service lines, including correlation with wasted spaces to be compiled and discussed at EDG People Meeting in July (week 2). **(Complete)**
- It was agreed at the Quality & Performance EDG in July that the Workforce Development Lead would work with the Care Group Business Managers to identify SMART actions, which would be brought back to the Quality & Performance EDG in August.
- The Training and Education Task Group are reviewing the courses that appear in the mandatory and statutory framework to understand the issues driving lower compliance and support the development of an action plan which will be reported back to EDG in August.
- 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.

Course Name	Number Compliant	Total Number	% Compliant
Rapid Tranquilisation 1**	218	315	69.21%
Positive & Safe Care Level 1*	3341	4526	73.82%
Positive and Safe Care Level 2 Update *	1287	1724	74.65%
Resuscitation - Level 1 - 1 Year *	1964	2621	74.93%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year *	1612	2063	78.14%
Incident Management-Corporate **	153	195	78.46%
Incident Management-Clinical **	1514	1836	82.46%
Annual Medicines Optimisation Module **	1737	2102	82.64%
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year *	849	1020	83.24%
Resuscitation - Level 3 - Adult Immediate Life Support - Test	846	1014	83.43%
ACCT Training	73	87	83.91%
Moving and Handling - Level 2 - 2 Years *	721	857	84.13%
MCA - MCA and Young People Aged 16/17.**	801	952	84.14%
MCA - Relationship Between MCA and MHA.	3626	4268	84.96%

**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 **6,955** eligible staff in post at the end of June; **6,179 (88.84%)** had an up-to-date appraisal.

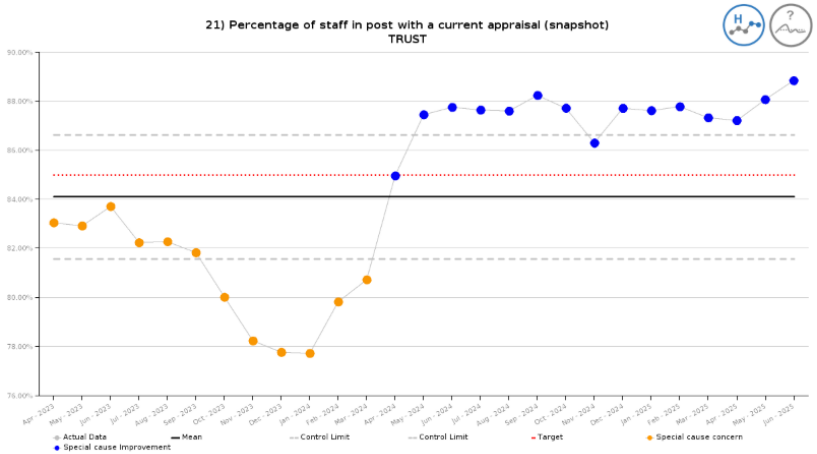
There is special cause improvement at Trust level and for a number of Directorates in the reporting period; there is no significant change in all other areas.

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

Directorate	Number Compliant	Total Number	% Compliant
THERAPIES	31	38	81.58%
CHIEF EXECUTIVE OFFICE	5	6	83.33%

Underlying issues:
- Whilst there are no underlying issues to report, there are several directorates not achieving standard (as outlined above).

Actions:
- Business Intelligence to action the changes required to remove resident doctors from the data. **(Complete).**
- Outstanding appraisals were to be undertaken in Assistant Chief Executive, Finance and Nursing & Governance by the end of May/June/July 2025 respectively. **(Complete)**
- Therapies lead to investigate outstanding appraisals with Workforce Team by the end of July 2025 to identify next steps.
- Outstanding appraisals to be undertaken in Chief Executive Office by end of September 2025 (previously June)
- 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. These will be completed by the end of August 25. As at 30th June 2025 the service is achieving standard.



22) Number of new unique patients referred

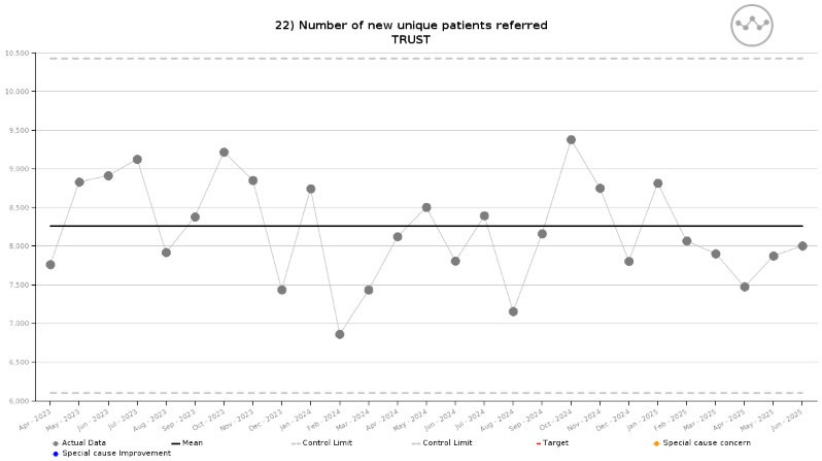
Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
8,004 patients referred in June 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 for Children and Young People's Services in North Yorkshire, York and Selby Care Group. There is a high shift 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



23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

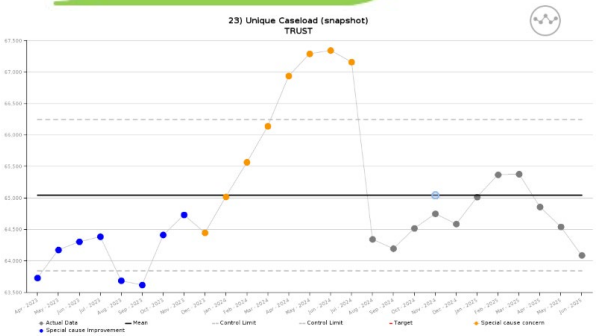
What does the chart show/context:
64,088 cases were open, including those waiting to be seen, as at the end of June 2025; 54,172 were active.

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

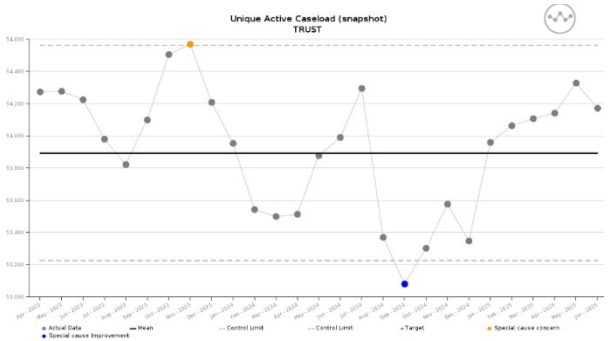
The **additional** SPC chart representing **Active Caseload** (excluding patients waiting for first contact) shows no significant change at Trust level, and for both care groups; however, an increasing trend is visible in the chart. There is special cause concern in AMH within DTVFCG and in CYP within NYYSCG. There is also an increasing trend visible in CYP within DTVFCG.

Underlying issues:
- 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:
- CYP General Managers to develop an action plan to address caseload sizes by the end of September 2025.
- The Performance Team to meet with the General Manager for AMH Planned Care in DVFCG to review the active caseload measure by the end of June 2025. **(Complete)** No areas of concern have been identified by the General Manager at this stage; however, this remains under review.
- Section Head of Research & Statistics, Clinical Outcomes and Business Analytics to scope the potential options for a revised Active Caseload measure by the end June (previously May) 2025. **(Complete)** Options appraisal to be shared with Associate Director of Performance in July 2025.



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



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 June 2025 against which Trust performance is assessed is a deficit of **£1.89m which is £0.89m better than planned**. 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 **£2.18m and is £0.10m above plan** which is based on an increasing monthly CRES trajectory in 2025/26 to deliver the nationally required 40% reduction in agency costs. Plan required an increasing trajectory of reductions, with Agency reducing from 2.1% of paybill in April 2025, to 0.84% of paybill in March 2026. Costs reflect a broadly consistent downward trajectory over the last two financial years. In-month costs were £0.65m and decreased by £0.05m compared to prior month and represented **1.79% of paybill**, which is lower than the 24-25 average of 2.56%. The 40% targeted reduction in costs during 2025/26 requires month on month rigour and control. The Trust is behind trajectory at month 3 and will need to recover under performance in future periods. Ongoing usage includes high premia rate locum costs for cover of medical vacancies and some residual price cap breaches, where cover is needed for geographically more 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 **0 non-Trust bed days in June** (0 in May) 2025. **Year to date costs were £0.028m**, including estimates for unvalidated periods of occupancy and average observation levels pending billing and were **£0.25m below plan**. This remains a key area of volatility due to ongoing bed pressures, and consequently clinical and management focus including through the Urgent Care Programme Board (chaired by the Managing Director for DTVF) is required. Flow 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 OPEL and bed management processes (Monday to Friday) will support optimal daily management and flow.
- 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. Year to date CRES are £0.343m behind plan, but with **recurrent schemes delivering £1.44m below plan**, and non-recurrent schemes delivering £1.10m higher than planned. Currently we are still expecting to deliver the full savings requirement through non recurrent mitigations, but the unmitigated forecast includes a shortfall of £5.4m on recurrent schemes, currently supported by non recurrent mitigations. Actions to quantify recurrent full year effects of schemes, and to then identify new recurrent mitigations and schemes are progressing, supported by a Sustainability and Transformation workshop in July.

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 and reducing delays when patients are ready to be discharged, 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 Temporary Staffing sub group has been set up to oversight and support work on reduction of all temporary staffing, and is putting in place additional bank arrangements, restrictions on overtime and reductions in agency use. There has been a Performance Improvement Plan in place to reduce the use of Agency staff, which has 2 outstanding actions due for completion in September 2025. Whilst the PIP has had some impact it has not had the impact that was intended; therefore, EDG have approved the PIP be stood down and for the wider improvements in agency reduction to be overseen by the Temporary Staffing Sub-Group.
- 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 trust-wide event took place on the 9th July to assess current progress and forecasts and identify additional actions and mitigations to deliver our plans. The event also started the process for looking at medium term financial sustainability and transformation.
- 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 **£2.18m at Month 3 are £0.10m above plan.**

NHS planning guidance for 2025/26 introduced a requirement to reduce agency cost by 40% compared to 2024/25 outturn. This is the basis of the plan, which has a trajectory to reduce costs incrementally over the year. Costs of 1.79% of pay bill in the current month reflect continued actions to reduce costs from c2.6% on average in 2024/25 and represent significant reductions from c4.5% on average through 2023/24 and 5.4% on average through 2022/23. The Trust needs to manage agency costs to within £6.5m in 2025/26, which represents 1.51% planned paybill and an increasingly challenging plan profile in the remainder of the year to recover the overspend incurred to date and reflect plan stepped reductions from current average costs of 1.99% paybill for the quarter.

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 182 worked Whole Time Equivalent (WTE) between April 2023 and June 2025** (falling from 240 to 58 WTE), and related annualised premia for price cap breaches reduced from £4.0m in April 2023 to £2.5m in June 2025 (£1.5m reduction). Whilst the trend for medical WTE and price cap breaches was broadly positive between April 2023 and June 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). It has now been agreed by EDG to incorporate the remaining PIP actions into the Flexible Staffing sub groups programme, and close the PIP.

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 through the safe staffing group:

- 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:

1,178 agency shifts were worked in June 2025, with **642 shifts compliant** (55%) and **536 non-compliant** (45%) (prior month 746 shifts or 59% compliant and 526 or 41% non-compliant) **with national price caps, representing a deterioration in number and percentage of breaches in-month**.

Most price cap breaches have related to medical or prison nursing cover for hard to fill vacancies.

- In month, 83% of non-compliant shifts (94% by value of breaches) were medical and 17% of non-compliant shifts (6% by value of breaches) were nursing.
- Of the nursing agency breaches, 86% of shifts related to prisons (87% by value of shifts).
- **Medical shifts breaching increased by 17 shifts**, increasing from 429 shifts in May to 446 in June 2025 (100% shifts breach price cap).

94 fewer overall agency shifts were worked this month compared to last, with shifts worked being equivalent to **approximately 39 shifts per day** (41 in May and 43 in April). The 94 shifts decrease was masked by 17 more higher cost medical, 49 less nursing, and 62 fewer HCA agency shifts. If sustained this would adversely impact the cost per average WTE agency worker due to medical premia rates.

This reflects **a reduction in total shifts worked of 894 (43%) over the last 12 months** from 2,072 shifts worked in June 2024 and **a reduction of 30% or 234 shifts breaching price cap since June 2024** (770 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.

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 approved a second phase of International Recruitment to aim to recruit a more sustainable medical workforce and reduce reliance on higher rate agency assignments, targeting reduced SAS locum medical assignments initially. Medical assignments attract the highest value and percentage premia rates and both Care Groups have been asked to develop medical staff recruitment and locum trajectories for 2025/26.
- 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 June 2025.
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 as an assessment of overall financial risk.

- 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 -0.01% which is a **rating of 2**.
- The Income and Expenditure **(I&E)** margin distance from plan is 2.30% 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 £2.2m are above plan by £98k and would therefore be **rated as a 2.** The Trust's year to date agency costs were 1.99% 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 June 2025 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 June was **£1.90m and £1.45m below plan**.

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** (£10.2m) with temporary staffing reductions, from Agency (40% reduction targeted), Bank (10% reduction targeted) and Overtime (£2.1m reduction targeted). 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.

Underperformance was principally on planned temporary staffing (Overtime, bank and Agency) reductions (£0.8m).

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, with central action being taken to restrict the use of agency and overtime shifts. Key planned dates for effecting stepped overtime reductions fall in July and October, following Executive Directors Group approval of related proposals. There is a risk that bank utilisation increases as other means of temporary staffing are restricted, and in some areas bank arrangements are being put in place to support the reduction in agency and overtime usage on a value for money basis.

Actions:

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

- To develop plans for all schemes, ensure timely QIA ahead of phased start dates, and assess full year effects of recurrent 2025/26 schemes to assess any recurrent under delivery impacting 2026/27.
- To identify additional mitigations and to consider whether any of those could be achieved recurrently.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Non Recurrent CRES performance was ahead of plan by £1.10m for the period ending 30th June, with £2.43m 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. Plans on a page are in place for most schemes. QIA's need to be booked in to ensure timely triumvirate review ahead of phased start dates. A number of schemes are planned for later in the year, and this creates a risk to delivery, reducing options for mitigation if performance is lower than planned.

The £1.10m over achievement year to date on non-recurrent schemes includes, £0.6m reduction on PDC and Depreciation expenses, £0.377m additional income from secure bed capacity, £0.39 slippage on mobilisation of new services, £0.19m management of cash to achieve maximum interest, £0.7m other actions, offset by under achievement of ALD Lanchester Road service provision £0.11m.

Underlying issues:
It was necessary to target non-recurrent CRES to deliver a break-even plan, however reliance on non-recurrent schemes leaves 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 ensure timely QIA ahead of phased start dates, as well as progressing detailed plans for central opportunities.
- To identify additional mitigations and to consider whether any of those could be achieved recurrently.

29) Capital Expenditure (Capital Allocation)

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Capital expenditure again the Trust's allocation was **£2.27m** at the end of June, which was £0.64m less 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.

£3.29m central cash-backed funding was allocated to TEWV via Provider Capital Collaborative Group arrangements. In 2024/25 TEWV supported system partners by agreeing to broker £1.40m capital slippage to support wider pressures, with those funds being returned and included in the 2025/26 £13.80m capital programme.

The Trust was allocated a further £1.21m centrally cash backed PDC funding to support Solar panel installation, giving a composite £15.01m capital programme.

The plans assume phase 2 Roseberry Park rectification works commence in August. The tender approval process completed on 1 July, with award, subject to relevant standstill periods, to complete during July, meaning no slippage is expected on this target start date. A revised capital plan, incorporating the full business case and tender outcome and estimated phasing will be recommended to Trust Board in August 2025.

Underlying issues:

Liquidity, due to reducing Trust cash balances and increasingly constrained national and regional capital allocations relative to need, is of significant concern going forward, especially given significant capital requirement 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. To this end a multi year capital plan is required to be submitted to NHS England, with submission date expected to align to medium term financial planning; guidance anticipated in the Autumn.

30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

The Trust had cash balances of **£50.60m** at the end of June 2025 which exceeded planned cash balances of **£44.10m** by **£6.50m** (favourable variance) and included a £4.60m higher than planned opening cash balance linked to higher than anticipated accrued expenditure.

- **Prompt Payment of Suppliers:** The Trust has achieved a combined Better Payment Practice Code (BPPC) compliance of **96.4%** 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 June 2025 was £2.2m, with **debts exceeding 90 days amounting to £0.30m** (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 than is generated internally from depreciation, meaning the Trust's annual cash reserves are gradually reducing, and materially impacted by the significant works programmed at Roseberry Park Hospital. The Trust is developing a medium term financial plan and associated capital programme.

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 - We will co-create high quality care	Goal 2 - We will be a great employer	Goal 3 - We will be a trusted 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%	92.11%
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	H	?	60%	60%	77.83%
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%	89.38%
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%	99.91%
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%	89.73%
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%	74.55%

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		?	42.0	42.6	41.18
Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness	L	?	48%	48%	46.07%
Talking Therapies - Reliable improvement rate for those completing a course of treatment	L	?	67%	67%	69.00%
Number of women accessing (1+ contact) specialist community PMH and MMHS services in the previous 12 months	H	N/A	N/A	N/A	1606
Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact		N/A	N/A	N/A	30388
Number of people accessing IPS services (rolling 12 month)	L	N/A	N/A	N/A	922

NOTES: 1. The above tables reflect the Trust-wide position (not the sum of commissioned services).

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.

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, with the exception of Tees Valley. For the month of June there were 3 patients that did not receive treatment within the 4-week standard. One patient was offered an appointment within 4 weeks which they could not attend. The remaining 2 breaches are attributable to data quality and steps are being taken to resolve this on Cito.
  - 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 June there was one patient reported as not receiving treatment within the 1-week standard. The service attempted daily contact with the patient, the first successful contact being made on day 6; however, no appointments were available within the standard. Daily reviews have been established by the service to ensure all urgent referrals are seen within 7 days.

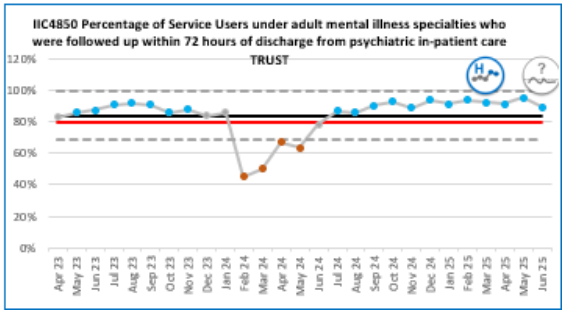
Mental Health Priorities

- **Active OAP (inappropriate):** Achieved Trust plan for June.
- **Average Length of stay for Adult acute beds *(new measure)*:** Achieved Trust plan for June.
- **Talking Therapies Reliable Recovery:** National Standard not achieved at Trust and commissioned place level, with the exception of North Yorkshire and York.
- **Talking Therapies Reliable Improvement:** National Standard not achieved at Trust and commissioned place level with the exception of North Yorkshire and York.
- **Specialist Community Perinatal Mental Health (PMH) services** Plan not achieved at commissioned place level in York; however, there is special cause improvement.
- **Children: 1 contact** We have provisionally agreed with Commissioners to focus on no significant change for this measure; however, this is not being achieved in North Yorkshire place and 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.

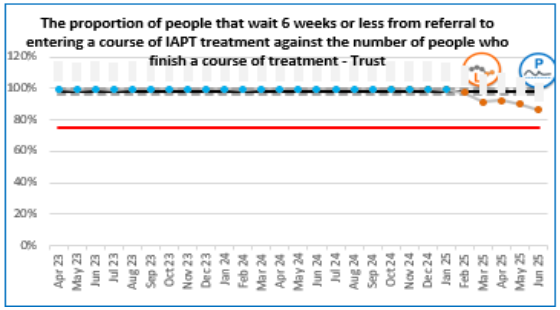
*All headlines are based on financial year to date unless otherwise stated.

National Quality Requirements

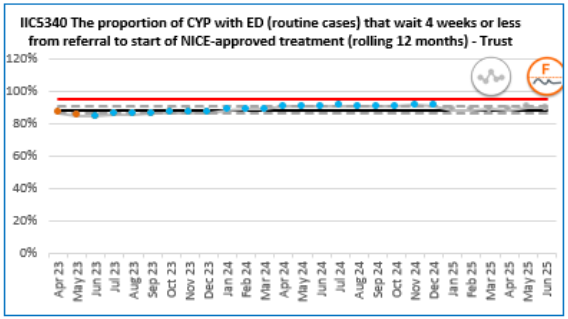
Tees, Esk and Wear Valleys NHS Foundation Trust



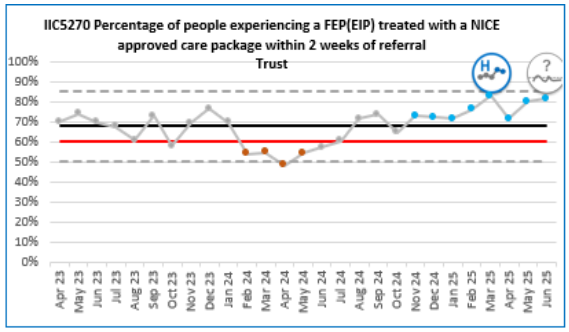
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	80%	92.11%			
County Durham	80%	92.27%			
Tees Valley	80%	92.83%			
North Yorkshire	80%	96.26%			
York	80%	89.77%			



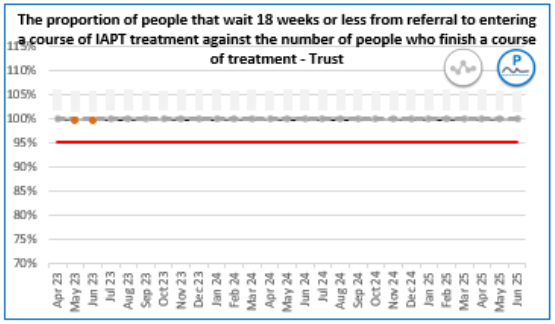
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	75%	89.38%			
County Durham	75%	81.10%			
Tees Valley	75%	81.44%			
North Yorkshire	75%	99.10%			
York	75%	96.48%			



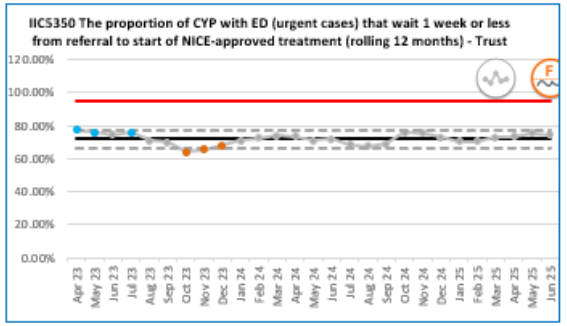
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	89.73%			
County Durham	95%	83.78%			
Tees Valley	95%	97.75%			
North Yorkshire	95%	87.50%			
York	95%	85.71%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	60%	77.83%			
County Durham	60%	79.55%			
Tees Valley	60%	70.73%			
North Yorkshire	60%	89.83%			
York	60%	68.42%			



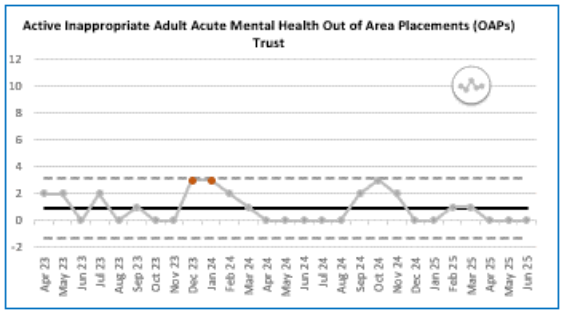
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	99.91%			
County Durham	95%	99.90%			
Tees Valley	95%	99.72%			
North Yorkshire	95%	99.93%			
York	95%	100.00%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	74.55%			
County Durham	95%	77.78%			
Tees Valley	95%	100.00%			
North Yorkshire	95%	55.56%			
York	95%	33.33%			

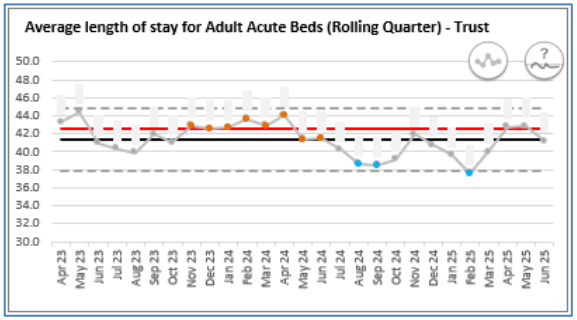
Mental Health Priorities

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

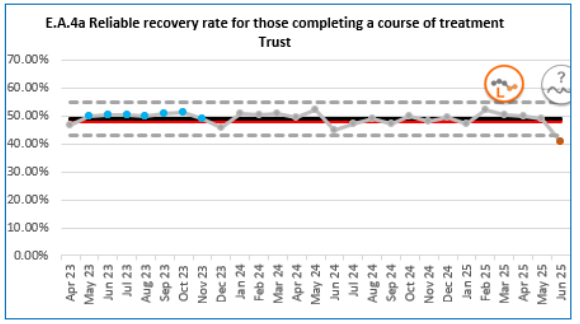


Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	0	0			

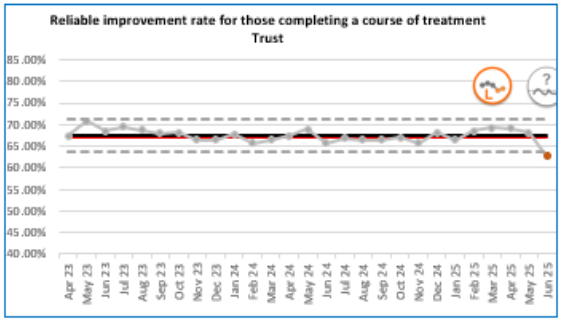
Please note the plan for this measure is zero for 25/26



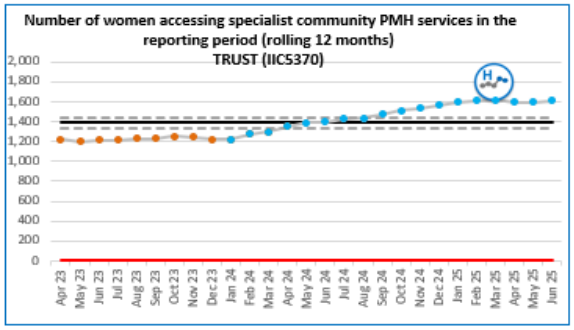
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	42.6	41.2			



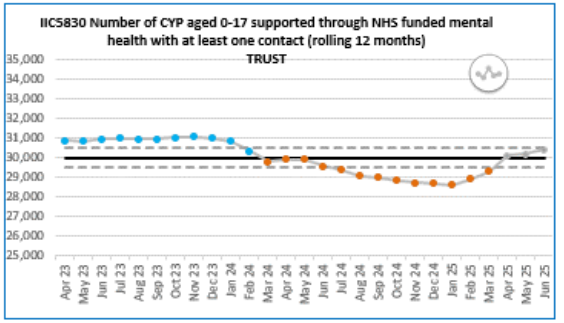
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	48%	46.07%			
County Durham	48%	40.91%			
Tees Valley	48%	42.60%			
North Yorkshire	48%	51.49%			
York	48%	50.40%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	67%	66.24%			
County Durham	67%	62.10%			
Tees Valley	67%	59.83%			
North Yorkshire	67%	70.74%			
York	67%	72.13%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	N/A	1606			
County Durham	456	558			
Tees Valley	447	506			
North Yorkshire	368	373			
York	156	138			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	N/A	30088			
County Durham		10782			
Tees Valley		11611			
North Yorkshire		4592			
York		2881			

Number of people accessing IPS services (rolling 12 months)

Organisation	Standard	Actual	Variation
Trust	N/A	922	
County Durham	TBC	273	
Tees Valley	TBC	332	
North Yorkshire	TBC	186	
York	TBC	122	

Average length of stay for Adult Acute Beds

Tees, Esk and Wear Valleys NHS Foundation Trust

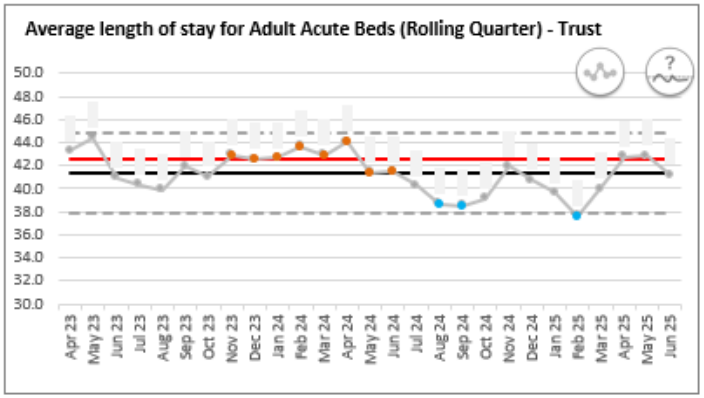
Background / standard description:
Whilst we are aiming to reduce our average length of stay within our adult acute inpatient beds to 42.0 days by the end of March 2026, by the end of June we are aiming to have an average length of stay of **42.6** days.

What does the chart show/context:
During the 3-month period ending June 2025, there were **734** discharged hospital spells from adult acute beds for patients aged 18+, accounting for a total of **30,226** bed days which equates to an average length of stay of **41.2** days.

There is no significant change at Trust level; however, there is special cause improvement in DTVFCG and special cause concern in NYYSCG. There is special cause concern in MHSOP within DTVFCG and in AMH within NYYSCG. There is also a visible increase in MHSOP within NYYSCG.

Underlying issues:
Not yet identified – see action below

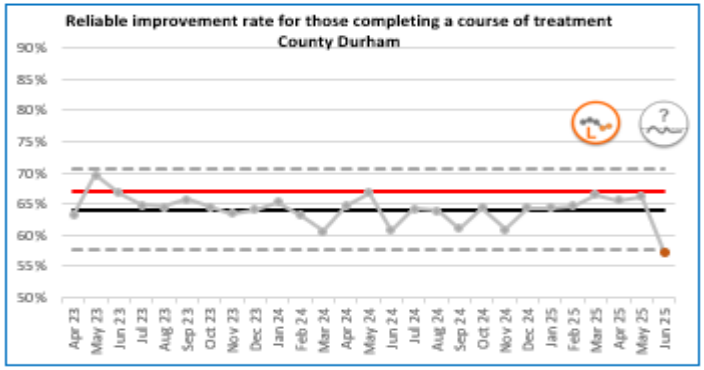
Actions:
The Performance Team have analysed the data at ward level and share the findings with General Managers in each Care Group during June 25. **(Complete)** No concerns have been identified by the General Managers as long lengths of stay are largely impacted by the discharge of patients that are clinically ready for discharge; however, this remains under review.



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	42.8	42.9	41.2									

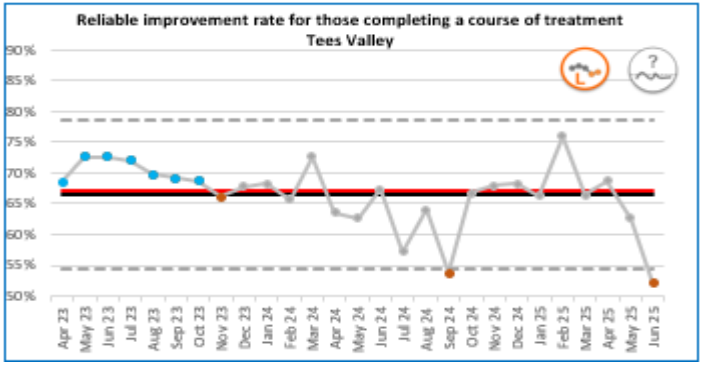
Talking Therapies: Reliable improvement rate for those completing a course of treatment – *by exception*

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 June, **57.24%** of patients demonstrated reliable improvement following completion of a course of treatment within **County Durham**.



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 June, **52.08%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**.

Underlying issues:

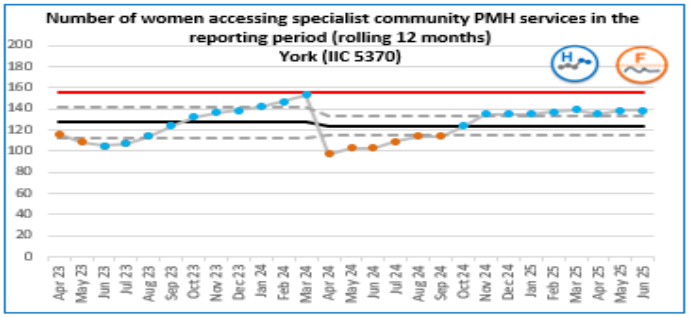
- High levels of complex patients are seeing a reliable improvement on two outcome measures (Patient health questionnaire - PHQ9 and Generalised anxiety disorder - GAD7); however, if an Anxiety Disorder Specific Measures (ADSM) is also undertaken and does not report an improvement, that supersedes the other scores.
- The measure includes patients that are not at clinical caseness (as per the national construction, a referral that has severe enough symptoms of anxiety or depression to be regarded as a clinical case) 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.
- A number of staff members on maternity leave and high levels of sickness are resulting in caseloads being reallocated or patients being added back to the waiting list which is impacting on both measures.

Actions:

- The Trust-wide action plan will be monitored through the Trust-wide Talking Therapies Group which will be relaunched in July, sharing quarterly updates with Care Group and Executive Directors Group commencing in August 2025.
- The Service Manager is in discussion with Finance and Temporary Staffing in respect of the back fill arrangements for those staff on maternity leave. Pending approval posts will be submitted through vacancy control as soon as possible.

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 **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 June 2025 there were **138** women accessing a specialist community Perinatal Mental health services in **York**.

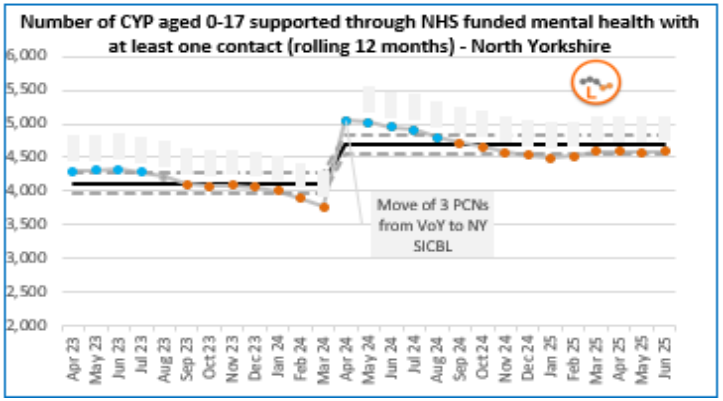
There is special cause improvement as indicated in the SPC chart above.

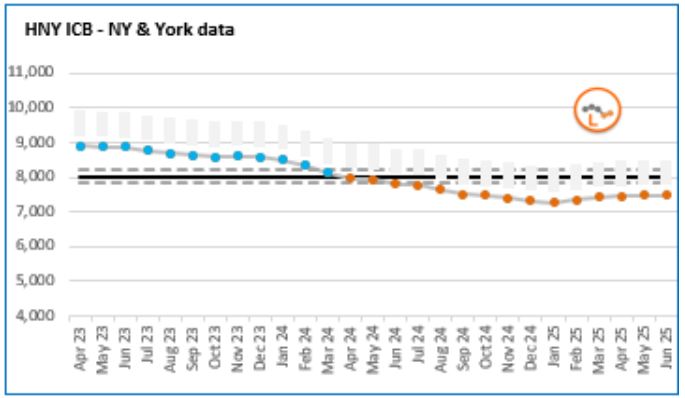
Underlying issues:
- Capacity issues within the Perinatal services, linked to sickness, vacancies, maternity leave and staff on formal support processes.
- Changes made to the assessment criteria in the recent RPIW has led to an increase in the caseload, however staff capacity cannot meet this demand

Actions:
- The Perinatal teams are currently being supported through a service recovery plan in line with business continuity processes. New vacancies and maternity leave cover are being progressed through the recruitment process. In the interim, the service are trying to recruit agency staff however, there have been no suitable candidates.
- 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.
- The Care Group has ensured the ICB and Provider Collaborative are fully sighted on the issues and recovery plan.
- An Options appraisal paper is to go to Care Group Board in June before being shared with EDG in July 25. (Complete) A preferred option has been identified pending a quality impact assessment. In the interim, operational support from wider Trust services is being explored.

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

Tees, Esk and Wear Valleys NHS Foundation Trust





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 June 2025 **4,592** 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. **(Complete)** Findings to be discussed with General Manager early August 2025.

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		2665	915	517	351	625	166	59	32	0	0	11	81
Adults with a learning disability Waiting for an Assessment		64	33	19	5	6	1	0	0	0	0	6	28*
Adults in Health and Justice services Waiting for an Assessment		33	22	8	3	0	0	0	0	0	0	4	13
Older People Waiting for Assessment		2643	898	481	330	642	272	18	2	0	0	12	61
Children and Young People Waiting for an Assessment		1023	578	218	73	100	17	5	25	7	0	8	136
Children and Young People Waiting for Treatment (excluding Neuro)		1832	147	241	175	578	203	93	188	92	115	40	326

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		4733	89	100	213	365	291	294	1339	1220	822	95	359*
Adults waiting for an Autism Assessment		3999	63	76	173	247	185	165	1109	1141	840	104	372*
Children and young people waiting for an Autism Assessment		5737	115	97	101	450	493	374	2628	1286	193	78	210*
Children and young people waiting for an ADHD Assessment		4832	150	162	163	590	469	423	1743	695	437	69	202
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		2199	40	38	33	112	200	275	303	1058	140	93	194

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)
Adults Waiting for EIP Treatment (2 week standard)		76	26	19	16	6	1	0	8	6	68*
Children & Young People Waiting for Eating Disorders Services - Urgent Referral (1 week standard)		2	0	0	2	0	0	0	0	3	4*
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		35	10	14	7	2	0	1	1	3	31*

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		3582	366	599	1148	541	640	288	13	54

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 **81 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 **22 weeks** in NYYSCG. The majority (81%) of adults 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 **13 weeks** in DTVFCG. The majority (91%) 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 **61 weeks** in NYYSCG. The majority (99%) of older adults are waiting less than 9 months for an assessment.
- **CYP** There is no significant change in the number waiting for an assessment. Our longest wait time is currently **136 weeks** in DTVFCG. The majority (78%) of children and young people 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 **326 weeks** in DTVFCG. The majority (65%) of children and young people are waiting between 1 and 9 months for treatment.

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 **341 weeks** (6.5 years) in DTVFCG. The majority (54%) 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 **275 weeks** (5.3 years) DTVFCG. The majority (56%) of adults are waiting between 1-3 years for an assessment.
- **CYP Autism** There is special cause concern (an increase) in the numbers waiting for an autism assessment. Our longest wait time is **210 weeks** (4 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 **202 weeks (3.9** years) in DTVFCG. The majority (50%) of children and young people are waiting between 1 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 **194 weeks** (3.7 years) in DTVFCG. The majority (48%) of children and young people are waiting between 2-3 years for an assessment.

National Waiting Times

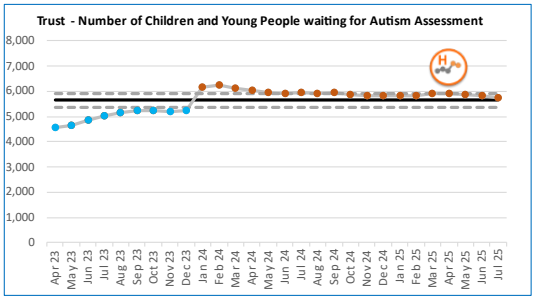
- **EIP** There is special cause improvement (a reduction) in the number of waiting for EIP Treatment. Our longest wait time is currently **6 weeks** in DTVFCG. The majority (59%) of adults are waiting less than 2 weeks for treatment
- **CED Urgent** There is no significant change in the number waiting from an urgent referral within our Eating Disorder Service. There are currently no children waiting for an urgent assessment. *See slide 67*
- **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 **10 weeks** in NYYSCG. The majority (69%) of children and young people are waiting less than 4 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 **54 weeks** in NYYSCG. The majority (81%) of adults are waiting between 4 and 28 weeks for their second appointment.

Waiting Times Neuro Services: Children & Young People

Tees, Esk and Wear Valleys NHS Foundation Trust

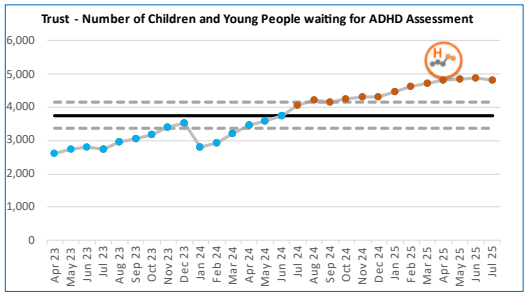


Children and young people waiting for an Autism Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	5737	78	210	
DTVF Care Group	4784	84	210	
NYY&S Care Group	953	47	128	

Commentary on Longest waits

DTVF: Data Quality - Specialist Assessment Commenced (longest genuine wait - 1467 days - specialist assessment booked)
NYY&S: Data Quality - Specialist Assessment Commenced (longest genuine wait - 867 days - specialist assessment booked)

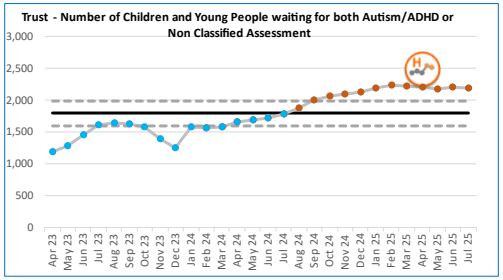


Children and young people waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4832	69	202	
DTVF Care Group	4029	74	202	
NYY&S Care Group	803	47	148	

Commentary on Longest waits

DTVF: Genuine Waiter - Specialist Assessment Required.
NYY&S: Data Quality - Specialist Assessment Commenced (longest genuine wait - 932 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	2199	93	194	
DTVF Care Group	1664	112	194	
NYY&S Care Group	535	34	107	

Commentary on Longest waits

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

Underlying issues:

- High levels of demand outweighing capacity
- Long wait times and projected waiting times in the County Durham areas.
- Long-term sickness absences within the York and Selby Neuro and Scarborough ADHD teams

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 further meeting with Trust and ICB Executives will take place on 20th June to progress. **(Complete)** *See below agreed action*
- A regional clinical model for neurodevelopmental services is to be progressed and 2 clinical prioritisation events will take place in July 2025 to develop the short and medium approach to reducing demand and improving access for assessments for both adults and children.
- Humber and North Yorkshire Health and Care Partnership Mental Health, Learning Disabilities and Autism Collaborative Programme Executive Strategic Leadership Group received a paper: “Age Autism and ADHD: Managing Risk and Potential Options” in June. This paper proposed several options including promotion of Right to Choose for everyone or £12m in new funding; none of which were approved as they are financially un-viable. Work therefore continues across the system regarding a pathway re-design. There is currently no date for completion.

Waiting Times Neuro Services: Children & Young People

Tees, Esk and Wear Valleys NHS Foundation Trust

Actions (Trust):

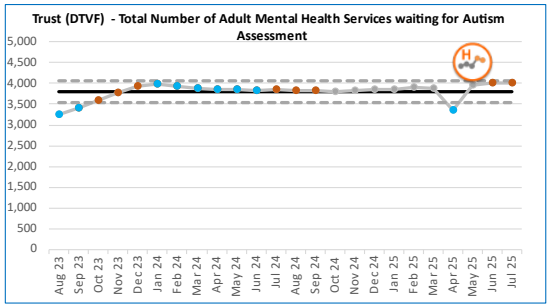
- DTVFCG have a recovery plan in place. Phase 2 testing on dual assessments continues in Darlington; however, this has been impacted by staff vacancies and leave, and the full evaluation of the clinical protocol is now due to be completed by the end of June 2025 (previously April 25). All actions within the recovery plan are progressing however demand currently continues to outweigh capacity. A meeting took place on 19th June with the Service Manager and Senior Leadership to review progress and agree next steps. **(Not Complete)** The meeting took place as arranged; however, the evaluation of the clinical protocol has been extended to the end of October 2025.
- A report with recommendations for York and Selby teams to manage their neuro waiters has been completed and will be shared with the Specialty Improvement Group in July 25.
- 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 July 2025 (previously June) and shared through governance meetings by end of August 2025. Whilst some improvement can be made, the demand outstrips the capacity of the service.

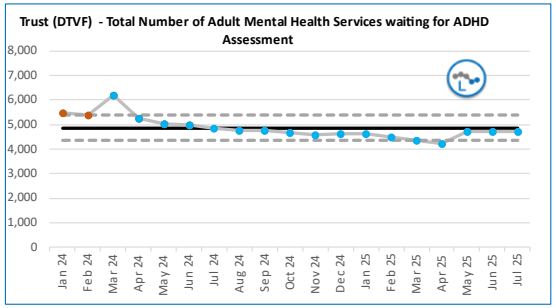
To Note: The trajectory submitted to NENC ICB, factoring in the additional assessments, remains on track for delivery.

Forecasts:	01/02/2025 Baseline	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
1) Do Nothing (on average 100 per month increase)		10,650	10,750	10,850	10,950	11,050	11,150	11,250	11,350	11,450	11,550	11,650	11,750	11,850	**11,950**
2) Factoring in the additional 20 assessments per month		10,650	10,730	10,830	10,930	11,030	11,130	11,230	11,330	11,430	11,530	11,630	11,730	11,830	**11,930**
Actual position	**10,550**	**10,649**	**10659**	**10616**	**10626**	**10477**									
Change		**99**	**10**	**-43**	**10**	**-149**									

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
)TVF Care Group)	3999	104	372	

Commentary on Longest waits

DTVF: Data Quality - Assessment Complete (longest genuine wait - 1927 - specialist assessment required)

Adults waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
t (DTVF Care Group)	4733	95	359	

Commentary on Longest waits

DTVF: Data Quality - Assessment Complete (longest genuine wait - 2386 - 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
- There are some data quality issues following the transfer of patients to the new neurodevelopmental teams.
- The recruitment of 4 additional staff to undertake extra assessments is not complete; 2 posts remain outstanding.

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 further meeting with Trust and ICB Executives will take place on 20th June to progress. **(Complete)** *See below agreed action*
- A regional clinical model for neurodevelopmental services is to be progressed and 2 clinical prioritisation events will take place in July 2025 to develop the short and medium approach to reducing demand and improving access for assessments for both adults and children.
- The Trust are undertaking work with the ICB at a regional level with some recurrent funds (for ADHD). Staff have been recruited and will be embedded into the central ADHD team to undertake assessments. **(Complete)**

Actions (Trust):

- 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. **(Not Complete)**
- General Manager to identify improvements within community services to increase assessments from September 2025.

Waiting Times Neuro Services: Adult Services

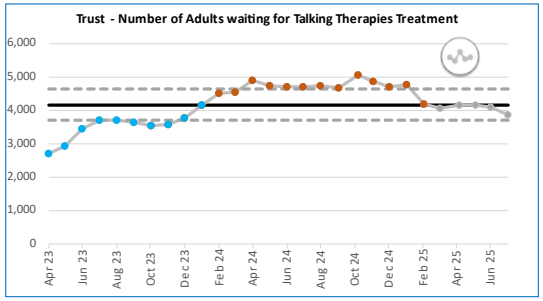
Tees, Esk and Wear Valleys NHS Foundation Trust

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

Forecasts:	01/02/2025 Baseline	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
1) Do Nothing		4,435	4,374	4,313	4,252	4,191	4,130	4,069	4,008	3,947	3,886	3,825	3,764	3,703	**3,642**
2) Factoring in the additional 40 assessments per month		4,435	4,334	4,273	4,212	4,151	4,090	4,029	3,968	3,907	3,846	3,785	3,724	3,663	**3,602**
Actual position	**4,496**	**4379**	**4236**	**4711**	**4735**	**4733**									
Change		**-117**	**-143**	**475**	**24**	**-2**									

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	3582	13	54	
DTVF Care Group	1789	12	48	
NYY&S Care Group	1793	14	54	

Commentary on Longest waits

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

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
- Counselling for Depression demand exceeds capacity
- Sickness is resulting in caseloads being reallocated or added back to the waiting list which is impacting on recovery, improvement and wait times

Underlying issues (NYYSCG):

- Underfunding within Step 2 and Step 3
- Reduced staffing capacity due x 3.8 Psychological Wellbeing Practitioner (PWP) posts becoming vacant impacting Step 2 waiting time.

Actions (Trustwide)

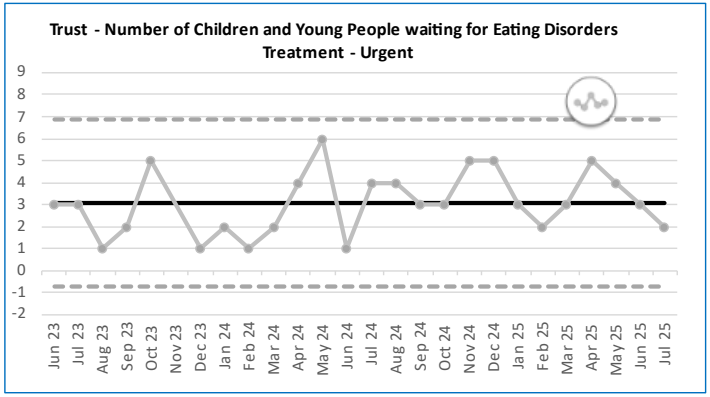
- The Trust-wide action plan will be monitored through the Trust-wide Talking Therapies Group which will be relaunched in July, sharing quarterly updates with Care Group and Executive Directors Group commencing in August 2025.

Actions (NYYSCG)

- One PWP post has been recruited and is anticipated to be in post in September 25 and one PWP is expected to return from a career break in October 2025. Further recruitment is currently on hold pending the qualification of the current PWP trainee cohort. Overtime has been offered to PWPs within York and North Yorkshire talking Therapy services however uptake is minimal (1/2 day per week).

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	2	3	4	
DTVF Care Group	1	3	3	
NYY&S Care Group	1	4	4	

DTVF: Data Quality - Treatment commenced (there are no patients genuinely waiting).
NYY&S: Data Quality - Treatment commenced (there are no patients genuinely waiting).

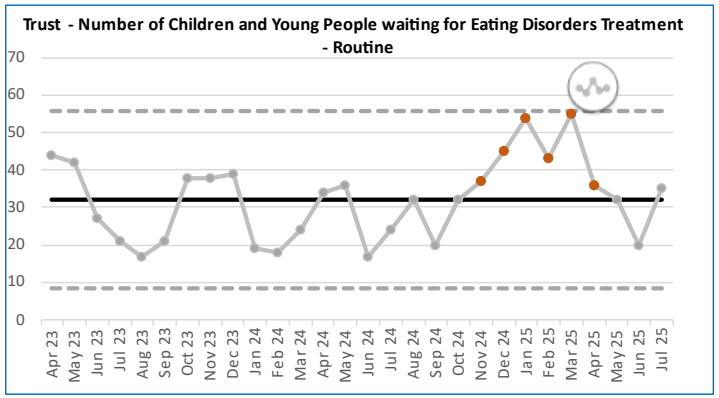
Summary:
There are 2 children and young people **reported** as waiting more than 1 week; however, **neither** of these are genuine waits as these are attributable to data quality

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 referral

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	35	3	31	
DTVF Care Group	23	2	5	
NYY&S Care Group	12	5	31	

DTVF: Genuine Wait - Treatment Appointment Booked
NYY&S: Data Quality - Treatment Commenced (longest genuine wait - 70 days - treatment not yet commenced)

Summary:
There are 4 children and young people **reported** as waiting more than 4 weeks; however, only **2** of these are genuine waiters:

- 1 patient (6 weeks) was not brought to 2 appointments in June (within 4 weeks) and declined a further offer. An appointment is booked in July.
- 1 patient failed to attend several appointments (within 4 weeks). An appointment was attended in June; however further assessment is necessary to establish treatment. The service are in process of re-booking this appointment following failure to attend a further session.

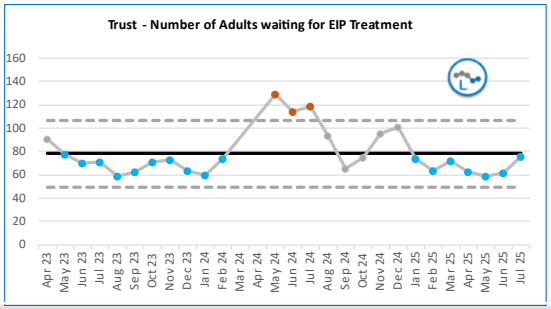
Of the remaining 2 patients:
- 1 patient has been assessed (within 2 weeks) and the service is not suitable for their needs; they are in the process of being discharged from the service.
- the remaining is attributable to data quality

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	76	6	68	
DTVF Care Group	58	4	51	
NYY&S Care Group	18	14	68	

Commentary on Longest waits

DTVF: Data Quality - Incorrect Referral Reason. (Longest genuine Wait - 42 days - Treatment appointment booked).
NYY&S: Data Quality - Incorrect Referral Reason. (Longest genuine Wait - 22 days - Treatment appointment booked). .

Summary:
There are 31 adults **reported** as waiting more than 2 weeks of which **13** are genuine waits:

- 1 patient offered an appointment outside of 2 weeks due to delay in referral from non EIP team **(waiting 6 weeks)**. An appointment is now booked.
- 1 patient attended an appointment within 2 weeks; however, did not have a key worker allocated. The service is in the process of allocating a key worker.
- 5 patients failed to attend appointments that were offered within 2 weeks. New appointments are now booked.
- 1 patient failed to attend an appointment that was offered within 2 weeks. They have now been assessed; however did not have a key worker allocated. The service is in the process of allocating a key worker.
- 2 patients failed to attend appointments which were offered outside of 2 weeks due to delay in referral from non EIP teams. New appointments are now booked.
- 1 patient has been assessed (outside of 2 weeks due to delay in referral from non EIP) and has been placed on an extended pathway to establish the most suitable treatment option.
- 1 patient offered an appointment outside of 2 weeks due to the ward following the incorrect referral process. An appointment is now booked.
- 1 patient failed to respond to contact until day 8 and was offered an appointment outside of 2 weeks due to capacity. An appointment is now booked.

Of the remaining 18 patients:

- 2 patients failed to attend appointments and have subsequently informed the service they no longer require an assessment. The service are in the process of discharging these patients.
- 4 patients have been assessed however EIP treatment is not appropriate. The service are in the process of discharging these patients/transferring one to CMHT.
- 12 are attributable to data quality.

Underlying issues:

- Delays in referrals from non-EIP teams
- Delay in allocating key worker
- Cancelled/Failed Appointments

Actions:
DTVF AMH General Manager to review Patient Tracker List and issues identified in this report to support the identification of improvement actions by end of July 2025.

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

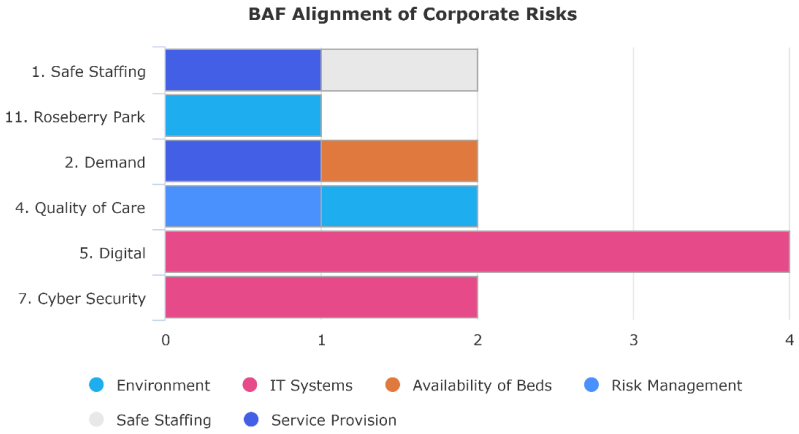
Meeting of:	**Board of Directors**
Date:	**14 August 2025**
Title:	**Corporate Risk Register**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**Kendra Marley, Head of Risk Management**

Report for:				
	Assurance	✓	Decision	
	Consultation		Information	

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

1: We will co-create high quality care	✓
2: We will be a great employer	✓
3: We will be a trusted partner	✓

Strategic Risks relating to this report:



EXECUTIVE SUMMARY:

Purpose:

To provide assurance to the Board over the management of risk and ensure oversight of organisational wide risks that are rated as high risk in the Corporate Risk Register.

Proposal:

The report provides good assurance over the risk management processes in place.

Overview:

This paper presents to the Board the risks on the Corporate Risk Register as of 1st August 2025, reflecting any movement and changes since 4th April 2025.

There are currently 13 risks on the Corporate Risk Register (was 11). 3 new risks added to the register as a result of increases in the current risk rating include:

- **Risk 1647, Digital and Data** - There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems. (increased from 10 to 15)
- **Risk 1642, Digital and data** - There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. (increased from 12 to 16)
- **Risk 1535, Digital & Data** - There is a risk that the organisation's will be unable to provide the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO) (increased from 12 to 16)

1 risk has been closed and a further 3 reduced, these remain on the Corporate Risk Register for review at the August Executive Risk Group.

Closed Risk:

- **Risk 1530 , Finance** - Finance risk relating to the trust financial position. This was reduced to 8 and then closed following the completion of the external audit review, with no changes to financial statements. A new risk has been created for 2025/26 performance requirements and is currently going through the governance approval processes.

Reduced Risks in the period:

- **Risk 1044, N&G** – Incidents that are more serious than initially reported are not identified within appropriate timescales. (reduced from 15 to 10)
- **Risk 1529, DTVF AMH -** Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards. (reduced from 16 to 12)
- **Risk 1137 – DTVF Management** - The current system (TEWVision) is unable to provide compliance and assurance of supervision. (Reduced from 16 to 12)

Existing risks of <15 remain on the register for Executive oversight:

- **Risk 909 - NYY Management** - risk relating to consultant recruitment, as although position improved in NYY, the strategic workforce review does highlight consultants as an area of risk. This risk will remain until a central risk relating to strategic workforce gaps is considered/added.
- **1646 – Digital and Data** – risk relating to cyber and our operational incident response, for ongoing monitoring in light of national and worldwide events.

Compliance with reviews

Risk review compliance for corporate risks remains at 100%. Actions across corporate risks are in place, with a total of 35 (increase of 5) current open actions across 13 risks, 2 of the actions (9%, previously 5/ 16%) are past their due (or planned revised completion) date.

Prior Consideration and Feedback:

All risks are considered at service level governance, Care Group Risk Group/ Directorate meetings and Executive Risk Group.

Implications:

Risks may impact on the delivery of individual services, patient safety and quality of care, and overall impact the achievement of the Trust strategic aims and objectives.

Recommendations:

The Board are asked to take good assurance over the risk management processes in place, the consideration of risks for addition to the Corporate Risk Register and the ongoing management of these risks.

Further Information

Report Title: Corporate Risk Register

1. Proposal

The report provides good assurance over the risk management processes in place.

2. Prior Consideration and Feedback

The Corporate Risk Register should be reflective of the highest risks affecting the organisation in the delivery of its objectives. It should also enable the Board, Committee's and Executive Sub-Groups to easily understand the highest risks that they need to be aware of. Corporate risks are aligned to strategic risks reflected on the Board Assurance Framework.

The Corporate Risk Register is reviewed and approved by the Executive Risk Group bi-monthly.

3. Commentary

This paper presents to the Group the ≥15 risks on the Corporate Risk Register as of 1st August 2025, reflecting any movement and changes from 4th April 2025.

3.1 Corporate Risk Register

There are currently 13 risks on the Corporate Risk Register (was 11).

3.2 Committee & Care Group Alignment

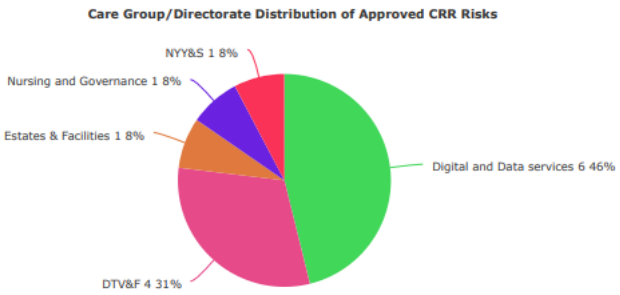
The current risks on the register align to the main Board Committees as shown in the following chart.

This shows that there are now

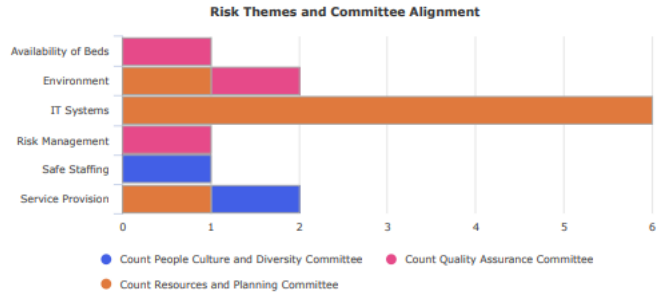
- 3 risks aligning to the Quality Assurance Committee
- 8 risks aligning to the Resources and Planning Committee
- 2 risks aligning to the People, Culture and Diversity Committee

There are currently no risks aligning to the Mental Health Legislation Committee.

Focussing on the Care Group and Directorate breakdown of the Corporate Risk Register shows us that 46% of the current Corporate Risk Register is made up of risks from Digital & Data Services, 31% Durham Tees Valley and Forensics Care Group, 27%, with North Yorkshire, York Care Group, Estates and Facilities, Nursing & Governance all at 8%.



3.3 Risk Themes



The 13 risks fall under the following themes within the Committee Alignment, with higher numbers of risks relating to IT Systems.

3.4 Risk Movements

The overall position of risks on the Corporate Risk Register is shown on the following Matrices.

The following key indicates the movement and Committee alignment.

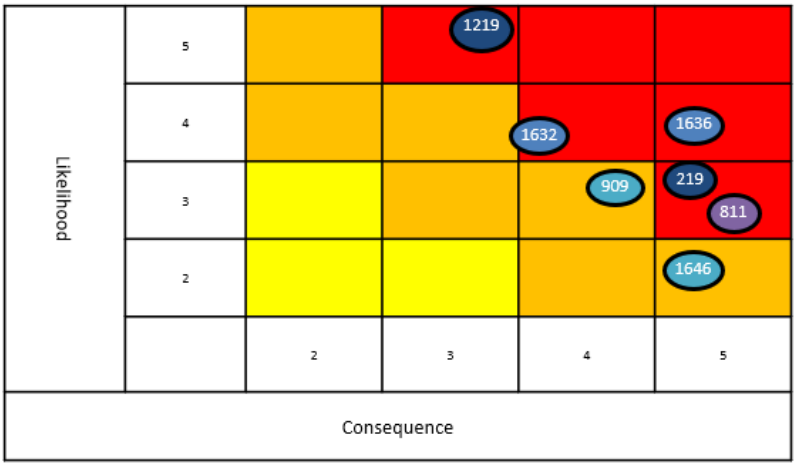
Outline – movement in period
- Black – static
- Green – reduced
- Red – increased

Inner colour Committee alignment
- Turquoise – People , Culture & Diversity
- Blue –Resources & Planning
- Purple – Quality Assurance

Risks with no movement in the period

The 7 risks on the register that remain static are shown on the following matrix.

Corporate risks at ≥15 remaining static in period

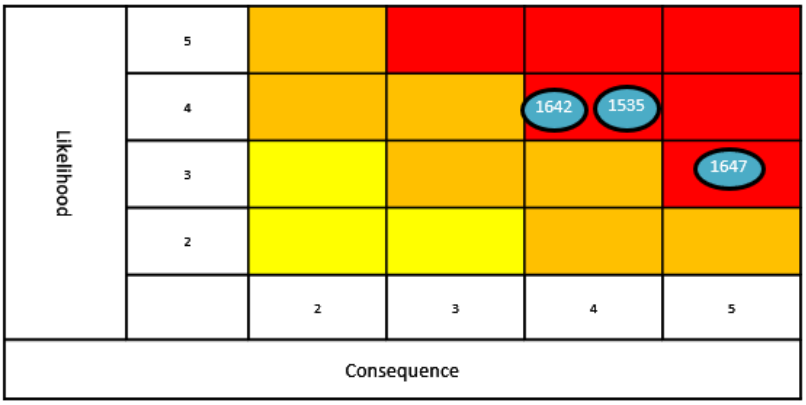


Risks are shown based on current risk rating

New risks added

3 new risks were added in the period. These were all existing risks that had been increased.

Risks added to Corporate Risk Register in the period



- **Risk 1647, Digital and Data** - There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems. (increased from 10 to 15)

Current risk rating has recently been increased (L to 3) as a result of the M&S & Boots cyber incidents.

- **Risk 1642, Digital and data** - There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. (increased from 12 to 16)

  Current risk rating increased following raising of a CG risk relating to this, resulting in discussion and agreement at Executive Risk Group that this risk should be raised and added to Corporate Risk Register.

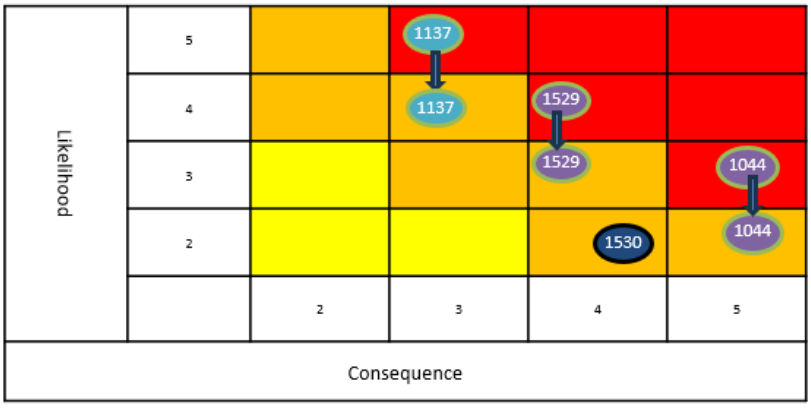
- **Risk 1535, Digital & Data** - There is a risk that the organisation's will be unable to provide the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO) (increased from 12 to 16)

  Duplicate capture of records identified in Cito, leading to secondary processing of MHCDS submission. Data error captured and reporting mitigated. Updated likelihood to a 4 on this basis.

Reduced and removed risks

3 risks were reduced and 1 risk was closed in the period.

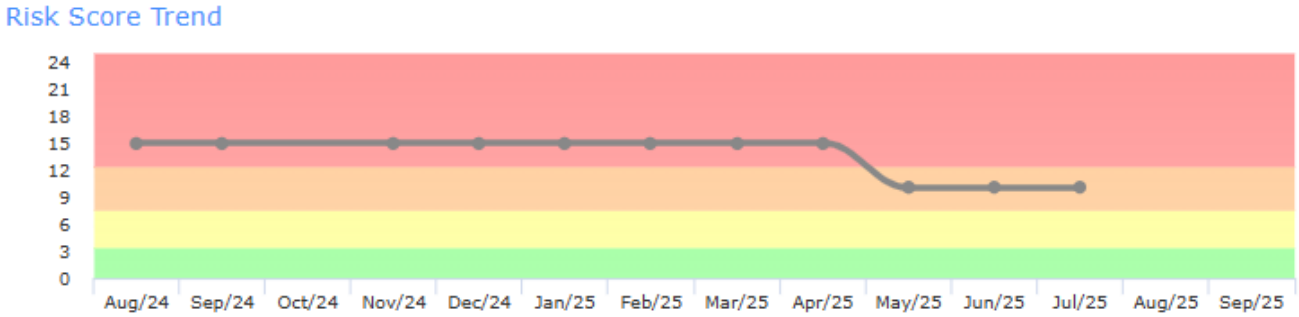
Risks closed/ replaced & reduced in the period



Reduced Risks

3 risks were reduced in the period:

Risk 1044, Nursing & Governance - Incidents that are more serious than initially reported are not identified within appropriate timescales. (reduced from 15 to 10)



Risk likelihood reduced from 3 to 2 (unlikely) following the confirmation of ongoing and sustained improvements in the review processes, training and ongoing quality improvement (QI) work.

The 4 day review of incidents from initial reporting is now much more consistent and the improvements made are being sustained. While there are still some areas of focus for improvement, these are being addressed, and scrutiny continues.

New e-learning training for incident recording and management went live in February 2025 and has risen from 40% compliance to 74% compliance.

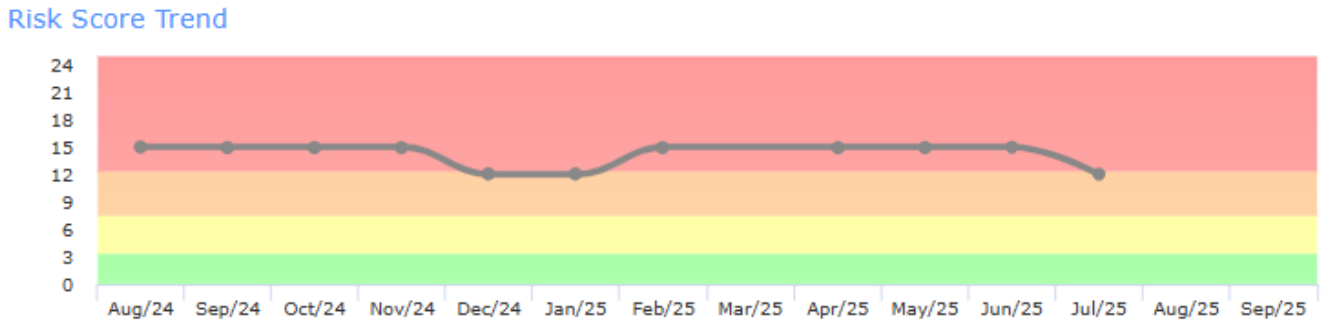
QI work on what is an incident, incident recording and review is ongoing and frequent discussion in quality and safety forums are driving improvements in review.

This risk has not materialised in the 18 months following the introduction of the new system, not withstanding that this was while introducing the new system and addressing a 2000 backlog from Datix as well as maintaining and managing current review and investigations.

Executive Risk Group Review – the group supported the reduction however triangulation of intelligence highlighted linked concerns over 4 day review and AAR timeliness. A new risk more appropriately reflecting this is to be considered/added, and in the meantime this will remain on the register for executive oversight.

Risk 1137 – DTVF Management - The current system (TEWVision) is unable to provide compliance and assurance of supervision. (Reduced from 16 to 12)

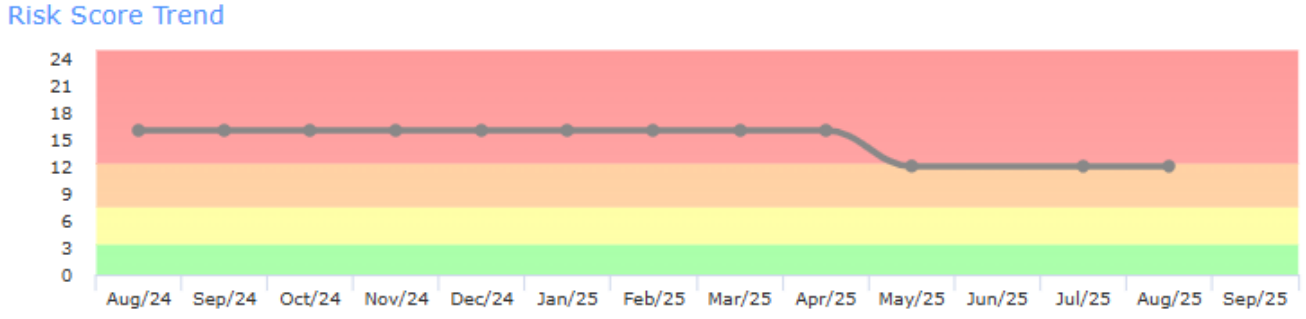
Full description - The current system (TEWVision) is unable to provide compliance and assurance of supervision. The Trust currently have limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care. Reliability is on team recordings as TEWVision is not performing assurance from the system. TEWVision is based on ESR and therefore individual teams need to be corrected to support the function. This will be monitored weekly at DTVF Q&P.



Rationale for Reduction - The current risk score has been reduced to 12 as some assurance is being received by TEWVision and manual evidence and recording by specialties is in place. The target risk score has also been reduced to 6.

This risk has only just been reduced so has not yet been to Executive Risk Group for review.

Risk 1529, DTVF AMH - Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards. (reduced from 16 to 12)



Rationale for reduction - although current number of reported CRFD patients across DTV AMH acute wards is 22, which is an increase of 4 compared to last risk review and 20 of those patients have a length of stay (LOS) of 90+ days, current risk score has been reduced following level of existing and new

mitigation now in place. A more structured approach to weekly LLOS meetings commenced in May-25 with supercell engagement and the appointment of a Patient Flow Manager to provide increased oversight and clinical management of patients CRFD across the LRH site has also been made.

This risk was considered by the Executive Risk Group in the May meeting as part of the detailed review, and while the rational for reduction was supported, sustained improvement was requested before removal from the Corporate Risk Register and an update requested in for the August meeting.

Executive Risk Group Review – the group supported the reduction however would like to see a sustained position before removal from the register.

The following risk was closed in the period:

Risk 1530, Finance - There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory breaches / interventions and / or adversely impact quality of services. (Current risk rating when closed – 8 (following reduction and review by the Executive Risk Group))

Rationale for closure - The external audit review has completed, with no changes to financial statements. A new risk has been created for 2025/26 performance requirements.

Executive Risk Group Review – the group supported the reduction and retention on the register until closure. The new risk will be added as it progresses through governance approval processes.

Risks below 15

The following risks remain for review by the Executive Risk Group on 4th August 2025.

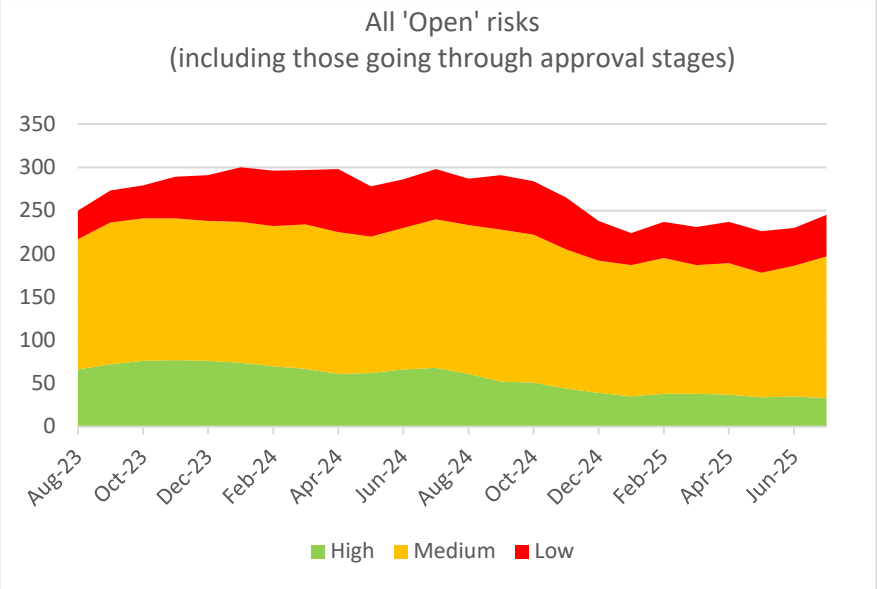
2 risks previously reduced and agreed to retain on the register for oversight,

- **Risk 909 - NYY Management** - risk relating to consultant recruitment, as although position improved in NYY, the strategic workforce review does highlight consultants as an area of risk. This risk will remain until a central risk relating to strategic workforce gaps is considered/added.
- **1646 – Digital and Data** – risk relating to cyber and our operational incident response, for ongoing monitoring in light of recent cyber events.

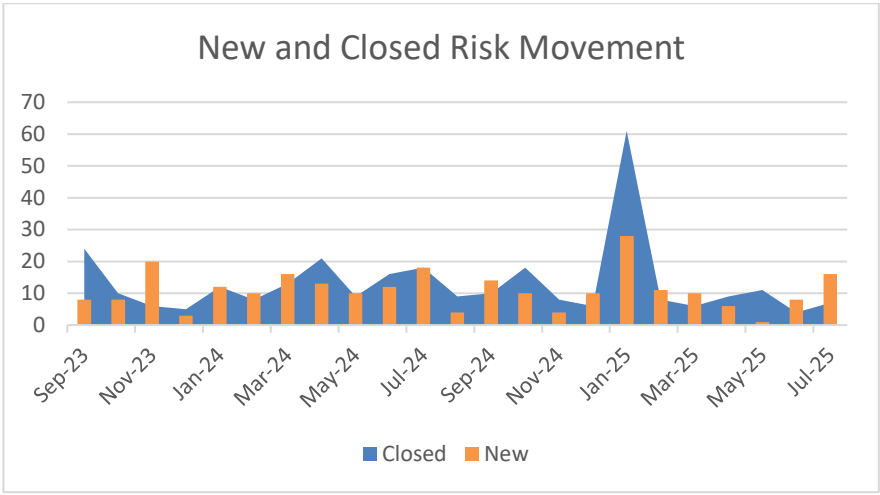
3.5 Detailed review of risks at ≥15 and changing risk profile

The new review process was agreed and a cycle of risk review within the Executive Risk Group will review risks grouped by BAF risk alignment to enable richer discussion of the related risks and cross Care Group/ Directorate controls and actions. This will also support assurance for the BAF risks themselves.

The increased focus, constructive challenge and support from executives to both actively manage and 'unblock' risks has resulted in improved timely risk review and reduction of many risks that were 'static' as demonstrated in the 'All Open risks' trend chart which shows the number of risks at 15 or above have significantly decreased in the past year.



The ongoing identification and successful mitigation and closure of risks is demonstrated in the 'New and Closed Risk Movement' chart, with a constant flow of new risks added each month. The spike in January 2025 related to a full review and overhaul of Digital and Data risks.



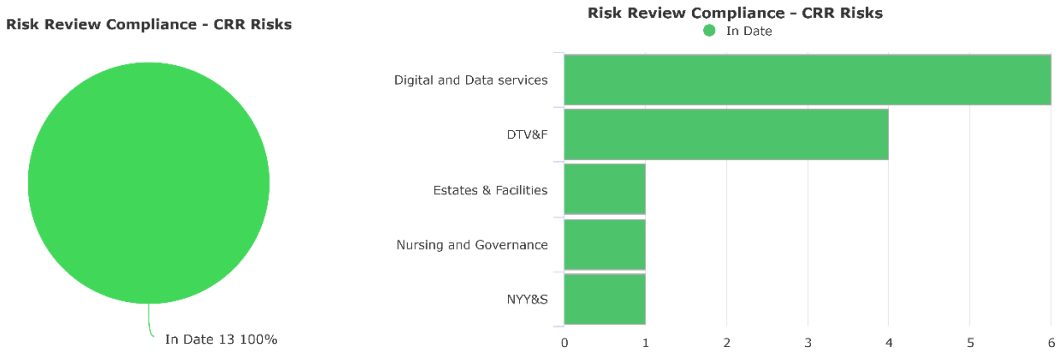
This years (2024/2025) Internal Audit of Risk Management and the Board Assurance framework provides substantial assurance and reflects year on year improvement over the last 2 years.

3.6 Risk and Action Review Compliance

The regular and timely review of risks as well as actions ensures that risk records are current, enabling demonstration of the effectiveness of controls and successful risk mitigation.

Risk Level	Review Frequency
15 or above	Monthly
12	Bi-Monthly
8 to 10	Quarterly

At the time of writing the paper the compliance of timely risk review for the Corporate Risk Register is 100% (previously 100%).



Actions across corporate risks are in place, with a total of 35 (increase of 5) current open actions across 13 risks, 2 of the actions (9%, previously 5/ 16%) are past their due (or planned revised completion) date.

Further information

A full risk register extract as well as individual Committee aligned extracts are provided as well as a breakdown by Committee at the end of this report. As development and improvements in the use and reporting from the risk register are made, additional data to provide further assurance will be visible. Control effectiveness is being introduced and will be reflected on reports as the process embeds.

4. Corporate Risk Register / Board Assurance Framework Review and Additions

The Executive Risk Group agreed a plan to combine the Board Assurance Framework quarterly risk review with the consideration and identification of underlying operational risks that would benefit from separate identification on the register and potentially be additions to the Corporate Risk register. The review and addition of BAF risks onto the risk register and into the BAF application on InPhase will enable wider discussion and identification of risks for addition.

Review and addition of the BAF risks and creation of an electronic BAF on InPhase is underway. This is being tested with BAF risk 1 – Safe Staffing, which is currently being updated on the electronic system during July, with a view to being used regularly by the People and Culture leadership team, to update controls and assurances and manage actions to test the ease of use of the reports developed and the benefits of using the system.

The initial report views are being kept familiar, aimed at reflecting the word documents where possible to make transition easier. Advice will also be sought from Internal Audit so as not to lose any progress made over the last couple of years and to ensure we maintain our substantial assurance rating.

5. Conclusions

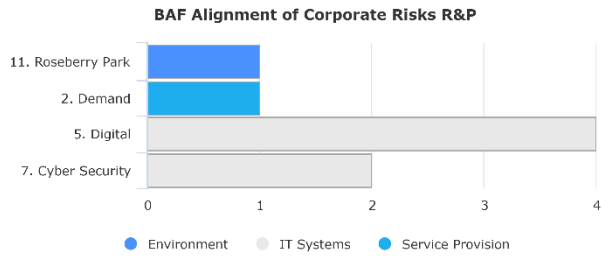
Governance meetings are being undertaken in line with policy and risks reviewed, and ongoing cyclic process of detailed review in Executive Risk Group. This is having a positive impact on risk review and increased information within risks. While more detailed work is needed on some of the current risks as controls and assurances are not fully reflected and actions are overdue, this work will continue to progress and improve capture and update.

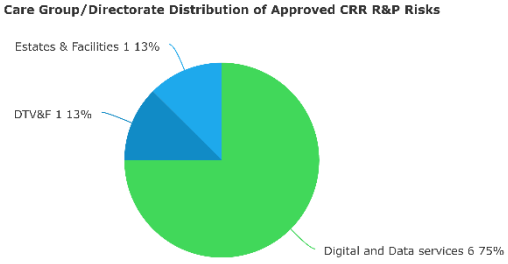
Compliance with review of corporate risks this month remains at 100%, and action compliance is improving with only 9% now showing overdue.

6. Recommendations

The Board Committees, Executive Director Group and Care Group Board and Sub-Groups are asked to take good assurance over the risk management processes in place, the consideration of risks for addition to the Corporate Risk Register and the ongoing management of these risks.

Resources and Planning Aligned Risks





3 risks were added to the Corporate Risk Register following review by the Executive Risk Group, these include:

- **Risk 1647, Digital and Data** - There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems.

  Current risk rating has recently been increased (L to 3) as a result of the M&S & Boots cyber incidents.
- **Risk 1642, Digital and data** - There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. (increased from 12 to 16)

  Current risk rating increased following raising of a CG risk relating to this, resulting in discussion and agreement at Executive Risk Group that this risk should be raised and added to Corporate Risk Register.
- **Risk 1535, Digital & Data** - There is a risk that the organisation's will be unable to provide the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO) (increased from 12 to 16)

  Duplicate capture of records identified in Cito, leading to secondary processing of MHCDS submission. Data error captured and reporting mitigated. Updated likelihood to a 4 on this basis.

The current summary of the register is shown below

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	31 Jul 2025 Control Effectiveness Current	Control Effectiveness Target	RMO3 Risk Rating Current	RMO3 Risk Rating Target
Risk 00000219	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	08 Sep 2016	25/07/2025	Simon Adamson	15		Phase 2 rectification works			15	10
Risk 00001219	Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments, leading to increased demand on specialist and urgent care services and poor patient experience.	01 Apr 2021	30/07/2025	Jamie Todd	16	▪ Activity levels and outputs ▪ Capacity and demand ▪ Capacity and demand work ▪ Clinical prioritisation ▪ Closely monitoring the changing picture nationally re ADHD meds supply. ▪ KiT processes ▪ PTLs ▪ Support whilst waiting and signposting	▪ Undertake impact assessment to prioritise cases for assessment within core GMH teams. ▪ Process of transition from Neuro Ass WL to current GMH to complete Neuro Assessment. ▪ ICB independent sector capacity for longest waiters across the region			15	6
Risk 00001535	There is a risk that the organisation's will be unable to provide the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO) which could lead to legal, compliance or financial action against the Trust through the inability to meet contractual obligations including CQC regulatory frameworks.	25 Mar 2024	31/07/2025	Brian Cole	16	▪ Logging of developments onto Cito backlog ▪ R153S ▪ R153S - Validation prior to submission of MHSDS	▪ Produce developmer plan for the IIC and/c Cito to address the g in data provision ▪ Review of all gaps in provision vs. Cito Stabilisation/Improv Programme delivera			16	4
Risk 00001632	There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers.	13 Jan 2025	31/07/2025	Lorraine Sellers	20	▪ Cito Stabilisationa and Improvement Project active ▪ Service desk ▪ Shared issue resolution plan ▪ Staff usability survey completed ▪ System speed issues addressed	▪ R1632 - Cito benefits realisation ▪ R1632 - Data Retention/Saving Requirements ▪ R1632 - Clinical change/ engagemen tasks to support end users ▪ R1632 - Clarify and reinforce documentation requirements ▪ R1632 - Performance/stabilit management			16	8
Risk 00001636	There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity.	15 Jan 2025	31/07/2025	Nick Black	25	▪ Access to Great North Care Record an Yorkshire Care Record ▪ Cito training mandated for new starters from 1 Jan 2025 ▪ Data migration (documents) completed ▪ Robust test scripts developed ▪ Speed issues with the system resolved ▪ Stabilisation programme in place for release management ▪ Standard Operating Procedures in place ▪ User confidence training underway ▪ User guides updated	▪ R1636 Compete data rectification ▪ R1636 Delivery bug fixes - R3 ▪ R1636 Enhance automated testing ▪ R1636 Delivery bug fixes - R4 ▪ R1636 Cito Improvement Programme ▪ R1636 Develop and publish team based data quality reports	Substantial	Substantial	20	10
Risk 00001642	There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. Including UPS, Network, Servers Links to KPIs that will be reported through DPAG	16 Jan 2025	14/07/2025	Steven Forster	20		▪ Capital Plan (Digital) ▪ Complete installation of Wi-Fi at all priority sites.			16	6
Risk 00001646	There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery.	17 Jan 2025	31/07/2025	Nick Black	25	▪ Cyber security assurance audit CIS controls - Advisory audit ▪ DSPT 2025/26 submission ▪ MDE secure score ▪ Privileged Access Controls	▪ Deploy Privileged Access Management solution - Supply chain ▪ CAF - Define essential functions			10	5
Risk 00001647	There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	17 Jan 2025	31/07/2025	Steven Forster	25	▪ Continuous patching ▪ Lease privilege and Multi Factor access ▪ Network & Perimeter security ▪ Regular scanning	▪ TEWV secure boundary tenant utilised for all internet traffic ▪ Privileged access management ▪ Vulnerability scanning of non-MDE hosts ▪ SIEM delivery			15	5

Current Risk Rating Movements

The following table shows the current risk rating at each month across the last year. Where there is no rating shown, this means a review was not undertaken in the period. Note that while the last period shows to the end of the current month, it reflects updates to the date of the report. All risks are within review dates. The risk closed was 1530, Finance, Delivery of the financial plan (8) following completion of the external audit. The 1 risk remaining below 15 is 1646, Digital, cyber response (10).

CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	31 Aug 2024	30 Sep 2024	31 Oct 2024	30 Nov 2024	31 Dec 2024	31 Jan 2025	28 Feb 2025	31 Mar 2025	30 Apr 2025	31 May 2025	30 Jun 2025	31 Jul 2025
Resources and Planning Committee	Risk 00000219	Risk of a H&S incident at Roseberry park Hospital	Actual	15	15	15	15	15		15	15	15	15	15	15
	Risk 00001219	CAMHS Neurodevelopmental assessment pathway	Actual	15	9	15		15		15	15	15	15	15	15
	Risk 00001535	There is a risk that the organisation's will be unable to provide the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording	Actual	16	16	16	16	16	12	16	12	12	16	16	16
	Risk 00001632	Risk that CITO benefits are not realised	Actual	n/r	n/r	n/r	n/r	n/r	16			16	16		16
	Risk 00001636	Incomplete or inaccurate patient record displayed on Cito	Actual	n/r	n/r	n/r	n/r	n/r	20	20		20	20	20	
	Risk 00001642	TEWV Critical digital network infrastructure failure	Actual	n/r	n/r	n/r	n/r	n/r	12	12	12	12	16		
	Risk 00001646	Cyber and operational incident response gaps	Actual	n/r	n/r	n/r	n/r	n/r	10	10	10	10	10		10
	Risk 00001647	Cyber security vulnerbilities	Actual	n/r	n/r	n/r	n/r	n/r	10	15	10	10	15		15

The following table shows all current actions related to these risks. 2 are showing overdue planned due dates.

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completion Date	Owner	Percentage Complete	30/06/25	31/07/25	31/08/25	30/09/25	31/10/25
Risk 00000219	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	Phase 2 rectification works	18 Sep 2026	18 Sep 2026	Simon Adamson	5%					
Risk 00001219	Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments, leading to increased demand on specialist and urgent care services and poor patient experience.	ICB independent sector capacity for longest waiters across the region	31 Mar 2026	31 Mar 2026	Claire Farley	0%					
		Process of transition from Neuro Ass WL to current GMH to complete Neuro Assessment.	22 Sep 2025	18 Aug 2025	Claire Farley	0%					
		Undertake impact assessment to prioritise cases for assessment within core GMH teams.	31 Dec 2024	19 Sep 2024	Mita Saha	25%					
Risk 00001535	There is a risk that the organisation's will be unable to provide the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO) which could lead to legal, compliance or financial action against the Trust through the inability to meet contractual obligations including CQC regulatory frameworks.	Produce development plan for the IIC and/or Cito to address the gaps in data provision	30 Jun 2025	29 Aug 2025	Brian Cole	0%					
		Review of all gaps in data provision vs. Cito Stabilisation/Improvement Programme deliverables	31 May 2025	29 Aug 2025	Brian Cole	0%					
Risk 00001632	There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers.	R1632 - Cito benefits realisation	01 Jan 2026	31 Dec 2025	Jo Turner	0%					
		R1632 - Clarify and reinforce documentation requirements	30 Sep 2025	30 Sep 2025	Gemma Pickering	50%					
		R1632 - Clinical change/ engagement tasks to support end users	29 Aug 2025	29 Aug 2025	Gemma Pickering	40%					
		R1632 - Data Retention/Saving Requirements	31 Dec 2025	31 Dec 2025	Andrea Shotton	20%					
		R1632 - Performance/stability management	29 Aug 2025	29 Aug 2025	Vianne Chapman	25%					
Risk 00001636	There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity.	R1636 Cito Improvement Programme	16 Jan 2026	27 Feb 2026	Gemma Pickering	0%					
		R1636 Compete data rectification	29 Aug 2025	29 Aug 2025	Vianne Chapman	5%					
		R1636 Delivery bug fixes - R3	29 Aug 2025	29 Aug 2025	Vianne Chapman	75%					
		R1636 Delivery bug fixes - R4	04 Apr 2025	31 Aug 2025	Vianne Chapman	0%					
		R1636 Develop and publish team based data quality reports	31 Mar 2025	31 Mar 2025	Brian Cole	0%					
		R1636 Enhance automated testing	29 Aug 2025	29 Aug 2025	Vianne Chapman	25%					
Risk 00001642	▪ There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. ▪ ▪ Including UPS, Network, Servers ▪ Links to KPIs that will be reported through DPAG	Complete installation of Wi-Fi at all priority sites.	11 Mar 2026	11 Mar 2026	Dale Hopper	0%					
Risk 00001646	There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery.	CAF - Define essential functions	03 Jul 2025	29 Aug 2025	Steven Forster	40%					
		Deploy Privileged Access Management solution - Supply chain	01 May 2025	28 Nov 2025	Steven Forster	15%					
Risk 00001647	▪ There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. ▪ ▪ Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	Privileged access management	01 Aug 2025	01 Dec 2025	Fayraz Hussain	15%					
		SIEM delivery	31 Mar 2027	31 Mar 2027	Steven Forster	0%					
		TEWV secure boundary tenant utilised for all internet traffic	01 Aug 2025	31 Oct 2025	Fayraz Hussain	20%					
		Vulnerability scanning of non-MDE hosts	31 Aug 2025	31 Aug 2025	Michael Fincken	0%					
▪ Risk 0000168 ▪ Risk 0000164	▪ Risk 00001642: There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. ▪ ▪ Including UPS, Network, Servers ▪ Links to KPIs that will be reported through DPAG ▪ Risk 00001680: There is a risk of lack of sufficient new / updated laptops and PC's as a result of loss of capital funds in 2025/26. This could result in the inability to	Capital Plan (Digital)	31 Oct 2025	31 Oct 2025	Steven Forster	25%					

Summary of risks

Risk 219 – Estates and Facilities - There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.

Owner – Simon Adamson

Initial rating 15 (C5, L3), Current Rating 15 (C5, L3), Target Rating 4 (C5, L2), Date to reduce risk 6 January 2032.

Risk Review – in date, Action Delivery – 1 action ongoing – in date.

Assurance – Reasonable Assurance – A review to change this risk to reflect a subset of risks which are contained within this instead of a broad H&S risk is still being considered. This is to enable a way to visibly monitor individual risks as some could be reduced and would show progress to date.

Risk 1219 – DTVF CAMHS - There is a risk that young people being referred for specialist neurodevelopmental assessment face unacceptable waits for commencement and conclusion due to a significant increase in referral demand post-pandemic and exacerbated by the backlogs created during the national lockdowns; resulting in a dissatisfactory experience for families, complaints, knock on effect of long waits for diagnosis-specific support, & reputational damage for TEWV.

Owner – Jamie Todd

Initial rating 16 (C4, L4), Current Rating 15 (C3, L5), Target Rating 8 (C2, L3), Date to reduce risk 31 March 2026. Extended from March 2025 as work continues with system partners.

Risk Review – in date, Action Delivery – 3 actions ongoing – 1 overdue

Assurance – Reasonable Assurance – the risk has been reviewed and controls are reflected in the risk, the action does require update and this is being reviewed. This risk was subject to detailed review in Executive Risk Group in May 2025.

Risk 1535 – Digital and Data - There is a risk that the organisation's will be unable to provide the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO) (current rating 16)

Owner – Brian Cole

Initial rating 16 (C4, L4), Current Rating 16 (C4, L4), Target Rating 4 (C4, L1), Date to reduce risk 30 September 2027.

Risk Review – in date, Action Delivery – 2 current actions, in date.

Assurance – Reasonable Assurance – the entry requires strengthening with sources of assurance, details of assurance and effectiveness of controls, and actions, however this replaced another risk as Digital and Data work through full update so completion is expected as this progresses.

Risk 1632 – Digital and Data - There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers. (current rating 16)

Owner – Nick Black

Initial rating 20 (C4, L5), Current Rating 16 (C4, L4), Target Rating 8 (C4, L2), Date to reduce risk 22 October 2026.

Risk Review – in date, Action Delivery – 5 actions ongoing, in date.

Assurance – Reasonable Assurance – the entry requires strengthening with sources of assurance, details of assurance and effectiveness of controls.

Risk 1636 – Digital and Data - There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity. (current rating 20)

Owner – Nick Black

Initial rating 25 (C5, L5), Current Rating 20 (C5, L4), Target Rating 10 (C5, L2), Date to reduce risk 22nd April 2026.

Risk Review – in date, Action Delivery – 6 actions underway, 1 overdue.

Assurance – Reasonable Assurance – controls effectiveness are beginning to be reflected.

Risk 1642 – Digital and Data - There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. (current rating 16)

Owner – Steven Forster

Initial rating 20 (C4, L5), Current Rating 16 (C4, L4), Target Rating 6 (C3, L2), Date to reduce risk 1 March 2027.

Risk Review – in date, Action Delivery – 2 current actions, in date.

Assurance – Reasonable Assurance – the entry requires strengthening with sources of assurance, details of assurance and effectiveness of controls, and actions, however this replaced another risk as Digital and Data work through full update so completion is expected as this progresses.

Risk 1646 – Digital and Data - There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. (10)

Owner – Nick Black

Initial rating 15 (C5, L3), Current Rating 10 (C5, L2), Target Rating 4 (C5, L1), Date to reduce risk 30 November 2028.

Risk Review – in date, Action Delivery – 2 actions in place, in date.

Assurance – Reasonable Assurance – this risk has been updated to reflect controls in place, assurance sources (although not yet assurances and control evaluation) and actions have been added.

Risk 1647 – Digital and Data - There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems. (current rating 15)

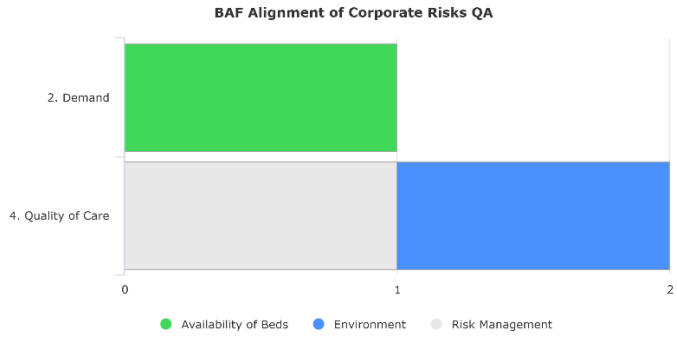
Owner – Steven Forster

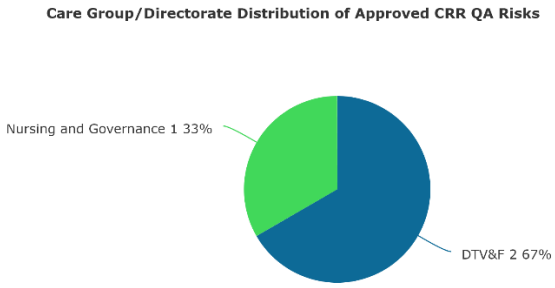
Initial rating 25 (C5, L5), Current Rating 15 (C5, L3), Target Rating 5 (C5, L1), Date to reduce risk 30 November 2028

Risk Review – in date, Action Delivery – 4 actions added, in date.

Assurance – Reasonable Assurance – the entry requires strengthening with sources of assurance, details of assurance and effectiveness of controls, although actions have now been added. This replaced another risk as Digital and Data work through full update so full completion is expected as this progresses.

Quality Assurance Aligned Risks





The current summary of the register is shown below

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	31 Jul 2025			
								Control Effectiveness		RM03 Risk Rating	
								Actual	Target	Actual	Target
Risk 00000811	There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of potential ligature points and access to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation.	01 Jun 2020	01/07/2025	Naomi Lonergan	20		R903 - Phase 3 delivery			15	10
Risk 00001044	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	08 Aug 2022	01/07/2025	Rachel Weddle	20	▪ INC - Patient Safety Huddle Daily - reviews moderate and above incidents ▪ Staff understand the initial review process and timelines	R1044 - QI work on operational management and governance of incidents from ward to board	Good		10	5
Risk 00001529	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	29 May 2024	01/08/2025	Shaun McKenna	20	▪ Incident Data ▪ Patient Flow Work ▪ Performance reporting	▪ Develop the "Transforming Mental Health Discharge" workstream ▪ Develop Patient Flow Transformation workstream ▪ Weekly LLOS Meetings ▪ Evaluation of Pilot ▪ Develop an electronic live visual bed state in conjunction with IT	Good	Good	12	9

Current Risk Rating Movements

The following table below shows the current risk rating at each month across the last year. Where there is no rating shown, this means a review was not undertaken in the period. Note that while the last period shows to the end of the current month, it reflects updates to the date of the report. Risks 1044 and 1529 have been reduced in the period.

CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	31 Aug 2024	30 Sep 2024	31 Oct 2024	30 Nov 2024	31 Dec 2024	31 Jan 2025	28 Feb 2025	31 Mar 2025	30 Apr 2025	31 May 2025	30 Jun 2025	31 Jul 2025
Quality Assurance Committee	Risk 00000811	Patients may attempt suicide using potential ligature points within clinical areas	Actual	15	15	15		15		15	15	15	15		15
	Risk 00001044	Incidents that are more serious than initially reported are not identified within appropriate timescales	Actual	15	15		15	15	15	15	15	15	10	10	10
	Risk 00001529	Risk if increased length of stay across AMH acute wards	Actual	16	16	16	16	16	16	16	16	16	12		12

The below table shows the actions ongoing in relation to the risks, all are in date.

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completio Date	Owner	Percentage Complete	30/06/25	31/07/25	31/08/25	30/09/25	31/10/25
Risk 00000811	▪ There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of potential ligature points and access to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation. ▪	R903 - Phase 3 delivery	30 Sep 2025	30 Sep 2025	Simon Adamson	50%					
Risk 00001044	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	R1044 - QI work on operational management and governance of incidents from ward to board	30 Sep 2025	30 Sep 2025	Kendra Marley	65%					
Risk 00001529	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	Develop an electronic live visual bed state in conjunction with IT and our digital journey to change	30 Nov 2025	30 Nov 2025	Shaun McKenna	0%					
		Develop Patient Flow Transformation workstream	31 Mar 2026	31 Mar 2026	Shaun McKenna	0%					
		Develop the "Transforming Mental Health Discharge" workstream	31 Mar 2026	31 Mar 2026	Shaun McKenna	0%					
		Evaluation of Pilot	31 Jul 2025	31 Jul 2025	Polly Mennell	0%					
		Weekly LLOS Meetings	30 Sep 2025	30 Sep 2025	Polly Mennell	0%					

Summary of risks

Risk 811 – EFM Estates - There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of potential ligature points and access to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation.

Owner – Naomi Longergan

Initial rating 20 (C5, L4), Current Rating 15 (C5, L3), Target Rating 10 (C5, L2), Date to reduce risk 30 September 2025.

Risk Review – in date, Action Delivery – 1 action ongoing, in date.

Assurance – Reasonable Assurance – while it is clear that work on the ligature reduction programme progresses the risk does not reflect progress and requires update. The current controls and management as well as actions are discussed regularly in the Environmental Risk Group, and the risk has been transferred to enable operational input and focus. This risk review and update needs further input to fully reflect the risk and controls and assurances in place.

Risk 1044 – N&G Quality Governance - There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.
Owner – Rachel Weddle

Initial rating 20 (C5, L4), Current Rating 10 (C5, L2), Target Rating 5 (C5, L1) (was 10 - reduced July 2025), Date to reduce 31 March 2026. Target reset following achieving initial target of 10 in May 2025, further work on processes to reduce to 5 by 31/03/2026.

Risk Review – in date, Action Delivery – 1 action ongoing, in date.

Assurance – Good Assurance – the risk has been updated and includes detail of progress made. While central controls are effective, local review management needs strengthening, and numbers of unreviewed incidents need to be further improved and sustained.

This risk is to remain on the Corporate Risk Register at present, and while reduced, there remain some negative assurances coming through over the timeliness of initial review and timely completion of the After Action Reviews. While linked to this risk, a new risk is to be added to comprehensively reflect the risk of 'repeat' safety incidents due to lack of timely incident review and management and embedding of learning, resulting in preventable harm to patients or staff.

Risk 1529 – DTVF AMH - Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.

Owner – Jamie Todd

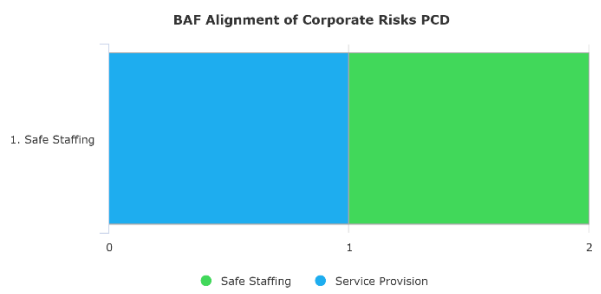
Initial rating 16 (C4, L4), Current Rating 12 (C3, L4), Target Rating 9 (C3, L3), Date to reduce risk – 31 March 2026. Date revised from June 2025, reduced in May 2025 to 12, but not yet to target, and further work ongoing with partners.

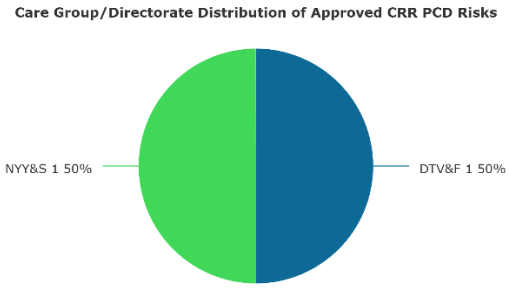
Risk Review – in date, Action Delivery – 5 actions now identified and ongoing, in date.

Assurance – Reasonable Assurance – There has been considerable work to update the risk to reflect controls and assurances in place as well as identify all actions to be undertaken.

This risk was subject to detailed review in Executive Risk Group in May 2025.

People, Culture & Diversity Aligned Risks





The current summary of the register is shown below

Risk 909 remains below 15.

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	31 Jul 2025 Control Effectiveness Actual	Control Effectiveness Target	RM03 Risk Rating Actual	RM03 Risk Rating Target
Risk 00000909	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	20 Oct 2020	01/08/2025	Parthipan Sivaraman	20	▪ Employment of international fellowship Doctors to fil gaps and reduce locun mind the gaf ▪ Mind the Ga arrangement ▪ Retention of Existing Consultant workforce	R1001 - Develop non-medic colleague skills to ensure consistent service delivery	Substantia	Substantia	12	9
Risk 00001137	The current system (TEWVision) is unable to provide compliance and assurance of supervision. The Trust currently have limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care. Reliability is on team recordings as TEWVision is not performing assurance from the system. TEWVision is based on ESR and therefore individual teams need to be corrected to support the function. This will be monitored weekly at DTVF Q&P.	22 Mar 2022	30/07/2025	Jo Nadkarni	15	▪ Manual Recording Systems ▪ TEWVision	▪ Routine performance monitoring of clinical supervision compliance with TEWVision in specialties ▪ All ward team managers to be using the same clinical supervision recording system TEWVision	Limited		12	6

Current Risk Rating Movements

The table below shows the current risk rating at each month across the last year. Where there is no rating shown, this means a review was not undertaken in the period. Note that while the last period shows to the end of the current month, it reflects updates to the date of the report.

Risk 909 remains below 15 and risk 1137 has also been reduced this period

CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	31 Aug 2024	30 Sep 2024	31 Oct 2024	30 Nov 2024	31 Dec 2024	31 Jan 2025	28 Feb 2025	31 Mar 2025	30 Apr 2025	31 May 2025	30 Jun 2025	31 Jul 2025
People Culture and Diversity Committee	Risk 00000909	Inability to recruit to vacant consultant posts	Actual	16	16		16		16	16	12	12	12	12	
	Risk 00001137	The current system (TEWVision) is unable to provide compliance and assurance of supervision.	Actual	15	15	15	15	12	12	15		15	15	15	12

The following table shows current actions for the risks, all are now in date with 2 having been extended in relation to supervision, where the eventual development and transition to TEWVision has now meant that progress in being able to report and gain assurance has been developed and full transition of all teams and improvements in use and reporting are embedded.

Risk ID	Risk Description	Action Name	Due Date	Planned Completio Date	Owner	Percentage Complete	30/06/25	31/07/25	31/08/25	30/09/25	31/10/25
Risk 00000909	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	R1001 - Develop non-medic colleague skills to ensure consistent service delivery	31 Jul 2025	31 Jul 2025	Parthipan Sivaraman	90%					
Risk 00001137	▪ The current system (TEWVision) is unable to provide compliance and assurance of supervision. The Trust currently have limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care. ▪ ▪ Reliability is on team recordings as TEWVision is not performing assurance from the system. TEWVision is based on ESR and therefore individual teams need to be corrected to support the function. ▪ ▪ This will be monitored weekly at DTVF Q&P. ▪ ▪ ▪	All ward team managers to be using the same clinical supervision recording system TEWVision	01 Jan 2026	25 Feb 2027	Jo Nadkarni	45%					
		Routine performance monitoring of clinical supervision compliance with TEWVision in specialties	31 Oct 2025	27 Jan 2027	Jo Nadkarni	45%					

Summary of risks

Risk 909 – NYY Management - There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.

Owner – Parthipan Sivaraman

Initial rating 20 (C4, L5), Current Rating 12 (C4, L3), Target Rating 9 (C3, L3), Date to reduce risk - 30 September 2025.

Risk Review – in date, Action Delivery – 1 actions ongoing, in date.

Assurance – Good Assurance – Significant work is reflected and the risk reduced as a result of the improvements in recruitment.

Risk 1137 – DTVF Management - 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.

Owner - Jo Nadkarni

Initial rating 15 (C3, L5), Current Rating 15 (C3, L4), Target Rating 6 (C3, L2), Date to reduce risk 31 December 2025. (was April, risk reduced July 2025, new reduction date set based on current actions. New target rating also set)

Risk Review – In date, Action Delivery – 2 actions ongoing, 1 completed and 2 revised dates set due to system changes and ongoing development.

Assurance – Reasonable Assurance – controls are now being reflected and actions updated TEWVision progressing. Risk reduction reflects progress made, although significant work still to do.

Corporate Risk Register - Risk Overview

Please update these filters to ensure the report accurately reflects the current period.

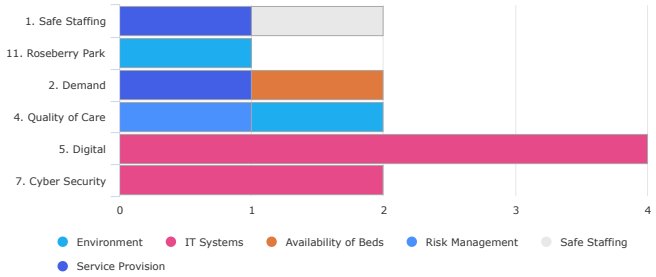
Date Added to CRR
View Date to View Date

Date Removed from CRR
View Date to View Date

Closed date
View Date to View Date

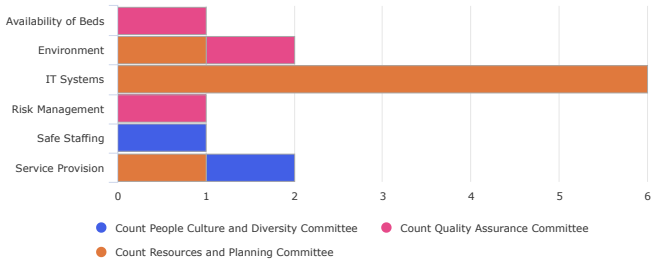
Risks on Corporate Risk Register	Risks Added	15+ removed from CRR	Risks Removed - Closed
13	8	96	1

BAF Alignment of Corporate Risks

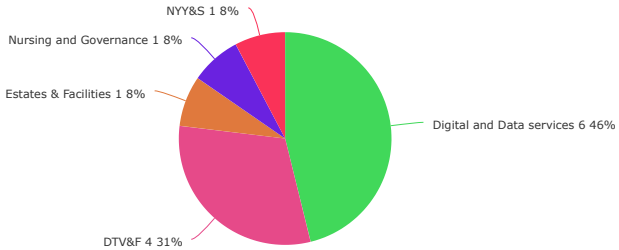


Committee Distribution of Corporate Risks

Risk Themes and Committee Alignment



Care Group/Directorate Distribution of Approved CRR Risks



Additions to the Corporate Risk Register

Committee Alignment	Risk Id	Legacy ID	Care Group/Directorat	Specialty/ Department	Date risk opened	Date Risk Review Due	Risk Owners	Description	Rating (Initial)	Rating (Current)	Rating (Target)	Value
People Culture and Diversity Committee	909	1001	NYY&S	NYY&S Manageme	17 Aug 2023	01 Sep 2025	Parthipan Sivaraman	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting	20	12	9	
	1137	1229	DTV&F	DTV&F - Manageme	17 Aug 2023	26 Sep 2025	Jo Nadkarni	The current system (TEWVision) is unable to provide compliance and assurance of supervision. The Trust currently have limited assurance that	15	12	6	
Quality Assurance Committee	811	903	DTV&F	DTV&F - Manageme	17 Aug 2023	08 Aug 2025	Naomi Lonergan	There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of	20	15	10	
	1044	1136	Nursing and Governance	N&G - Quality governance	17 Aug 2023	01 Sep 2025	Rachel Weddle	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely	20	10	5	
	1529		DTV&F	DTV&F - AMH	29 May 2024	30 Sep 2025	Shaun McKenna	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	20	12	9	
Resources and Planning Committee	219	295	Estates & Facilities	EFM - Estates	17 Aug 2023	22 Aug 2025	Simon Adamson	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	15	15	10	
	1219	1311	DTV&F	DTV&F - CAMHS	17 Aug 2023	30 Aug 2025	Jamie Todd	Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments,	16	15	6	
	1535		Digital and Data services	DADS - Business intelligence clinical	10 Jun 2024	30 Aug 2025	Brian Cole	Since the implementation of Cito, the organisation has been unable to provide all of the appropriate information to commissioning bodies such as	16	16	4	
	1632		Digital and Data services	DADS - It & systems	13 Jan 2025	31 Aug 2025	Lorraine Sellers	There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a	20	16	8	
	1636		Digital and Data services	DADS - Quality governance	15 Jan 2025	03 Aug 2025	Nick Black	There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance	25	20	10	
	1642		Digital and Data services	DADS - It & systems	16 Jan 2025	20 Aug 2025	Steven Forster	There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to	20	16	6	
	1646		Digital and Data services	DADS - It & systems	17 Jan 2025	02 Oct 2025	Nick Black	There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced	25	10	5	
	1647		Digital and Data services	DADS - It & systems	17 Jan 2025	01 Oct 2025	Steven Forster	There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and	25	15	5	

15+ Removals from the Corporate Risk Register

Committee Alignment	Risk Id	Legacy ID	Date Removed from CRR	Reason for Removal	Care Group/Directorat	Specialty/ Department	Risk Owners	Description	Rating (Initial)	Rating (Current)	Rating (Target)	Open in T

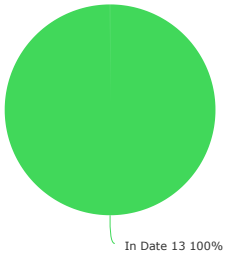
202	276	22 Nov 2022	Risk agreed to be CG level risk, however a Trustwide risk reflecting trustwide and system wide issues and strategic approach to be reflected and owned by Medical Director, with oversight from the Bed oversight Group. Risk 1374 added.	DTV&F	DTV&F - AMH	Shaun McKenna	There is a risk that we may be unable to admit DTVF patients due to bed unavailability as a result of (over) occupancy levels. There is also a potential impact on patient safety and our partner organisations if admissions are delayed we also may not be able to maintain colleague wellbeing due to the impact of over occupancy resulting in increased sickness absence rates.	20	9	6
447	532	22 Nov 2022	Reviewed at ERG and agreed to be CG level risk - however a trust wide risk to be added. 1375 - MB and KM to work up.	DTV&F	DTV&F - SIS	Jamie Todd	There is a risk that patients in the secure service may continue to have extended lengths of stay and/or clinically ready for discharge due to the lack of ICBs and Local Authority provided single occupancy/bespoke accommodation for individuals with complex challenging presentations including Autism/LD/PD, resulting in delayed transfers of care, the number of patients waiting for a bed, and a negative impact on patient experience.	20	16	6
693	785	22 Nov 2022		NYY&S	NYY&S MHSOP	Bridget Lentell	There is a risk that patients will deteriorate while waiting a dementia diagnosis, due to historical waiting lists, and increased demand, resulting in carer breakdown, reduced quality of life and increased risk of admission.	15	12	3
735	827			DTV&F	DTV&F - AMH	Shaun McKenna	There is a risk of fire setting on the wards due to non-adherence to the nicotine management policy and smoking paraphernalia being on the wards.	15	9	5
812	904			NYY&S	NYY&S CAMHS	Melanie Woodcock	There is a risk that children and young people wait for up to 3 years for ADHD diagnostic in Scarborough, due to consistently high caseload of around 400 and limited MDT staff available to work on the Neuro Pathway, resulting in a poor service with non - NICE compliance care offer. As a consequence a lack of diagnosis also results in a reduced service offer available via other providers. The waiting times for ADHD assessment remain between 2-3 years in Scarborough.	20	16	12
962	1054			NYY&S	NYY&S AMH	Billie Cameron	There is a risk that patients will wait longer for access to Step 3 York Talking Therapies interventions due to the gaps in service capacity to fund and recruit the workforce needed to meet demand, resulting in delays to treatment, deteriorating mental health and recovery rates.	20	12	9
971	1063	22 Nov 2022		NYY&S	NYY&S CAMHS	Melanie Woodcock	There is a risk that service users may not be able to access timely psychiatric care including medication initiation following ADHD diagnosis, and reviews across NYY CAMHS due to high vacancy levels and gaps in cover arrangements resulting in potential for patient harm and poor experience, negative impact on staff wellbeing and staff retention.	20	6	6
1033	1125			DTV&F	DTV&F - AMH	Ranjeet Shah	There is a risk that people needing care in hospital across Durham and Darlington Urgent Care teams do not have timely access to a substantive Responsible Clinician (RC) or Approved Clinician (AC) due to established vacancies. This could result in inconsistencies for service users accessing assessment and intervention and increased workload for existing AC/RC's. There is a financial impact to the Trust due to the use of agency doctors and mind the gap arrangements.	20	12	9
1147	1239			NYY&S	NYY&S MHSOP	Bridget Lentell	There is a risk that NYY AMH patients may be admitted to MHSOP wards due to challenges accessing AMH beds resulting in a reduced experience for AMH patients not being clinically managed by an AMH in-patient team, impact on MHSOP patients and staff, potential increased length of stay and difficulty managing two specialties within the ward environment.	16	10	6
1169	1261			NYY&S	NYY&S AMH	Billie Cameron	There is a risk to not being able to offer timely assessment and interventions within the AMH Ripon ICT due to the inability to recruit into vacant posts, resulting delays to initial assessment, extended episodes of care and delayed transfers back to primary care.	20	12	4
1196	1288			Nursing and Governance	N&G - Nursing and quality	Beverley Murphy	There is a risk that there will be a reduction in capacity and organisational memory in N&G due to a number of key posts becoming vacant resulting in an impact on wider quality and service provision as well as possible significant reputational impact as a result of long-standing high profile investigations.	20	8	8
1246	1338			DTV&F	DTV&F - AMH	Lisa Taylor	There is a trust wide risk that autistic people with a co-morbid personality disorder diagnosis are not treated in line with evidence based practice due to the diagnostic overshadowing resulting in inappropriate intervention responses, concerns around clinical oversight, unclear records and inappropriate patient care.	20	15	10
1264	1356			DTV&F	DTV&F - AMH	Shaun McKenna	Organisational risk that the demand for seclusion is more than the availability within AMH meaning either having to manage patients outside of seclusion or utilising seclusion within SIS. This can also lead to having an unsafe amount of patients in seclusion due to utilising SIS seclusion due to their not being any guidance or agreement of how many seclusions is safe for one ward to manage.	20	12	6
1270	1362			NYY&S	NYY&S ALD	Melanie Woodcock	Risk that when we require an inpatient bed we will be unable to source one as there are no ALD inpatient beds currently available in York since the closure of Oak Rise and no beds available in NY due to Bankfields not being open to admissions. In addition beds nationally for ALD service users are not available. This results in service users being placed in inappropriate settings or remaining in the community with increased risk. This increases the ask from community ALD teams and places additional pressure on teams currently operating with no home treatment/crisis offer specific to LD clients. The request for more external beds has an added financial pressure for the Trust due to the additional costs in funding private beds.	12	12	8
1299	1391			DTV&F	DTV&F - SIS	Jamie Todd	There is a risk that unless identified health and safety issues are addressed impact on the health and well-being of staff and patients. The currently remaining open fault with H&S implications are around mis-fitting doors which forcefully slam closed due to a vacuum, and separately flooding waters across various parts of the site causing further Estates damage and restrictions of patients leave and safety implications.	20	15	4
1349	1441			DTV&F	DTV&F - Manageme	Naomi Lonergan	There is a risk identified that the CGB will be unable to recruit and retain sufficient senior medical staff to safely run services. there will be a risk to the quality and safety of services and a significant financial risk to the Trust in employing agency medical staff to backfill into vacant positions	20	12	9
1369	1461			Nursing and Governance	N&G - Manageme	Carole Rutter	There is a risk of ligature cutters being ineffective due to not being sharp enough resulting in delayed removal of ligatures and unintended patient harm.	20	10	5
1379	1471			DTV&F	DTV&F - AMH	Shaun Mayo	A number of case reviews in May 2023 have identified that safety summaries and safety plans have quality concerns both in relation to timeliness of reviews and quality of information held within these clinical care documents across a number of community teams which poses a risk to patient safety by not having the most relevant clinical risk information in date and available.	16	9	6
1381	1473			DTV&F	DTV&F - AMH	Shaun McKenna	Risk that the oxehealth system may not always operate as required, due to poor wifi signal across the Roseberry Park AMH inpatient wards. This increases the risk of potential harm to patients staff ability to intervene in a timely manner is reduced.	20	9	6
1391	1483			DTV&F	DTV&F - AMH	Shaun McKenna	Due to the lack of available level 2 positive and safe training places and the length of time the training takes staff away from clinical work (between 2 and 5 days) there is a risk across AMH Urgent Care Inpatient and Crisis Services that compliance continues to reduce across teams which may result in reduced ability for staff to respond correctly to incidents.	20	12	6

1399	1491		DTV&F	DTV&F - CAMHS	Corrine Reid	As a result of medical vacancies (63% fill rate across medic establishment) there is a risk of delay for medical assessments and interventions. This carries a risk in relation to timely patient care, with a potential for patient deterioration and increased risks whilst awaiting care. There is a risk of consultants not delivering across the job plan, including reduced capacity for CPD, teaching and supervision. The vacant posts also impact upon the out of hours provision, with a risk that there may be times when the on call rota cannot be staffed. There is a risk of substantive consultants working unsustainably to cover Mind the Gap during working hours and locum on call slots out of hours. There is financial risk to the trust due to increased agency/locum spend. The Trust locum spend has reduced through the combination of the D&D and Tees on call rotas.	20	9	9
1413	1505		DTV&F	DTV&F - SIS	Jamie Todd	There is a risk that IT systems will be less accessible when it is critical to patient safety due to the problems with wifi provision on the Ridgeway site. It is a concern that this will impact on operational delivery further.	20	16	4
1415	1507		DTV&F	DTV&F - AMH	Emma Scarr	Due to the current number of OT vacancies across the DTVF AMH inpatient Service, there is a current risk to timely intervention for AMH inpatients across RPH, WPH and LRH hospital sites.	15	12	6
1512			DTV&F	DTV&F - AMH	Shaun McKenna	Due to poor wifi connections across RPH, LRH and WPH hospital sites there is a risk to patient and staff safety and experience due to the delays being experienced when using Trust systems such as EMPA, CITO, Health Roster, MS teams and also when attempting to make contact with colleagues and family members. This results in lack of timely availability of accurate and concise patient information to support clinical decision making and does not support positive experience for staff or patients.	20	16	4
1571			DTV&F	DTV&F - SIS	Jamie Todd	There is a risk that Cito will continue to have system issues which at Ridgeway will involve Cito re-entry of patient data, training, varying levels of changes in practice, and lowering of staff morale. This may mean that we do not have all of the assurance mechanisms in place for this being used correctly (training, configuration, SOPs, BCP, etc) whilst at the same time delivering safe patient care at Ridgeway.	20	16	4
1573			DTV&F	DTV&F - H&J	Lisa Taylor	There is a risk that the inconsistency of CITO, in addition to system issues, is affecting oversight of patients and has the potential to cause patient and staff safety risks. This relates to a lack of consistency of the system reliability, causing variability in when data does or does not pull through accurately and lack of or inaccurate information in relation to risk alerts, patient contact numbers and safety summaries.	20	15	2
1645			Digital and	DADS - It &	Steven	There is a risk that that the Trusts digital infrastructure and data	25	15	5

Removals from the Corporate Risk Register - Closures

Committee Alignment	Risk Id	Legacy ID	Closed date	Rationale for Closing Risk	Care Group/ Directorate	Specialty/ Department	Risk Owners	Description	Rating (Initial)	Rating (Current)	Rating (Target)	Open Form in Tab
Resources and Planning Committee	1530		30 May 2024	External audit review has completed, with no changes to financial statements. A new risk has been created for 2025/26 performance requirements.	Finance	FIN - Financial managemei	Liz Romania	There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory breaches / interventions and / or adversely impact quality of services.	15	8	8	

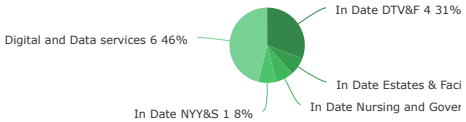
Risk Review Compliance - CRR Risks



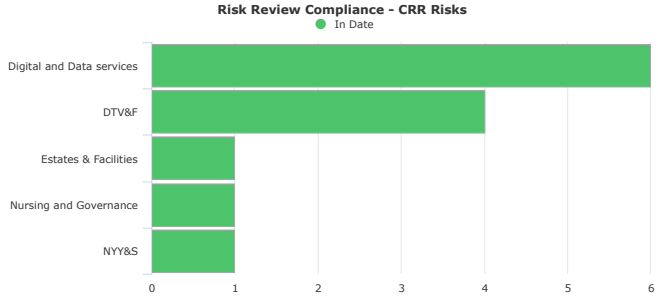
Risk Review Compliance - CRR Risks Overdue

Count

Risk Review Compliance - CRR Risks In Date



Risk Review Compliance - CRR Risks



CRR risks - monthly current rating

CRR

Yes

Risk Number	Risk Title		Current Risk Rating	31 Aug 2024	30 Sep 2024	31 Oct 2024	30 Nov 2024	31 Dec 2024	31 Jan 2025	28 Feb 2025	31 Mar 2025	30 Apr 2025	31 May 2025	30 Jun 2025	31 Jul 2025	31 Aug 2025
Risk 00000219	Risk of a H&S incident at Roseberry park Hospital	Simon Adamson	Actual	15	15	15	15	15		15	15	15	15	15	15	

Risk 00000811	Patients may attempt suicide using potential ligature points within clinical areas	Naomi Lonergan	Actual	15	15	15		15		15	15	15	15		15		
Risk 00000909	Inability to recruit to vacant consultant posts	Parthipan Sivaraman	Actual	16	16		16		16	16	12	12	12	12		12	
Risk 00001044	Incidents that are more serious than initially reported are not identified within appropriate timescales	Rachel Weddle	Actual	15	15		15	15	15	15	15	15	10	10	10		
Risk 00001137	The current system (TEWVision) is unable to provide compliance and assurance of supervision.	Jo Nadkarni	Actual	15	15	15	15	12	12	15		15	15	15	12	12	
Risk 00001219	CAMHS Neurodevelopmental assessment pathway	Jamie Todd	Actual	15	9	15		15		15	15	15	15	15	15		
Risk 00001529	Risk if increased length of stay across AMH acute wards	Shaun McKenna	Actual	16	16	16	16	16	16	16	16	16	12		12	12	
Risk 00001535	There is a risk that the organisation's will be unable to provide the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient	Brian Cole	Actual	16	16	16	16	16	12	16	12	12	16	16	16		
Risk 00001632	Risk that CITO benefits are not realised	Lorraine Sellers	Actual	n/r	n/r	n/r	n/r	n/r	16			16	16		16		
Risk 00001636	Incomplete or inaccurate patient record displayed on Cito	Nick Black	Actual	n/r	n/r	n/r	n/r	n/r	20	20		20	20	20			
Risk 00001642	TEWV Critical digital network infrastructure failure	Steven Forster	Actual	n/r	n/r	n/r	n/r	n/r	12	12	12	12	16				
Risk 00001646	Cyber and operational incident response gaps	Nick Black	Actual	n/r	n/r	n/r	n/r	n/r	10	10	10	10	10		10		

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14 August 2025**
Title:	**NHS 10 Year Plan summary and implications**
Executive Sponsor(s):	**Kathryn Ellis, Director of Strategy and Transformation**
Report Author(s):	**Chris Lanigan and Gail Johnston**

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

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

1: We will co-create high quality care	√
2: We will be a great employer	√
3: We will be a trusted partner	√

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
		The breadth of the 10 Year Plan means that it is relevant to all BAF risks.

EXECUTIVE SUMMARY:

Purpose:

This report summarises the content and potential implications (i.e risks and opportunities) for TEWV of the document *Fit for the Future: 10 Year Health Plan for England* (referred to as the ***10 Year Plan*** in the rest of this report*).*

Due to the length of the publication (143 pages plus bibliography) and its importance, this report includes an **appendix** which pulls out the most significant points and implications. This appendix includes boxes which provide commentary on the risks, opportunities and action to date taken by the Trust in response..

Proposal:

It is proposed that the Board of Directors are assured that

- The 10 Year Plan has already been discussed by Executive Directors who have commenced work to fully understand the implications, pursue opportunities and mitigate risks;
- Exec have instigated a planning approach which will integrate transformation and financial / workforce sustainability and which will be structured around the 3 shifts laid out in the plan, and a fourth “how we do things” group of actions which will improve how we work as an organisation (including aspects such as culture, improvement, transformation and productivity)
- There is an opportunity for all board members to discuss the wider implications of the 10 Year plan on our business strategy, and to understand the content of our

emerging integrated finance/business/transformation plan at the board workshops of 11 September and 13 November.

Overview:
The current government commissioned Lord Darzi to review the state of the NHS shortly after the general election of July 2024. His report identified a need to produce a 10 year health plan, and also introduced the 3 "shifts" which underpin that plan. These shifts are:

1) Hospital to Community
2) Analogue to Digital
3) Sickness to Prevention

The 10 Year Health Plan for England: fit for the future - GOV.UK is the government's formal response to Darzi's review, taking into account the feedback in the Change NHS engagement campaign which took place from Oct 24 and through last winter.

The 10 year plan is clear that reducing demand and increasing productivity through the use of technology will be central to government strategy. The future NHS imagined will have fewer, not more staff and the proportion of government spend channelled into health will stop growing. The NHS will also make sure that health inequalities of access and outcome are tackled. Patients will be empowered, through the NHS App to take back control of their care by gaining instant access to help and appointments. Frontline staff will be empowered to reshape services. The NHS principles and mission will be delivered with the help of a wider network of technology, life sciences, local government, civil society and third sector organisations, working in partnership to improve the nation's health.

A *Modern Service Framework* for Mental Health is being produced and intelligence suggests this will be published during autumn. We anticipate this is likely to continue the emphasis on community mental health transformation, 24/7 easy access (building on the pilot in York and 5 other places) and elimination of inappropriate out of area placements. We expect to see a further commitment to the full roll out of mental health support teams for schools and possibly a requirement to re-establish stand alone assertive outreach teams. It is unclear whether any additional resources will be available to back these potential service development priorities at this stage. A separate frailty and dementia *Modern Service Framework* is also being developed, with links to Baroness Casey's ongoing review of social care.

The Plan is clear that financial deficits will no longer be seen as the norm. Accountability mechanisms, including the new Outcomes Framework give a strong weighting to financial performance. The Plan also emphasises individual foundation trust accountability to the Department of Health / NHSE and through transparency and league tables, to the public. To assist this, data will routinely be collated and displayed using local authority boundaries. The government has also announced a rationalisation of quality/regulatory bodies and tasked the National Quality Board with developing outcome measures for branches of medicine that have an over-reliance on measuring activity and inputs.

It signals that the NHS will move to multi-year financial settlements and planning. In line with this, planning guidance is expected in September this year (rather than Christmas, or even Easter as has been experienced in recent years) and FTs are required to submit a medium term financial plan in December covering 5 years.

Finally, the plan and the recently published blueprint for ICBs see a partial re-emphasis on the commissioner-provider split. ICBs are clearly tasked with the role of strategic commissioning. However, the plan also includes a commitment to move towards Integrated

Health Organisation (IHOs), which will manage much of the budget for a particular place in one organisation. The IHO would be a population health manager which would commission neighbourhood level acute (and possibly primary care and mental health) services. Progress towards this will probably start with a small number of high performing Trusts, which might include the Northern Care Alliance / Northumbria FT in the north of the North East North Cumbria ICB area. There is also a pledge in the plan to develop integrated neighbourhood health provision – a *neighbourhood health service*. NHSE are seeking to support 42 pilot sites, and TEWV is engaged with place-based partners to ensure that local bids into this programme include, as a minimum, a reference to including mental health in any new arrangements.

Prior Consideration and Feedback:

Executive Directors Group have discussed the 10 Year Plan and its implications following an initial Board Seminar session in July.

Implications:

This paper is for information, intended to facilitate discussion and for noting of progress and plans for further exploration over the coming weeks to ensure the Trust is well positioned to respond. Therefore there are no decisions directly resulting from this paper. However the 10 Year Plan has a wide range of financial and quality implications. Some of these are highlighted in Appendix 1 along with a summary of the initial Trust response to them. More detailed responses and actions determined through the Trust's planning processes. Any resulting service changes will have a quality and equality impact assessment to ensure that risks can be mitigated to an acceptable level before they progress.

Our Journey to Change: The Next Chapter was approved in April 2025 but had the likely contents of the 10 Year Plan in mind. All of the objectives under the Trust's 3 strategic goals are in line with the 10 Year Plan 's contents.

Recommendations:

The Board of Directors are recommended to:

- Note the main aspects of the 10 Year Plan, and the action already underway to mitigate the risks / pursue the opportunities that arise;
- Note that the Trust's Executive Directors' Group have commenced a planning process to ensure that we can submit a medium term financial plan, underpinned by a set of transformation initiatives closely linked to the 3 shifts and to boosting productivity by improving how we work within the Trust

Appendix

Briefing Paper

Fit for the Future
10 year Health Plan for England

Implications for TEWV as a Mental Health & Learning Disabilities NHS Trust

July 2025
Gail Johnston, Programme Manager (Strategy)
Chris Lanigan, AD Strategic Planning and Programmes

Briefing purpose

The purpose of this briefing paper is to provide an analysis of the newly published 10 year health plan for England, which sets out the government's vision for the NHS. The plan can be located here: Fit for the future: 10 Year Health Plan This plan follows on from Lord Darzi's *Investigation into the state of the NHS* undertaken last year, which revealed the extent of the challenges in the NHS, and concluded that it was in 'critical condition'. The 10 Year Health Plan is designed to 'get the NHS back on its feet and fit for the future' and consists of three fundamental shifts in how the NHS works:

1) **From hospital to community.** *More care to be available on citizens' doorsteps from the comfort of each person's own home. It will be easier to see a GP and Neighbourhood Health Centres will be available in every community*.
2) **Second, from analogue to digital.** *New technology will liberate staff from time wasting admin and make booking appointments and managing patient care as easy as online banking or shopping.*
3) **Finally, from sickness to prevention.** *Patients will be reached earlier, to catch illness before it spreads and prevent it in the first place, by making the healthy choice the easy choice.*

The government has pledged to 'slash unnecessary bureaucracy giving more power and resources to the frontline' whilst 'adding an extra £29 billion in investment will fund the reforms, service improvements and new technology required' (UK Government, 2025 p7).

10 year health plan summary points

The plan focusses on health services in general, and does not have specific chapters about mental health, learning disabilities nor other health specialities such as orthopaedics, oncology or paediatrics. However, there is a set of Modern Service Frameworks currently in production which are likely to be published during this autumn. These include one for mental health and another for frailty and dementia.

However, it is possible to identify potential risks and opportunities that will impact upon mental health and learning disabilities providers like NHS TEWV. These include the following:

Neighbourhood health service

The key message from the 10 year health plan is of a *neighbourhood health service* which the government proposes will improve access to healthcare with care organised around the patient. Over time, it will combine with the new genomics population health service to provide predictive and preventative care that anticipates need. At its core, the neighbourhood health service will embody a new preventative and integrated care approach as locally as it can; digitally by default, in a patient's home, where possible, in a neighbourhood health centre when needed; in a hospital if necessary.

Across England, 250-300 neighbourhood health centres will be established, ministers announced, with 50 up and running by 2029, providing a single place for more

integrated care, available at least 12 hours a day, six days a week. They will be staffed by GPs, nurses, physios, care workers, mental health workers and employment advisers. However, the population served by TEWV represents 3.5% of the national figure (England) so the total number in the Trust's footprint may be only 10 or fewer.

The cost of each centre would vary "from the low millions to around £20m", said the health secretary, Wes Streeting, "depending on whether it's an upgrade, a refurb, an expansion, or indeed a new build". The aim is to "end hospital outpatients as we know it" by 2035. Urgent treatment centres and other same-day emergency care services that prevent patients needing to be admitted to acute hospitals will also be expanded.

Implications for TEWV

TEWV has a strong track record in engagement in community transformation and integrated working at neighbourhood level. Clinical, operational and strategic leaders from TEWV have been actively involved in work locally to support applications across our places to become one of 42 national pilot sites to test the model of neighbourhood working as part of the National Neighbourhood Health Improvement Programme (NNHIP). Irrespective of the outcome of that bidding process the Trust will continue to work closely with partners to integrate and improve care at neighbourhood level in line with population needs.

Specialist mental health emergency departments

The plan pledges £120m to be spent on 85 mental health emergency departments to prevent patients from presenting and being admitted to A&E, meaning there will be one co-located with (or very close to) 50% of existing type 1 A&E units. The government asserts it will improve assertive outreach care and treatment to ensure 100% national coverage in the next decade, with a focus on narrowing mental health inequalities. Many people experiencing a mental health crisis go to A&E because it is the most visible or accessible option. However, emergency departments are not always the best environment for mental health needs, and historically mental health services have not been sufficiently integrated into urgent care pathways. The government will increase capacity for urgent mental health care by developing dedicated mental health emergency departments (MHEDs), ensuring patients get fast, same-day access to specialist support in an appropriate setting.

Implications for TEWV

TEWV leaders are already taking action to understand the potential opportunities and risks which the introduction of mental health emergency departments means for TEWV. We are well placed as we already have a facility of this type, the Crisis Assessment Suite at Roseberry Park in Middlesbrough. We are already in discussion with Cumbria, Northumberland, Tyne and Wear Foundation Trust (CNTW) and can liaise with acute providers through the North East North Cumbria Strategic Approach to Clinical Services Board to understand the "mental health" demand they are facing and to agree where crisis assessment provision should best be situated. Similar discussions will commence in the Humber North Yorkshire ICB area once more is known about the bidding process.

As the national capital funding is only £120m and there are 85 Emergency Departments across England, the cash equates to approximately £1.4m per ED unit. There are currently 7 EDs located across the communities served by TEWV. The population based "fair share" amount for TEWV would be less at around £4.2m. Therefore senior managers are already taking action and working with partners to agree on potential locations and ways of working prior to any bid processes going live..

As this investment is capital, not revenue discussions will be needed around the staffing of any unit and an understanding of where budget savings may occur. As such savings are most likely to be realised by Acute Trusts there may be high-level conversations required about the sources of ongoing revenue funding.

Digital front doors for mental health support and other conditions

New digital front doors for mental health support and digitised therapies are to be introduced to 'prevent people travelling to hospitals and clinics outside their area' . The plan refers to new digital tools, digitised therapies and real-time suicide surveillance to improve mental health and lead to a reduction in suicide rates. Third party digital technology will become an asset in bringing people access to personalised care delivered through the Health Store. AI is expected to support people with anxiety and depression. The expectation is for providers and wider agencies to collaborate with business, investors, social enterprises, employers and many more to address the mental health crisis. For people with more severe illness, remote monitoring will help support a proactive response in crisis.

The NHS app will be expanded from its current form to become a "*doctor" in patients' pockets* enabling 24/7 access to all elements of care. The *My Carer* tool will give family, friends and carers access to the NHS app. A new part of it, *My NHS GP*, will use artificial intelligence (AI) to help people navigate the service better, evaluating symptoms, asking questions and providing guidance. Patients will also be able to use the NHS app to book remote or face-to-face appointments, manage prescriptions, enrol in a clinical trial and check vaccines are up to date. They will be able to book urgent appointments, rather than wait for hours in A&E, with services able to triage patients in advance. The plan claims that ending the "8am scramble for a GP appointment" and allowing patients to book an appointment digitally, rather than via "today's convoluted process", would save £200m over three years.

Patients will be able to self-refer using the My Specialist tool part of the NHS app for a host of outpatient services from musculoskeletal issues, podiatry, audiology and mental health talking therapies in a move that ministers hope will "dramatically slash" waiting lists and free up GPs and the new neighbourhood health services. This will help to transform the working lives of GPs - letting them focus on care where they provide the highest value.

In addition, there will be a single patient record (SPR) created that will bring together the medical records of each patient into one place. Legislation will be passed to ensure all providers of health and care services log patient information they hold on a "single patient record". From 2028, patients, as well as health and care professionals, will be able to access this record on the NHS app, which will hold medical records, personal

health risk and other data. Pharmacies will be given more responsibility to manage long-term conditions, which will also be linked to the single patient record.

Implications for TEWV

As more becomes known about the development of the NHS App, the Trust will need to consider how to deal with self-referrals and with online appointment booking.

In addition, TEWV digital leaders must take the need for interoperability into account in the future development of our electronic patient record..
As more emphasis is put on data usage and data transparency we may need to take do more to further improve our data quality and our analytical capacity.

Finally, out clinical leaders, supported by managerial and technical experts will need to consider how technological developments in clinical delivery should be adopted into Trust pathways and clinical policies, and how to model the impacts on our future workforce requirements. This will require looking into the future and learning lessons from other sectors that have already utilised modern technology effectively so that we understand the likely future impact on clinical / back-office practice, required skills and hence our future workforce. The clinical model work already underway under the leadership of our Senior Clinical Directors has been considering some of these issues, but executives also intend to set up a small group to help the Trust think strategically about what technology-supported care in the 2030s might look like, and how we can prepare for / introduce the required changes.

Continued expansion of Individual placement and support

The government has pledged to continue to expand provision of Individual Placement and Support (IPS) services to help people with severe mental illness or drug and alcohol addiction find quality work, provide employment support through primary care and offer employment advice to those accessing Talking Therapies. The changes made to the NHS App will allow many more people out of work due to stress and depression to access online support.

Implications for TEWV

Individual Placement and Support (IPS) has been very successful and achieved good outcomes for its target group of people with severe and enduring mental health issues and helping them contribute to local economies. Our services score well in national fidelity assessments. Future investment into IPS may come from combined authorities / elected mayors rather than NHS commissioners and so we will need to find ways of influencing combined authorities and think through whether we can extend our IPS approach to a wider group of patients without risking the quality and success rate of our work.

Greater support for children and young people

The government will address longstanding issues with access to specialist children and young people's mental health services by recruiting 8,500 mental health staff focused on reducing long waits for both children and adults. Mental health support teams in school and Young Futures hubs will be expanded to increase support for

children's mental health. The roll out of mental health support teams in schools and colleges will continue and will reach full national coverage by 2029 to 2030 – and will include health practitioners in the child protection teams that the government will legislate to create through the Children's Wellbeing and Schools Bill.

At present, NHSE regional teams are being instructed to include mental support team roll out in plans, despite the end of ring-fenced funding for MHST expansion. If the forthcoming planning guidance does not reinstate ring fenced funding (for training of new teams as well as ongoing revenue) then there will be a requirement to move cash from elsewhere in the mental health system. TEWV will need to be alert to this risk, even as we welcome the opportunities this brings.

The plan outlines that in working with local authorities, the government and the NHS will ensure that children with the most complex mental health needs in residential care get the treatment and support they need to avoid even more expensive hospital admissions and repeated emergency department visits. This summer, the Department for Culture, Media and Sport will publish a new National Youth Strategy, which will set out how the government will support young people in all aspects of their lives including, support for mental health, wellbeing and the ability to develop positive social connections.

Implications for TEWV

The commitment to continue to roll out of mental health support teams in schools and colleges to reach full national coverage by 2029 to 2030 is welcome.

However, there are risks around the source of funding for this expansion, with a risk that mental health trusts such as TEWV will be expected to fund it from existing budgets. If this is the case this increases the requirement to find such resources through the transformation of current services.

Patient league tables from this summer

The government wants greater transparency in the NHS and has pledged to enable patients to be empowered to choose where they have their care, in a section of the app called My Choices, with the inclusion of easy-to-understand 'league tables.' The NHS app will also provide data on waiting times, patient ratings and quality of care, including data on particular clinical teams and clinicians. Complaints processes will be speeded up. The App will also show data on clinical teams and clinicians, include patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) to help patients when choosing their provider on the NHS App. Data will be displayed using local authority boundaries rather than provider geography.

Implications for TEWV

TEWV already has a number of PROMs in place and under the leadership of our Medical Director we are working through an action plan in order to improve the availability and use of outcome data.

We have recently received our Outcomes Framework score of 2 (1=best; 5 = worst). This is positive, but we have started to work through the new framework to understand what improvements we need to make to improve our score to 1.

Expansion of personal health budgets and other patient-led payments

About 180,000 people currently have an NHS personal budget, allowing them to decide how to spend money for their care on interventions such as physiotherapy, mobility aids, a particular wheelchair, or activities. Ministers plan to double the number of people on personal budgets by April 2029, with 1 million patients offered them by 2030. By 2035, ministers want PHBs to be available to everyone entitled to them.

We know that past attempts have been made to unpick block contracts as money needs to be extracted to fund individual PHBs. However, in extracting money out of block contracts the argument has always been that this could destabilise the NHS provider funding model.

The 10 Year Plan though states that the NHS will, "*deconstruct block contracts - paid irrespective of how many patients are seen or how good care is - with the intention of realigning the activity delivered and funding being provided by an ICB. Payment for poor-quality care will be withheld and high-quality care will attract a bonus*. "

The government also plans to test the development of 'year of care' payments starting in financial year 2026 to 2027. This will drive the shift of activity and resource from hospital to community and could have financial implications for the Trust as a large NHS secondary care provider.

Implications for TEWV

This is a complex area, and it is not always clear to what extent reforms to the Acute sector payments system will apply to mental health providers.

Nevertheless, the best way to prepare for a system in which patients may have more choice, or more influence over the level of payment the Trust receives is to ensure that we implement the objectives of the Service User and Carer goal in Our Journey to Change, and promote the revised Trust values and behaviours. This work has commenced.
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Changes to the Operating Model

Alongside this the Department of Health and Social Care will seek to approve the first "new foundation trusts (FT)" in 2026, but the plan confirms an ambition for every NHS provider trust to become an FT by 2035. FTs will no longer be required to have governors, although it is not clear whether there will be a choice to retain / relinquish them or whether there will be national direction / standardisation..

The Plan says there will be a "greater focus on partnership working and on population health outcomes" than the current FT model. As part of capital regime reforms, new FTs will also be able to "process larger self-financed schemes as long as they are consistent with overall financial planning". The "very best" FTs will have the opportunity

to hold the entire health budget for a defined local population as an "integrated health organisation". IHOs will "become the norm" over time. Initially, a small number of IHOs will be designated in 2026, with the aim for these to become operational in 2027. Closer collaboration with local government, aligned planning cycles, and co-terminosity will be vital for supporting integration. Integrated care boards (ICBs) will become even more significant institutions, playing a central role in shaping the market.

Currently structural reform is underway in NHS England and the Department of Health and Social Care – roughly half of all roles at the two organisations. In addition, bodies responsible for overseeing and running parts of the NHS in England will be stood down - such as Healthwatch, which advocates on behalf of patients, and the National Guardian's Office, which supports whistleblowers along with the 4 remaining CSUs including NECs which will be stood down.

Implications for TEWV

The IHO model could present an option for TEWV (or other NHS organisations) to take a lead role as a commissioning / co-ordination body in some or all of the places we work within. However, there are other NHS organisations who have more concentrated current geographical footprints who could also take on an IHO role. Further guidance is anticipated on what this may mean in practice, and will be important in considering how this policy goal may be enacted. Board members will have opportunity to consider this strategic direction over the coming weeks and months, together with partners.

The Trust Secretary is seeking clarity about the parameters of future policy expectations in relating to Foundation Trust constitution and the role of governors.

Prevention agenda

The 10 year plan overwhelmingly refers to prevention as the way forward with easier access to screening, weight loss services and mental health support to improve the health of the nation. Much emphasis is also placed on the wider social determinants of health, which need to be tackled to improve life chances.

The government argues that the shift from sickness to prevention will reduce the number of people at risk of developing dementia by supporting people to live healthier lives for longer and targeting the biggest causes of ill health: 'Prevention is how we change this course, by pushing poor health into later life - and helping millions more get on with their lives, raising their children and progressing their careers unimpeded by avoidable sickness. The possibilities are huge: around 70% of cardiovascular disease, 40% of cancers and 40% of dementia are preventable' (UK Government, 2025, p60). In addition, by 2028 the government plans to create a smoke free generation through the Tobacco and Vapes bill which it expects will reduce dementia and other long term health conditions.

Implications for TEWV

For TEWV the opportunity is that effective primary or secondary prevention can reduce the number of people reaching a state of severe mental distress and hence

the level of demand for our most intensive interventions (crisis / intensive home treatment and inpatient care).

However, given the importance of the wider social determinants of health as drivers of mental health demand there is an important question of where, when and how a mental health Trust can best use its clinical expertise to support prevention without impeding our important treatment role.

There will be opportunities for directors to discuss this strategic issue in the coming weeks and months.

Innovation and research emphasis

To drive innovation, the government has pledged to invest in the infrastructure needed for improving research, such as setting up Regional Health Innovation Zones "to give health systems the permission and flexibility they need to be more radical and forward-looking on innovation". The funding of research into prevention and detection of physical and mental health long term conditions will be executed by reforming the NIHR and better promote a focus on prevention.

Implications for TEWV

The news of greater innovation and research emphasis, particularly on the Prevention agenda is to be welcomed. TEWV is already committed to research and development and has good links to Universities in Teesside and York and can maximise benefit from the Research & Learning Team, including a pipeline of future research and PHD funding.

However our support for innovation is finically limited. The Medical Director is developing a modest investment proposal. But in addition to consideration of this by Executives, the way the Trust currently operates struggles to find the right balance between supporting innovation and ensuing that risks are not taken that jeopardise the quality, performance and financial demands upon the Trust. The development of a TEWV operating framework in the months ahead will be Important in making it clearer how innovative ideas can be developed, tested, supported and spread.

Staffing and workforce plan

A new 10-Year Workforce Plan will be released later this year replacing the one written by Rishi Sunak's government in 2024. The new 10 year health plan states there will be fewer staff in 2035 than projected by the previous NHS long-term workforce plan, but that they will have "better training and more exciting roles". The government had already announced that NHS providers must reduce the number of staff recruited from overseas including moving from the number of doctors hired from overseas currently at 34% to under 10%, to give homegrown medics a better chance of progressing their careers. There will be a focus on monitoring the level of recruitment of people from deprived communities and backgrounds.

The plan will create 2,000 more nursing apprenticeships and 1,000 speciality training posts, and expand medical school places, prioritising UK students. Thousands more GPs will be trained and the number of nurse consultants will be expanded. Dentists trained in the UK will have to work for the NHS for three years.

The 10 year plan also pledges to completely reform statutory and mandatory training by April 2026. The training which is referred to as 'often repetitive' and 'irrelevant' to the work that staff do and has 'little or no impact on the quality of care that patients receive.' There will be a move from 'train to role' to 'train to task' and reviews of the education and training curricula. Appraisals, revalidation and basic HR processes like requesting leave will be modernised, and providers expected to improve the working environment / staff experience. This will include "staff standards" which will be published in April 2026 and form part of providers' oversight framework assessment. A Management and Leadership Framework will be published later in 2025 with clear standards for managers, a College of Executive and Clinical Leadership and a barring system for senior managers found to be unsuitable for future NHS roles.

Implications for TEWV

As more detail emerges the Trust's executive and People and Culture committee will need to consider how to address any of our current approaches that is not in line with what will be required in future.

The replacement of the current national workforce plan highlights the need for TEWV to think through what skills and types of workers we will need in a technology-enabled future. Such thinking is likely to be undertaken by a "strategic future initiatives" group being set up by our Executive Directors Group as part of the process needed to produce the medium-term financial plan and accompanying transformation plans and will be influenced by Clinical Models work being led by the Trust's clinical leaders

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14 August 2025**
Title:	**Our Journey to Change - Next Chapter**
Executive Sponsor(s):	**Kathryn Ellis, Director of Strategy and Transformation**
Report Author(s):	**Kathryn Ellis, Director of Strategy and Transformation** **Chris Lanigan, AD Strategic Planning and Programs**

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

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

1: We will co-create high quality care	√
2: We will be a great employer	√
3: We will be a trusted partner	√

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
All	**All**	Our Journey to Change sets the strategic framework for the Trust, and is the basis on which the BAF is constructed. As such successful delivery of this approach will contribute to reduced strategic risk across all areas of the BAF.

EXECUTIVE SUMMARY:

Purpose:

To provide an update to Trust Board on progress in implementing Our Journey To Change - the Next Chapter, and specifically:

- To introduce a purposeful framework and approach to strategic planning, transformation and delivery, moving from the intent of Our Journey To Change – the Next Chapter, to integrated planning and delivery for impact
- To update on work to enhance the Trust's measurement of the impact of transformation; aligning the assessment of impact with the Trust's Integrated Performance Report (IPR) data
- To update on communications and engagement activities to raise awareness of the refreshed Strategy approved at April Trust Board

The Board is being asked to consider this paper as part of their seeking assurance on the Trust's approach to Strategy and Integrated Business Planning, in line with the Trust's strategic context and Business Cycle.

Proposal:

It is proposed that Board should take **reasonable assurance** that:

- the Trust is continuing its work to communicate the implementation of Our Journey to Change – the Next Chapter
- the Trust is developing a robust and engaging process to translate the strategic intentions captured in Our Journey to Change - the Next Chapter into an Integrated Business Plan and Medium-Term Financial Plan
- the Trust is continuing to deliver its Strategy, and its efforts to assess the impact of transformation, drawing on data drawn from the Trust's IPR (as a key tool for Board assurance)

Overview:

Communication of Our Journey to Change – the Next Chapter

Communication of OJTC – the Next Chapter is continuing as the communications plan is enacted. Engagement sessions have been held with Trust leaders via the Quarter Leadership Events and communication to staff. The new graphic (Appendix 1) has been finalised and the old OJTC posters are being replaced across the Trust. In addition, the Trust's staff induction packs have been changed to reflect the new wording, and work is almost completed to produce guidance on how to interpret the new behaviours statements so that they can be included in people processes such as appraisals. This work has made use of the insights that the lived experience strategy reference group gave us.

The next 6 months: From strategic intent to planning for impact

Board approval of Our Journey to Change - the Next Chapter in April 2025 marked the Trust's entering a new phase of strategic transformation. The Next Chapter signals our response to the voice of service users and carers, staff and partners, reflecting both internal ambition and external shifts. Our transition from National Oversight Framework (NOF) Segment 3 to Segment 2 reflects the Trust's improvement journey, and with it the newly published Oversight Framework brings increased expectations for assurance, alignment, and delivery. The publication of the Fit for the Future: 10 Year Health Plan for England sets a bold national direction, requiring us to respond with clarity and purpose. Further detailed guidance will follow in the coming months.

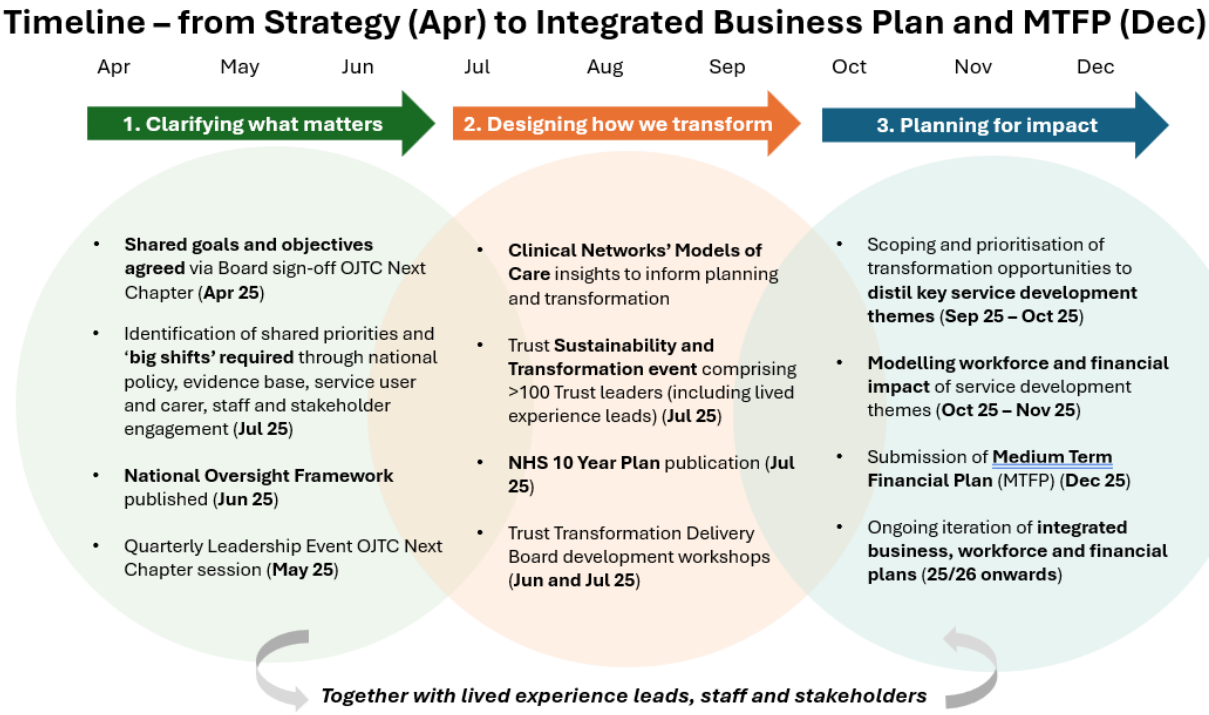
Given this evolving context, and our continuing commitment to improving the mental health and wellbeing of those we serve, we are seeking to strengthen our strategic focus, align planning architecture, and connect our Strategy to delivery and impact. Our planning framework and approach is designed to support that ambition—providing a structured yet adaptive planning process designed to build confidence and engagement in our direction and approach over the coming months. If we are successful in our efforts we will not only deliver a robust Medium Term Financial Plan for submission in December 2025, but crucially develop our strategic response, delivery planning and demonstration of impact, aligning our strategic and transformation efforts Trust-wide, together with stakeholders to improve care.

This process has commenced, led by Executive Directors of Strategy and Transformation, Finance and Estates, and People and Culture, and is planned in three broad phases:

- Phase 1: (Clarifying What Matters) – shaping the priorities that will guide our work
- Phase 2: (Designing How We Transform) – developing our vision and transformation themes
- Phase 3: (Planning for Impact) – developing integrated plans to deliver with impact

These steps are iterative, evolving as we engage, test and develop our thinking over the coming months. Together, they are intended to support a confident transition from strategic intent to meaningful impact, grounded in shared purpose and a clear sense of direction.

Our approach is set out below, with key activities highlighted in each phase:



This approach is designed in line with best practice[1], to support:

- Clear articulation of strategic goals and large-scale transformational shifts
- Consistent language and planning structure across the organisation
- Strengthened governance and oversight through integrated planning
- Confidence in delivery through tested plans with clear impact measures

It is intended to provide a shared frame for strategic planning in collaboration, enabling us to move forward with clarity and assurance.

Further development and demonstration of the impact of transformation

Care Groups and corporate departments continue to deliver their business plans based on Our Journey to Change. Further to the discussion at the June Board Appendix 2 provides an illustration of the continuing work underway through the Trust's Transformation Delivery Board to articulate the impact of key transformation activities in the past 12-18 months. The Trust's Integrated Performance Report measures have been used as a key contributor to the content of this, recognising its critical function in providing the Board with strategic assurance of delivery. The transformational themes in Appendix 2 align broadly with the required 'Three Shifts' identified in the NHS 10 Year Plan, demonstrating a strong foundation

[1] "Strategy Development: A Toolkit for NHS Providers" (NHS England cited Monitor publication)

of impact on which the Trust can build as part of the strategic planning approach outlined in the previous section.

Prior Consideration and Feedback:

The strategic planning approach outlined above has been discussed at Executive Directors Group (5 Aug) and Transformation Delivery Board (Jun and Jul). The Sustainability and Transformation Event held on 9th July cited in the visual included representatives from across the organisation and lived experience representatives.

The contents of Appendix 2 illustrating the impact of transformation has been discussed and reviewed at Transformation Delivery Board (Jun and Jul) and Executive Directors Group (5 Aug).

Implications:

The identification of the implications of future proposed strategic plans will be tested in line with the Trust's equality and impact assessment processes, with oversight from the Medical, Nursing and Therapies Directors. Any business cases proposing change will be subject to appropriate financial and risk assessment.

Recommendations:

The Board is asked to confirm the level of assurance proposed, and:

- Note the progress being made to communicate 'the Next Chapter' of Our Journey to Change
- Endorse the planning framework and approach as the organising structure for strategic transformation, noting the alignment with national priorities and oversight expectations
- Note that the Executive has commenced work to produce an integrated business plan and medium term financial plan, ensuring the Trust will develop robustly informed and detailed strategic plans to deliver over the medium-term
- Note the work that continues to articulate the impact of transformation work to date as a basis for ensuring strengthened articulation of impact in our future work

Our Journey to Change – the next chapter

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our mission: We will support people to lead their best possible lives.

Our vision: We provide consistently good healthcare which helps our communities become healthier and safer.

Our values are at the heart of everything we do

Respect

We are:
- Inclusive
- Considerate
- Open and honest

Compassion

We are:
- Kind
- Fair
- Listening and acting

Responsibility

We are:
- Accountable
- Reliable and productive
- Challenging and improving

Our three goals

1. We will co-create high quality care
2. We will be a great employer
3. We will be a trusted partner

journey to change

www.tewv.nhs.uk/about/trust/our-journey-to-change

Appendix 2

Tees, Esk and Wear Valleys
NHS Foundation Trust

Articulating the impact of our transformation programmes

Board of Directors, August 2025

Respect Compassion Responsibility

journey to change

Purpose and ‘reason why’

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Purpose

- To share the progress, and importantly the impact, of our transformation programmes since April 2024. It encompasses both designated transformation workstreams of the Trust Transformation Delivery Board, and broader work overseen by Care Groups.

Measuring impact

- We are currently reviewing how we define and describe impact in a meaningful way. Going forwards we will also ensure it links with the key shifts within the government’s 10-year health plan.
- For the purpose of this update, we have primarily used data from our Integrated Performance Report. These have been drawn from ‘points in time’ as illustration of trends – further analysis will ensure this is tested from a statistical perspective. Future updates will reflect an updated approach to how we measure the impact of our work, and the benefit this has on our communities.

Patient safety (1)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our key aims:

- Implement the Patient Safety Incident Response Framework(PSIRF). This is a national requirement for trusts and is part of national patient safety strategy. This supports us to have effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
- Embed a Learning from Patient Safety Events (LFPSE) compliant, single risk and quality management system. This provides ward to board oversight of all quality governance and risk management. It also meets the national requirement for trusts to comply with Learning from Patient Safety Events and feed patient safety incident data into a national system.

What has changed?

- Implemented the Patient Safety Incident Response Framework
- Embedded a Learning from Patient Safety Events) system
- Reduced the incident review backlog

The positive impact of these changes (2023/24 – 2024/25):

- A reduction in the number of incidents of moderate or severe harm
- A reduction in the number of medication errors with a severity of moderate harm
- An increase in the percentage of patients who feel safe on the ward
- Reduction in the number of self ham incidents

Expected future impact

A reduction in the number of:

- Incidents of moderate or severe harm
- Medication Errors with a severity of moderate harm and above
- Unexpected Inpatient unnatural deaths reported on STEIS
- Restrictive Interventions used

And less time taken to complete reviews

Patient safety (2) – measures of impact

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Measure	23/24	24/25	% increase / decrease
Number of Incidents of moderate or severe harm	644	372	42% decrease
Number of Medication Errors with a severity of moderate harm	11	4	63.6% decrease
% of patients who feel safe on the ward has increased from 78.63% to 80.66%	78.63%	80.66%	2.5% increase
Reduction in the number of self ham incidents	8356	7428	11.1% decrease

Data source

Positive impact:
- Number of Incidents of moderate or severe harm - IIC5601 My metrics
- Number of Medication Errors with a severity of moderate harm - IIC5621 My metrics
- % of patients who feel safe on the ward has increased from 78.63% to 80.66% - IIC5640 My metrics
- Reduction in the number of self ham incidents -IIC6120 My metrics

Future impact:
- Less time taken to complete reviews – soft intelligence
- Reduction in the number of Incidents of moderate or severe harm - IIC5601 My metrics
- Reduction in the number of Medication Errors with a severity of moderate harm and above - IIC5621 My metrics
- Reduction in the number of unexpected Inpatient unnatural deaths reported on STEIS - STEIS
- Reduction in the number of Restrictive Interventions used - IIC My metrics

Urgent care (1)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our key aims:

- NHS England introduced an Inpatient Quality Transformation Framework in 2023. This promoted improvements in the effectiveness and culture of inpatient care, and a reduction in out of area placements. Our aim is to improve our urgent care services (including non bed-based crisis aid intensive home treatment services).
- We want our services to be there for anyone in our community experiencing a mental health crisis.
- To provide timely, safe care that understands and meets individual needs.

What has changed?

- Embedded NHS 111 Option 2
- Culture of Care programme (across 6 wards)
- York 24/7 access pilot (in mobilisation)
- Improved bed management processes
- Improved PIPA process

The positive impact of these changes (2023/24 – 2024/25):

- An increase in call answer rates within both care groups to around 90% and a conversion to triage rate from screening between 30-40%.
- Call waiting times have reduced and patients have the option to maintain their place in a queue without remaining on the line.

Expected future impact

A reduction in:

- Adult mental health ward capacity to below 90% on a consistent basis
- The number of clinically ready to discharge patients
- Adult mental health assessment and treatment admission rates
- Bed occupancy
- Length of stay
- The number of restrictive interventions used
- The number of uses of the Mental Health Act

And increased patient satisfaction

Urgent care (2) - measures of impact

Impact outcome measure	Apr 24			Sept 24	Dec 24	Mar 25
DTV						
NHS 111/ screening						
NHS 111 - KPI –Percentage of abandoned call (% calls answered)	13% (87%)			12% (88%)	10% (90) %	10% (90%)
NHS 111KPI average time to answer	60			70	56	47
Percentage of screening calls passed to triage	40%			36%	31%	29%
Crisis and triage						
CYPS triage call response rate	89%			94%	94%	96%
AMH triage response rate tees	82%			77%	74%	81%
AMH triage response rate DD	62%			73%	72%	69%
Percentage of professional lines answered	Not available			74%	81%	79%
NYYS						
NHS 111/ screening						
NS 111 - KPI –Percentage of abandoned call (percentage calls answered)	Not live			23% (75%)	17% (83%)	16% (84%)
NHS 111KPI average time to answer	Not live			182	96	86
Percentage of screening calls passed to triage	Not live			30%	29%	35%
Crisis and triage						
Hub triage response rate	52%			58%	52%	52%

Data source

Positive impact:

- DTV and NYY data NHS 111 and crisis and triage data taken from IIC Crisis line dashboard as part of home first workstream of urgent care
- Number of inappropriate OAP bed days for adults that are external to the sending provider - IC5560a

Future impact:

- Reducing AMH ward capacity to below 90% on a consistent basis – IIC my metrics/OPEL
- Reduction in number of clinically ready to discharge patients - IIC6460 my metrics
- Reduced AMH assessment and treatment admission rates - IIC my metrics
- Reduced Bed Occupancy - IIC1730 My metrics
- Reduced length of stay - IIC my metrics
- Reduced number of Restrictive Interventions used - IIC My metrics
- Reduced number of uses of the Mental Health Act – IIC My metrics
- Increased patient satisfaction – IIC My metrics

Community transformation (1)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our key aims:

- the Community Mental Health Framework sets out to transform mental health care by delivering an integrated, place-based model that delivers holistic, person-centred support within communities.
- To ensure people with mental health needs receive timely, appropriate, and coordinated care. This is aligned with primary care networks and local services, while addressing inequalities and promoting recovery through co-production and community engagement.
- To have Integrated services delivering collaborative pathways which meet the needs of the local population and to empower individuals to choose and manage their own personalised recovery, as experts in their own mental health (informed by social, cultural and ethnic needs).

What has changed?

- Teesside – spread of physical multi-agency hubs.
- Durham – mix of physical and virtual hubs – over 40,000 appointments delivered in primary care by TEWV staff in “GP aligned” roles.
- York – two hubs up and running including the national 24/7 access pilot.
- North Yorkshire – slower progress due to lack of resources. Harrogate furthest advanced.

The positive impact of these changes (2023/24 – 2024/25):

Durham and Tees Valley:

- Only 948 (2.5%) of patients seen by TEWV staff in primary care stepped up to secondary care services.
- 15%-20% reduction in secondary care referrals, at a time when we expected secondary care mental health referrals to increase.

North Yorkshire and York:

- 85% of users of first York hub reported positive clinical outcomes.

Expected future impact

- A more holistic and planned way of identifying and tracking benefits of this work.
- Improved access and early support.
- Improvement in patient and clinician reported outcomes.
- Reduction in waiting times.
- Operational and workforce improvements through the development of multi agency hubs.

Community transformation (2) - measures of impact

Tees, Esk and Wear Valleys NHS Foundation Trust

Data source

Positive impact:

- Only 948 (2.5%) of patients seen by TEWV staff in primary care stepped up to secondary care services; 14.8% of GPA patients stepped up - This information is from IIC for referrals into secondary care with referral source Primary Care for Durham Tees Valley
- 15%-20% reduction in secondary care referrals, at a time when we expected secondary care MH referrals to increase - This is data from IIC for Durham Tees Valley Planned Care
- 85% of users of first York hub reported positive clinical outcomes – data collected via prototyping work by the service

Future impact:

- Measured via System one, IIC and qualitative intelligence from service
- Improved access and early support
- Improvement in patient and clinician reported outcomes
- Reduction in waiting times
- Operational and workforce improvements through the development of multi agency hubs

Digital (1)

Tees, Esk and Wear Valleys
NHS Foundation Trust

Our key aims:

- Use digital technology and data to deliver a great experience and high-quality care for our service users.
- Ensure staff can work seamlessly with partners across the wider health care system.
- Create a safe digital culture. Ensure IT technology is reliable for all that use it.
- Operating within a robust governance framework that is transparent and provides assurance to the Trust.
- The work covers projects required to ensure the Trust continues to meet its statutory obligations in terms of IT security and those required to ensure effective supplier and contract management. In addition, the Digital Programme includes projects which are enablers as part of the NHS England frontline digitisation agenda to ensure the Trust meets minimum digital capability standards.

What has changed?

- Electronic expenses – system implementation of free offer available through national ESR contract.
- Centralised asset management – move away from individual purchasing and review costing process for hardware and review of contract for mobile devices and data .
- Enhancing collaboration – embedding of the Office 365 suite available as part of the national offer from NHS England.
- Electronic Prescribing and Medicines Administration (EPMA) – implementation of EPMA product across inpatient areas.
- Integrated Information Centre – re-procurement of Integrated Information Centre product set and migration of products to the cloud from current infrastructure.

The positive impact of these changes (2023/24 – 2024/25):

- Hardware
- Mobile Data
- Mobile devices
- Attend Anywhere
- Integrated Information Centre move to cloud

Electronic Prescribing & Medicines Administration (EPMA) specific :

- Increase in safe medicines administration
- Time saved by pharmacists and clinicians transcribing leave and discharge prescriptions

Digital (2)

Tees, Esk and Wear Valleys
NHS Foundation Trust

Expected future impact

EPMA

- Reduction in drug expenditure.
- Reduction in errors on drug prescriptions.
- Reduction in leave / discharge pads expenditure / time saved by pharmacists and clinicians transcribing leave and discharge prescriptions.
- Improved and embedded business continuity processes.

Inpatient Internet :

- Improved inpatient experience.

Integrated Information Centre

- The IIC team will be able to better manage the IIC environment and upgrade the IIC software with minimal impact on IIC users and the IIC development team.
- Use of new products e.g. IBM Watson will allow research and statistics team to undertake analysis much faster than previously.

Patient & Carer Experience System procurement (PACE)

- Improved understanding of the inpatient experience.

Digital (3) - measures of impact

Tees, Esk and Wear Valleys
NHS Foundation Trust

EPMA Measure	Impact
Reduction in leave / discharge pads expenditure	£1276 p.a (average spend)
Increase in safe medicines administration	83% reduction in dosing errors in first quarter 2025
Time saved by pharmacists and clinicians transcribing leave and discharge prescriptions	Initial observations show 65% reduction in time spent writing leave and discharge prescriptions.

Digital and data programme financial benefits	01/04/24	31/03/25	+/-
Cash Release	£3,072,123	£1,815,881	-£1,256,242
Cost Avoidance	£250,358	£0	-£25,0358
Total	£3,322,481	£1,815,881	-£1,506,600

Data source

Impact so far:
Financial data
- sourced from digital and data

Electronic Prescribing & Medicines Administration
- Source and monitoring via medicines management group and Inphase assessments, measuring expenditure and softer feedback from wards
- Integrated Information Centre – Re-Procurement and migration to the cloud

Future expected impact:
Electronic Prescribing & Medicines Administration
- Source and monitoring via medicines management group and Inphase assessments, measuring expenditure and softer feedback from wards

Integrated Information Centre
- The IIC team will be able to better manage the IIC environment and upgrade the IIC software with minimal impact on IIC users and the IIC development team. - measured when the IIC team undertake their first software upgrade later this year.
- Use of new products e.g. IBM Watson will allow research and statistics team to undertake analysis much faster than previously - measured by the BICO section going live with a new product that's underpinned by new IBM functionality. e.g. The Research and Statistics team delivering deep dive analysis underpinned by IBM Watson.

Inpatient Internet :
- Improved inpatient experience –source IIC/IPR

Patient & Carer Experience System procurement (PACE)
- Improved understanding of the inpatient experience – source IIC/IPR

Adult learning disabilities

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our key aims:

- To transform services to provide efficient high quality equitable provision for the people who need access to it whilst maintaining good partnership relationships and supporting staff wellbeing.
- This work meets the national policy to reduce the use of beds for adults with learning disabilities and implements our action plan as a result of the CQC review.

What has changed?

- Remodelled tertiary teams to create an intensive support team (IST).
- Enhanced IST to include step up/down facility (Bluebell apartments) in partnership with Durham Council.
- Combined Physical Health teams to ensure equity across DTV.
- Sustained recruitment at Bankfields Court incl. international nurse recruitment.
- Co-created trauma informed care training to support care providers.

The positive impact of these changes (2023/24 – 2024/25):

- Avoided at least three admissions.
- Reduced staff sickness levels and increased staff retention (IST).
- Plans in place for clinically ready for discharge (CFRD).
- Reduce length of stay – for example a recent admission had a length of stay of 26 days (national average of 747 days).
- Increased support for green light admissions.
- Significant reductions in restrictive practice and seclusion.

Expected future impact

- Further reduction in adult learning disability admissions (due to increase in alternatives to admission).
- Further reduction in length of stay in learning disability beds.
- Reduction in number of bed days used by people who are clinically ready for discharge.
- Further support for green light admissions.
- Further reduction in length of stay in adult mental health beds for autistic or learning disabled people.

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For General Release

Meeting of:	**Board of Directors**
Date:	**14th August 2025**
Title:	**Report of the Freedom to Speak up Guardian**
Executive Sponsor(s):	**Sarah Dexter-Smith/ Kate North**
Report Author(s):	**Dewi Williams and Sarah Dexter-Smith**

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

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

1: We will co-create high quality care	**x**
2: We will be a great employer	**x**
3: We will be a trusted partner	**x**

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
All		The role of the FTSUG and their feedback to services and ultimately to the board underpins all BAF risks but particularly those related to safe staffing and quality of care, by providing an independent and anonymous route for serious concerns to be raised if local resolution is unavailable.

EXECUTIVE SUMMARY:

Purpose:

This paper outlines the activity of the FTSUG in the last quarter, in the context of previous activity rates and outlines the initial stages of moving to our new provider.

Proposal:

This report is unusual in being written by both the FTSUG and the DoP&C, in order to provide Board with an update on the procurement process for an external FTSU provider.

Overview:

Governance

The FTSUG is line managed by the Director of People and Culture but with regular contact and a direct line to the CEO and Chair. The NED FTSU champion has changed from Roberta Barker to Jules Preston (SID), given Roberta's role in chairing the People committee. This is working well and any allegations of detriment are reviewed by the deputy director of HR before being shared with the SID. Any concerns within People and Culture are shared with the Chief Nurse for an independent view.

FTSUG activity

Data is provided for the past two years in order to show the trends in numbers of staff contacting the Guardian. The total number of cases is not the total of the types of issues in that quarter, as individuals often raise more than one concern.

	Q1 23-24	Q2 23-24	Q3 23-24	Q4 23-24	Q1 24-25	Q2 24-25	Q3 24-25	Q4 24-25	Q1 25-26
Total Cases Received	**46**	**44**	**61**	**55**	**52**	**56**	**46**	**70**	**33**
Bullying and Harassment	10	5	7	4	2	0	9	15	7
Worker Wellbeing	20	15	29	32	27	20	11	30	7
Patient Safety/Quality	22	9	15	18	8	7	6	3	3
Inappropriate Behaviours	18	20	25	17	9	18	10	13	14
Other	18	7	17	20	0	4	9	7	2
Demeaning Treatment	2	3	3	3	0	1	1	2	1

With regards to trends/themes these remain difficult to quantify. The only difference the FTSUG can see is how many people who previously would have described their experiences as bullying tend to prefer the term inappropriate attitudes. The reduction in referrals continues, for example last month we only had 9.

Lessons Learnt – example case studies

Speak Up	**Staff Wellbeing/Staff Safety/ Patient Safety/Quality.** 2 workers spoke up about their concerns relating to the current levels of workload pressure in their community service following service reconfiguration, and the importance of ensuring that there are appropriate staffing numbers /skill mix to mitigate this.
Lisen Up	We spoke to the staff and raised with the managing director.
Follow Up	**Actions taken / Lessons learnt:** Information was used as part of ongoing review of the service. The director of operations met with the staff and agreed a range of interventions. Information fed into a transformational service change Those who spoke up valued the opportunity to meet with a senior leader and felt listened to and content that their speaking up contributed to the service development.

Speak Up	**Staff Safety/Wellbeing / Patient Safety/Quality** 2 staff spoke up about their manager and unsafe practices and a culture of discouraging speaking up Subsequently a third person spoke up anonymously reiterating the same concerns but with greater detail including names and a number of concerns related to medicines management.
Lisen Up	Having met the staff we referred on to the managing director
Follow Up	**Actions taken / Lessons Learnt:** The anonymous concern was widely distributed so many senior leaders became involved, but carefully coordinated by the managing director. A comprehensive action plan was delivered to ensure safe practice. Involvement of the PNA's and medicines management team also

	contributed. There have been some HR processes and staff changes

Speak Up	**Inappropriate Attitude / Behaviour / Staff Wellbeing / Safety / Demeaning Treatment** We met with 13 staff at the request of the service manager to proactively support the managers ongoing review following a range of concerns shared by staff during supervision..
Lisen Up	Following meeting with the staff team we delivered a report of our finding/themes, and suggest options to support the team which included the involvement of OD. We continued to listen and speak to staff during the action plan delivery stage.
Follow Up	A number of HR processes have been on going. Some staff have been offered forms of ongoing support and some have chosen to choose to leave the team. However some who spoke up have shared that the service now feels like it has a plan and is becoming a better place to work

Follow up and impact

In the last six months we have consistently moved to an immediate conversation with a senior member staff linked to the area of concern eg General Manager or Care group board member, if the person raising the concern is comfortable with this. This has sped up the process and improved the concerned person's assurance that they have been listened to and concerns acted on. This triangulates well with the monthly Speak Up group where we have had a run of three months where issues raised in that group are already known to services and being addressed.

Procurement of a new independent service

The tender process is complete and work is underway with the preferred provider to

- complete the DPIA,
- meet senior colleagues eg CEO, Chair, FTSU NED,
- meet key service leads including chaplaincy, staff networks, PALS, complaints/comms, staffside, the Guardian of Safe working, and HR

ahead of the contract going live. We will also be sharing policies and information about tribunals, disciplinary/ grievance trends, staff survey data, and workforce demographics so that our lead Guardian and the wider Guardian support network have the appropriate information to work with us from day one.

The service we have commissioned will provide us with one named Guardian who will be our main point of contact and be on site 8 days a month. 24-hour cover will be provided by the wider network of Guardians. Twice yearly in person board reports will be provided. Quarterly meetings will be in place with the CEO, Chair and FTSU NED. Day to day contract oversight will be within People and Culture.

Prior Consideration and Feedback:

Reports go to committee in between each board

Implications:

The transition to a new independent guardian service is an important step for increased resilience of the service (with the wider network of Guardians), full time provision, and independence from the Trust.

However, we want to take the opportunity to thank Dewi Wiliams for the safe service he has provided over the time he has been in role, his unfailing commitment to the people who have

spoken with him, and his support to the trust in flexing his hours as needed through covid in particular.

Recommendations:
That Board takes good assurance that the service being provided to employees is safe and provides good governance to board through the various mechanisms in place to ensure independence and oversight.

That Board welcome the movement in the provision of the external FTSU provider and request a more detailed update to the next People committee as the contract gets underway.

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Committee Key Issues Report		
Report Date to Board of Directors – 14 August 2025		
Date of last meeting: 3 July 2025	**Report of: The Quality Assurance Committee**	
	Quoracy was achieved.	
1	**Agenda -** The Committee considered the following matters: • Minutes of meetings held on 5 June 2025 • Board Assurance Framework • Summary of the Executive Review of Quality Group meeting held on 24 June 2025 • Trust Level Quality Governance Report • CQC Activity and Delivery of the Integrated Oversight Plan and Improvement actions • Safer staffing • Specialist Services • Use of Digital Technology (Oxehealth) • Health Services Safety Investigations Body (HSSIB) • Quality Impact Assessments 2025/26 (QIA/QEIA) • Quality Priorities – deferred • Perinatal Services NYYS • DTVF Teams in Recovery • Focus for the 2025 Developmental Day • Committee Workplan	
2a	**Alert**	The Committee alerts the Board on the following matters: **From DTVF Care Group:** • Bed occupancy, both organic and functional, has increased in MHSOP to 98.51%, this is related to an increase in people who are clinically ready for discharge. • Limited confidence that we can demonstrate the quality of clinical supervision. • One unintentional prone restraint (incident on Bransdale) **From NYYS Care Group:** • The perinatal services have required additional support for a sustained period, additional steps have been taken to utilise resources across both care groups to collaborate for solutions. • Planning for safe section 17 leave compliance has dropped from 85% to 68%, an area for ongoing focus. **Both:** • The number of people clinically ready for discharge across both care groups has increased. Whilst bed occupancy is improving overall, there are several specialist services, such as Bankfields where six out of seven of the patients remain ready to move on to placements. • Limited assurance on progress with the timely completion of after-action reviews (AAR's) and part one mortality reviews. Three AAR's remain outstanding from 2024 – it is understood these do not present any safety risk, however, they do still pose a governance issue. • Those staff not attending training (DNA's) has increased and ILS competency would be impacted by the end of the year if this is not addressed.

2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **DTVF:** • Birch ward has now stepped down from increased oversight by the Provider Collaborative due to demonstrating sustained improvements. • Above target for patients reporting a good experience – 92.93% • Good assurance from specialist services across a range of indicators for example the responsiveness of the perinatal with increased access and significant reductions in waiting lists, particularly in Persistent Physical Symptoms service. Governance has also strengthened, with improved sickness rates and high compliance for training and appraisals. **NYYS:** • Above target for patients reporting a good experience – 96%. **Both:** • Mandatory training compliance is averaging at 85.89% for NYYS and 90.76% for DTVF, however beyond these headlines could potentially lie areas of concern. • No breaches of mixed sex accommodation. **Other Business Matters:** • Five teams have won awards in the national positive practice MH Awards and five teams highly commended. • Committee confirmed reasonable assurance following review of the May 2025 Quality Dashboard and the Quality Risks to the Quality Assurance Schedule. • Approval was given to change the average length of stay measure to the national measure in the Dashboard to "average length of stay for acute beds (rolling quarter). • Committee confirmed good assurance that all 14 CQC Improvement actions within the Integrated Oversight Plan are progressing. • A letter will be sent in response to the Regulation 28 received in May 2025 from the Coroners following an incident when the Police did not refer a person into services due to them being intoxicated. This is not Trust practice and all key agencies, Chief Superintendent and Safeguarding have been made aware. • Committee is seeking further assurance on the variance in compliance across the care groups for level loading leave for staff in inpatient wards. • Committee confirmed there is good assurance that we have considered learning in the Health Services Safety Investigations Body (HSSIB) reports into mental health and agreed that the Organisational Learning Group will have oversight on progress of the learning actions for TEWV. • The QIA and Equality Impact Assessment will be merged into a single Quality/Equality Impact Assessment (EQIA) and this will be accommodated through the Project Management Office (PMO). The committee confirmed good assurance on awareness of the EQIA pipeline and workstreams. **Board Assurance Framework:** Committee took good assurance on the management of the strategic risks assigned to it.
	Advise	The Committee wishes to advise on the following matters to the attention of the Board: **DTVF:** • Two unintentional prone on Cedar ward to facilitate a seclusion exit. • Concerns raised about some elements of leadership at The Orchards which have been followed up.

		NYYS: • DTVF care group are supporting NYYS with answering CAMHS calls to the crisis line. **Both:** • There is a lack of consistent practice across all wards in relation to using Oxehealth to measure physical health vital signs. Alison McIntyre, Associate Director of Nursing is leading the improvement across services. **Restrictive Practice:** • Tear proof clothing – not used. • Mechanical restraint – 6 uses of soft cuffs in SIS all for medical appointments at acute Trust. • NYY – no seclusion. • Two intentional prone restraint (Cedar seclusion exit). • One unintentional prone restraint (incident on Bransdale). • Seclusion – no remote seclusion reviews in SIS. • Long Term Segregation – two, one on Bedale and one on Jay.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that good assurance can be provided that the risks to quality are understood and are being managed appropriately.
3	**Actions to be considered by the Board**	That the Board note the report and take good assurance that there is good oversight and management of risks to quality of care.
4	**Report compiled by**	Jules Preston, Acting Chair of the Quality Assurance Committee, Deputy Chair of Trust/Non-Executive Director, Beverley Murphy, Interim Deputy Chief Executive/Chief Nurse and Donna Keeping, Corporate Governance Manager

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For General Release

Meeting of:	**Board of Directors**
Date:	**14th August 2024**
Title:	**Quarterly Report of the 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: We will co-create high quality care	
2: We will be a great employer	**X**
3: We will be a trusted 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 Q1 report for 2025-2026. The appendices 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. Reports and 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. Some exception reports may yet be submitted by doctors in relation to the quarter. In terms of timescales, 100% of exception reports in both the North and the South were responded to within 7 days.

All fines have been levied due to breach of the 5 hours overnight rest requirement on NROC 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 has moved from being hybrid to being fully resident. This change will reduce the risk of breaches relating to achievement of 5 hours of continuous overnight rest for the 1st tier rota but the second tier (middle grade) rotas remain NROC and so the risk remains for these rotas.

The internal system for covering out of hours rota gaps appears to generally continue to function well in that there is no reported use of agency locums on out of hours postgraduate doctors' rotas. There have been occasions when doctors on the higher tiers have had to 'act down' for periods of time when internal locums cannot be appointed at short notice.

Overview:

Appendices 1 and 2 give details relating to DTV&F (North) and NYY&S (South) Care Groups respectively for the quarter April to June 2025.

In the North there have been 4 exception reports in Q1, which is a decrease over Q4 (17) and Q3 (17) and is back down at what was observed in Q1 in 2024. There appears to be no pattern of concern. One exception was in relation to breach of the requirement for 5 hours of overnight rest on an NROC Senior Registrar rota. This exception occurred in March 2025 but was submitted in May 2025. The corresponding fine (£40.10) does not appear to have been processed yet and medical staffing are currently looking into this.

There have been 11 exception reports in the South in Q1, which is a slight increase on Q4 (7) but a decrease from Q3 (20), Q2 (39), and Q1 (15) in relation to breach of the requirement for 5 hours of overnight rest. We will need to observe the data over the next few quarters to see the anticipated impact of the new rotas in NYY and Scarborough.

Additional information about reasons for the exception reports are given within the appendices.

I continue to emphasise the importance of exception reporting to postgraduate doctors' representatives in the resident doctors training fora (RDTFs) and at inductions.

Data for the number of locum shifts picked up by resident doctors for out of hour shifts has been listed. All doctors who have taken on these shifts have opted out of the 48 hour week. Although for some of the second tier doctors this increases the weekly hour worked substantially, in reality the actual hours worked are less as these are NROC shifts. We know from the exception reporting that there is not high level of proportionate NROC breaches of 5 hours continuous rest.

Vacancies for normal working day posts are given within the appendices along with the number of shifts remaining uncovered after use of the Trust Doctor Scheme or, where necessary, agency locums. The remaining uncovered normal working day shifts, after accounting for annual leave, have been presented. 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.

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.

From September 2025, following the implementation of exception report reforms, all residents must receive their choice of either payment or time off in lieu (TOIL) for all time worked above contracted hours following exception, except when a breach of safe working hours mandates the award of TOIL. All resulting payments and TOIL must be facilitated by responsible parties and must not be substituted without residents' consent. Historically TOIL has been the standard for additional hours worked and so there may be a change in the cost to the Trust with this reform. At present there is not a high level of exception reporting for working late and so based on this we do not anticipate a high cost to the Trust.

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.

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:
There is potential for industrial action to impact the number of exception reports.

Fines are likely to continue to be generated, particularly from the middle tier rota, in relation to NROC rotas and as detailed above. Established patterns of breaches such as these should continue to be reviewed by the Trust.

Recommendations:

The Board are asked to read and note this quarterly 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. These appendices have been written and provided by the Medical Staffing Manager.

Appendix 1 DTV&F (North Care Group)

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 April 2025 – 30th June 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	0	0	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	0	0	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	0	0	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	1	1	0
Trust Doctors -	0	0	0	0

Teesside				
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	0	0	0
Total	**0**	**4**	**4**	**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	0	0	0
North Durham (F2/ CT1-3/GP/trust)	0	0	0	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	1	1	0
DTV CYPS Senior Registrars	0	0	0	0
Total	**0**	**4**	**4**	**0**

North Durham – 1 exception report submitted by an ST6 – unable to achieve breaks.
South Durham – 3 exception reports submitted by the same CT1 due to late finishes.

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	0	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	3	0	0
South Durham Senior Registrars	0	0	0	0
North Durham	0	1	0	0

Senior Registrars				
Total	**0**	**4**	**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	
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	41	40	0	318	314
	CT2			0		
	GP			0		
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	11	11	0	168	168
North Durham	F2	0	0	0	0	0
	CT1	4	4	0	40.5	40.5
	CT2			0		
	GP			0		
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0

	Middle Tier (SR/SAS)	33	33	0	648	648
South Durham	F2	0	0	0	0	0
	CT1	12	11	0	106.5	94
	CT2			0		
	GP			0		
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	8	8	0	160	160
CAMHS	Middle Tier (SR/SAS)	56	56	0	1028	1028
Total		**165**	**163**	**0**	**2469**	**2452.5**

The discrepancies in the figures are due to:

- *1 day shift on Teesside Resident Rota was not covered, the middle tier acted down.*
- *1 shift on South Durham Rota was not covered, the middle tier acted down.*

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	29	29	0	260	260
Service requirement	0	0	0	0	0
Sickness	41	41	0	562	562
On call cover	83	81	0	1495	1478.5
Paternity leave	4	4	0	72	72
Maternity leave	3	3	0	48	48
Special leave	5	5	0	32	32
Annual Leave	0	0	0	0	0
Total	**165**	**163**	**0**	**2469**	**2452.5**

Locum work carried out by trainees						
Grade	**Rota**	**Number of shifts**	**Number of hours worked**	**Rostered weekly hours**	**Actual weekly hours**	**Opted out of WTR**
CT2 (A)	Teesside	1	12.5	42.50	45.30	Y
	NYY	1	24			
SpR (B)	North Durham MT	5	104	44.25	52.25	Y
SpR (C)	North CYPS	1	24	43.25	48.75	Y
	Teesside MT	3	48			
CT3 (E)	North Durham	1	12	44	49.45	Y
	South Durham	1	12			
	Teesside	2	8			
	NYY	2	10			
	Scarborough	2	28.5			
SpR (F)	North CYPS	12	232	34.50	70.15	Y
	Scarborough MT	12	216			
	South CYPS	1	16			
TD (G)	Teesside	4	50	43.75	47.50	Y
SpR (H)	North CYPS	14	256	43.25	69.00	Y
	North Durham MT	1	24			
	Teesside MT	3	56			
TD (I)	Teesside	6	58	43.75	48.15	Y
SpR (K)	North CYPS	4	80	43.25	52.15	Y
	North Durham MT	1	16			
	Scarborough	2	32			

	MT					
SpR (L)	North CYPS	6	96	42.00	49.45	Y
CT1 (M)	North Durham	1	4	43.25	43.55	Y
CT1 (O)	South Durham	3	12	43.25	44.15	Y
TD (P)	Teesside	1	4	43.75	44.00	Y
SpR (Q)	North Durham MT	4	88	43.25	66.00	Y
	South Durham MT	4	88			
	Teesside MT	1	16			
	Scarborough MT	5	88			
	NYY MT	1	16			
TD (R)	South Durham	3	37	43.75	52.50	Y
	Teesside	9	78.5			
CT1 (S)	Teesside	1	12.5	43.25	44.45	Y
	South Durham	1	4			
GP (T)	Teesside	4	33	43.75	46.30	Y
SpR (U)	North CYPS	3	48	34.50	42.50	Y
	South Durham MT	1	16			
	North Durham MT	1	24			
	Teesside MT	1	16			
CT1 (V)	North Durham	2	24.5	43.75	53.00	Y
	South Durham	1	12.5			
	Teesside	8	83			

SpR (X)	North Durham MT	4	80	43.75	49.90	Y
CT2 (Y)	Teesside	1	12.5	42	43.00	Y
SpR (Z)	North Durham MT	3	56	44	59.45	Y
	Teesside MT	3	56			
	Scarborough MT	4	72			
	NYY MT	1	16			
SpR (AA)	North Durham MT	2	48	43	48.50	Y
	South Durham MT	1	24			
CT2 (CC)	Teesside	1	12	43.75	53.30	Y
	South Durham	1	12.5			
	Scarborough	4	64			
	NYY	3	36.5			
SpR (DD)	North CYPS	2	32	42	44.45	Y
CT1 (EE)	South Durham	1	4	43.75	45.00	Y
	Teesside	1	12.5			
SpR (FF)	North Durham MT	1	16	43	44.25	Y
CT2 (HH)	Teesside	1	4	43.75	44.00	Y
CT1 (II)	Teesside	2	16.5	42	43.25	Y
Total		**176**	**2694.5**	**1194**	**1394.25**	

The discrepancies in the figures are due to:

- *Additional shifts due to doctors completing shifts in NYY as well as the DTV. Those shifts have been removed from the NYY report.*
- *Middle tier (MT) are on non resident on call for 16 or 24 hours, however, the actual work carried out is much less.*

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	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2					
	CT3					
	ST4 -6	3	3	3	3	148.5
	GP	4 (ITP)	4 (ITP)	4 (ITP)	4	198
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	1	1	1	49.5
	GP	1 (ITP)	1 (ITP)	1 (ITP)	1	49.5
South Durham	F1	0	0	0	0	0
	F2	1	1	1	1	49.5
	CT1	0	0	0	0	0
	CT2					
	CT3					
	ST4 -6	3	3	3	3	148.5
	GP	2 (ITP)	2 (ITP)	2 (ITP)	2	99
Total		**15**	**15**	**15**	**15**	**742.2**

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 1.

Appendix 2 NYY&S (South Care Group)

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 April to 30th June 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	1	1	0
F2 - York	0	0	0	0
CT1-2 / GP - Northallerton	0	0	0	0
CT1-2 / GP – Harrogate	0	0	0	0
CT1-2 / GP - Scarborough	0	1	1	0
CT1-2 / GP - York	0	2	2	0
CT3 – Northallerton	0	0	0	0
CT3 – Harrogate	0	0	0	0
CT3 – Scarborough	0	1	1	0
CT3 – York	0	2	2	0
ST4-6 - Northallerton	0	1	1	0
ST4-6 - Harrogate	0	0	0	0
ST4-6 - York	0	3	3	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	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**
Trust Doctors - Scarborough	0	0	0	0
Trust Doctors - York	0	0	0	0
Total	**0**	**11**	**11**	**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	5	5	0
Scarborough (F2/CT1-3/ GP/trust doctor)	0	3	3	0
NYY middle tier	0	4	4	0
Scarborough middle tier	0	0	0	0
South CYPS middle tier	0	0	0	0
Total	**0**	**11**	**11**	**0**

Three exception reports submitted by Scarborough resident doctors, 2 out of these were for breach of not having 5 continuous hours of rest from 10pm to 7am. One exception submitted incurred a breach and a payment for additional plain hours.

Eight exception reports were submitted by NYY resident doctors, 6 out of these were for breach of not having 5 continuous hours of rest from 10pm to 7am. There was 1 exception reported for additional hours and 1 exception reported for late finish. The reasons for the exceptions were multiple telephone advice, mental health assessment, acuity 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	1	0	0
NYY Middle tier	4	0	0	0
Scarborough Resident doctors	2	0	0	0
Scarborough Middle tier	0	0	0	0
Total	**10**	**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	6	0	0	86.5
	CT1/CT2/GP	50	20	0	546	233
	CT3	0	1	0	0	4
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	85	83	0	1472	1436
Scarborough	F2	0	7	0	0	168
	CT1/CT2/GP	20	13	0	480	312
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	87	79	0	1496	1392
Total		**242**	**209**	**0**	**3994**	**3627.5**

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

- *Consultants voluntarily picked 2 locum middle tier shifts in NYY*
- *23 resident doctor's shifts were picked by SAS (IFDs that are not eligible for middle tier shifts).*
- *Consultants voluntarily picked 8 locum middle tier shifts in Scarborough*

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	2	2	0	25	25
Vacancy	212	186	0	3585.5	3287
Sickness	26	19	0	359.5	291.5
Increase in workload	0	0	0	0	0
Special leave	2	2	0	24	24
Extra weekend support	0	0	0	0	0
Annual Leave	0	0	0	0	0
Total	**242**	**209**	**0**	**3994**	**3627.5**

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

- *Consultants picked 8 locum middle tier shifts in Scarborough*
- *Consultants picked 2 locum middle tier shifts in NYY*
- *The consultants voluntarily selected these middle tier shifts on Patchwork, and the shifts were subsequently allocated to them.*

Locum work carried out by trainees						
Grade	**Rota**	**Number of shifts**	**Number of hours worked**	**Rostered weekly hours**	**Actual weekly hours**	**Opted out of WTR**
F2 (A)	Scarborough	4	48	43.5	47.19	Y
CT1/2 (B)	Scarborough	2	28	43.5	45.65	Y
CT1/2 (C)	Scarborough	2	28	43.5	45.65	Y
CT1/2 (D)	NYY	1	16	43.75	44.98	Y
CT1/2 (E)	NYY	3	41	43.75	46.90	Y
CT1/2 (F)	NYY	1	12.5	43.75	44.46	Y
CT1/2 (G)	NYY	1	24	43.75	45.60	Y
CT1/2 (H)	NYY	1	16	43.75	44.73	Y
CT3 (I)	NYY	1	4	43.75	44.06	Y
ST 4-6 (J)	NYY SpR	6	120	44	53.23	Y
ST 4-6 (K)	NYY SpR	4	72	44	49.54	Y
ST 4-6 (L)	Scarb SpR	11	208	44	60	Y

ST 4-6 (M)	Scarb SpR	10	192	44	58.77	Y
ST 4-6 (N)	NYY CAMHS SpR	7	128	26.5	36.35	Y
ST 4-6 (O)	NYY CAMHS SpR	7	120	44.5	53.73	Y
ST 4-6 (Q)	NYY CAMHS SpR	6	96	44.5	51.88	Y
Total		67	1153.5			

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

- *LYPFT SPR working with the trust were allocated 35 shifts*
- *Doctors who no longer work with the trust were allocated 70 shifts*
- *North doctors (included in the north report) were allocated 27 shifts*
- *SAS/IFDs that are not eligible for middle tier rota were allocated 23 shifts*
- *Consultants were allocated 10 shifts*
- *Some shifts are non resident on call for 16 or 24 hours, resulting in high weekly hours, however, the actual amount of work done is always less.*

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	1	1	1	1	49.5
	ST4 -6	0	0	0	0	0
	GP	1	1	1	1	49.5
	Trust Doctor	0	0	0	0	0
Harrogate	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	1	1	1	1	49.5
	ST4 -6	0	0	0	0	0
	GP	1	1	1	1	49.5
	Trust Doctor	0	0	0	0	0
Scarborough	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	1	1	1	1	49.5
	ST4 -6	1	0	0	0.33	16.33
	GP	2(1ITP+1GP)	2(1ITP+1GP)	2(1ITP+1GP)	2(1ITP+1GP)	99
	Trust Doctor	0	0	0	0	0

York	F1	0	0	0	0	0
	F2	1	1	1	1	49.5
	CT1-3	0	0	0	0	0
	ST4 -6	1	1	1	1	49.5
	GP	0	0	0	0	49.5
	Trust Doctor	0	0	0	0	0
Total		**10**	**9**	**9**	**9.33**	**461.83**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	1	£456.60
Harrogate, Northallerton & York	3	£485.02
Total	**4**	**£941.62**

All fines were for breach of not having 5 hours continuous rest

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14th August 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: We will co-crate high quality care	**x**
2: We will be a great employer	**x**
3: We will be a trusted 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 April to June 2025 (Quarter 1). 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 Q1 information for the Trust and includes 2024/25 data for comparison.

- During Q1 557 deaths were reported on Inphase of patients who had been in contact with our services in the 6 months preceding the date of death. Of these, 340 patients were still open to a Trust service at the time of their death, of which 9 patients were open to an Adult Learning Disability service. These figures represent all deaths (including natural expected/unexpected, and unnatural/unexpected) in relation to people who were open to the Trust's caseload which is largely community and includes older people and memory services (>70,000).
- 4 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 1 inpatient death occurred in an Adult Mental Health (AMH) ward and has been reported on the national Strategic Executive Information System (StEIS) and is subject to a Patient Safety Incident Investigation (PSII). This patient death was reported as suspected suicide and occurred off the ward.
- 1 unexpected community death was reported on StEIS during the reporting period and is being investigated as a PSII.
- There was 1 other unexpected death reported on StEIS during the reporting period which is being investigated as PSII. This was in a relation to a patient was who was transferred from an AMH ward and later discharged to an acute hospital following a deterioration in physical health.
- Immediate After Action Reviews were conducted or are in progress for all the above PSII deaths and where appropriate, rapid improvements have been made to improve patient safety.
- All PSIIs have commenced.
- 13 Part 2 Structured Judgement Reviews (SJRs) were requested.
- 70 Part 1 reviews and 6 SJRs were completed.
- 7 Patient Safety Incident Investigations for unexpected deaths were completed.
- 12 patient deaths were reported to LeDER during Q1. These include the 9 patient deaths that occurred in Q1 as well as patient deaths that occurred towards the end of Q4. 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.

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

- 4 in relation to environmental risks and issues
- 1 in relation to recording of reasonable adjustments in CITO
- 1 in relation to the Sullivan Review; Process Change for Re-assigning Gender and Sex Identity in the GP Record

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 Executive Directors Group. 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.

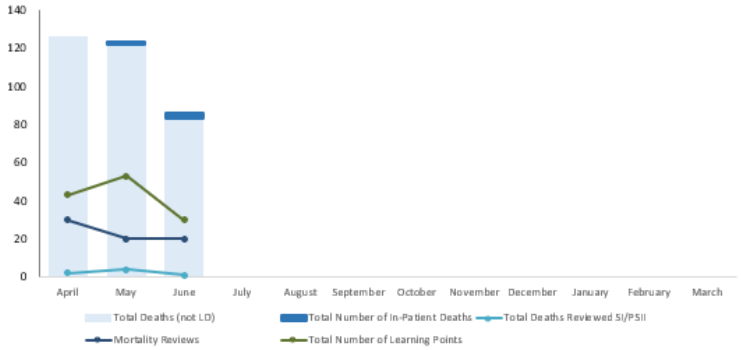
Appendix 1: Learning from Deaths Dashboard Q1 2025/26

Learning from Deaths Dashboard - Data Taken from Cito
Reporting Period - Q1 2025-26

Summary of total number of deaths and total number of cases reviewed under the SI Framework or Mortality Review

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

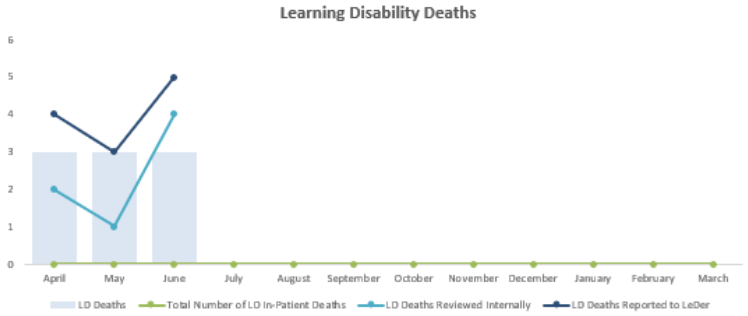
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI/PSII		Mortality Reviews		Total Number of Learning Points	
	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25
Q1	331	↘ 453	4	↘ 5	7	↘ 32	70	↗ 52	126	↗ 123
Q2	0	↘ 445	0	↘ 7						
Q3	0	↘ 480	0	↘ 8						
Q4	0	↘ 434	0	↘ 6						
YTD	331	↘ 1812	4	↘ 26	7	↘ 32	70	↗ 52	126	↗ 123



Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI 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	
	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25
Q1	9	↘ 24	0	↘ 1	7	↗ 6	12	↗ 9
Q2	0	↘ 20	0	↔ 0				
Q3	0	↘ 25	0	↔ 0				
Q4	0	↘ 19	0	↔ 0				
YTD	9	↘ 88	0	↘ 1	7	↗ 6	12	↗ 9



Appendix 2

Mortality Reviews 2025/2026

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 2025/2026

6 structured judgement reviews were discussed and reviewed by the Mortality Review Panel during Q1.

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

- Care planning, interventions and record keeping
- Safeguarding
- Medication

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 After Action Reviews (AARs) or Patient Safety Incident Investigations (PSIIs). The themes from mortality reviews are triangulated with learning from AARs/PSIIs to establish any new themes occurring.

1.2 Learning from deaths and patient safety incidents

Within Quarter 1 there were a total of 45 learning points from both Patient Safety Incident Investigations and mortality reviews. In addition, there were 81 learning points from After Action Reviews undertaken following patient deaths. The most frequent actionable learning theme identified related to record keeping and documentation. Processes was the second most frequent learning point identified.

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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For General Release

Meeting of:	**Board of Directors**
Date:	**14 August 2025**
Title:	**Leadership Walkabouts Feedback – June 2025**
Executive Sponsor(s):	**Ann Bridges, Exec Director of Corp Affairs & Involvement**
Author(s):	**Ann Bridges**

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

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

1: We will co-create high quality care	✓
2: We will be a great employer	✓
3: We will be a trusted partner	✓

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
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 June 2025.

Proposal*:*

This report is presented to Board as good assurance. Full feedback reports are received by Management Group monthly and actions reviewed and monitored for completion.

Overview:

The Trust undertakes monthly leadership walkabout visits to services, which offer an opportunity for teams to have conversations directly with Board members and Governors to raise any matters of importance. These visits 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.

Leadership walkabouts took place on 30 June 2025 across CAMHS community / respite and Mental Health Services for Older People (MHSOP) inpatient and community services. July walkabouts were stood down due to service pressures and holiday cover. Summarised feedback follows.

<u>Oak Ward, MHSOP inpatient, West Park Hospital, Darlington</u>

- **Strengths / achievements:** positive impact of a multidisciplinary team approach, strong team culture, and stable staffing with no vacancies.

- **Challenges**: included delayed patient discharges due to social care response times, managing patients who do not attend appointments, staffing needs for hospital transfers, and responsiveness of facilities contractors.
- **Support needed and actions:** actions were assigned to relevant attendees to improve social care connections, (estates) supplier responsiveness, outcomes reporting, and coordination of corporate information requests.

Easington Community CAMHS Getting More Help

- **Strengths / achievements:** valuing mutual support, effective caseload management, with stable leadership and long-serving managers and returning trainees, boosting morale and service consistency. Holistic approaches were outlined including strong ties with schools and safeguarding, new initiatives like piloting virtual prescription clinics for ADHD medication.
- **Challenges**: high demand in deprived communities, inconsistent VCSE support especially for post-diagnostic Autism, system functionality issues, and staffing vacancies, with managing public and partner expectations being the top concern.
- **Support needed and actions:** clearer service expectations, improved electronic patient records (EPR) systems, and creative staffing use. An action was completed to discuss facility limitations and VCSE provision with relevant stakeholders to support young people's recovery.

Beech Unit, Community MSHOP, West Park Hospital, Darlington

- **Strengths / achievements:** team values their collaborative teamwork, resilience, and compassionate, patient-focused care. Recent experienced managerial cover has improved staff morale, despite past losses and burnout.
- **Challenges:** long-term sickness and vacancies, and staff picking up additional responsibilities, impacting caseloads and ability to provide supervision and medical cover availability. Frustrations were expressed around Cito.
- **Support needed and actions:** additional clinical room to accommodate patient appointments, review of skill mix and recruitment processes, including psychology vacancies.

Stockton Community CAMHS Getting More Help

- **Strengths / achievements:** good skill mix, strong mutual support during staff sickness or increased demand, and a dedicated Looked After Children (LAC) offer. Caseloads are managed to allow flexibility, and additional support is provided during local incidents. Ongoing transformation work with good leadership on transition initiatives, eg early planning and joint appointments. ROMS completion is increasing with processes to ensure data collection before discharge, and quality improvement projects considered to further support clinical outcomes.
- **Challenges**: include managing transitions from child to adult services, recurrent changes to processes, embedding Routine Outcome Measures (ROMS) in clinical practice, and limited physical space at the base. There is also a need for wider understanding of the service offer.
- **Support needed and actions**: clarity on referral criteria and collaboration with adult mental health services and identifying appropriate support for needs not covered within the team, such as post-diagnostic autism support. Staff retention is influenced by progression opportunities, and issues like limited meeting spaces and transportation access affect service delivery.

Community CAMHS Lake House, Scarborough

- **Strengths / achievements:** supportive team ethos, extensive clinical experience, and resilience. Team have extended working and opening hours to offer patients and families more appointment flexibility
- **Challenges:** ADHD team managing high caseloads and long waiting times since 2020, leading to long waits for ADHD assessment and medication initiation, compounded by staff sickness.
- **Support needed and actions:** additional CITO training, air conditioning / environmental modifications (high indoor temperature at visit, with some patients shortening sessions due to heat). Management support for resource balancing and commissioning requested.

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NHS Foundation Trust

Committee Key Issues Report				
Report Date: 14 August 2025		**Report of: Charitable Funds Committee**		
Date of last meeting:		16 June 2025 – The meeting was quorate		
1	**Agenda**	The agenda included: - Charitable Trust Fund Annual Report and Accounts - Funding criteria and approval process - Job Description for a Fundraising Officer		
2a	**Alert**	Committee considered the Charitable Trust Fund Annual Report and Accounts and recommended to Audit and Risk Committee that the Charitable Fund could be considered a going concern. Committee agreed the job description for a two-year fixed term Fundraising Officer, who will cocreate the brand identity and web presence and establish internal procedures and a digital platform for donations.		
2b	**Assurance**	Committee received a transaction report for 2024/25 and agreed to receive the report quarterly, which will provide an opportunity to review all transactions of the funds, to be assured that they continue to be used appropriately. This assurance will be supported by an internal audit review of the charitable funds during 2025/26.		
2c	**Advise**	Committee agreed to seek advice from the Company Secretary in relation to the trustee status of executive directors who do not have a voting right at the Board of Directors and (if needed) details of trustees listed in the Annual Report and Accounts will be updated accordingly. In respect of the application and approval process it was agreed that a business case/application template would be developed, to support consistency and transparency. For funds administrated by trustees, it was agreed that the process will be amended to include delegated authority to the Executive Director of Corporate Affairs and Involvement and/or the Executive Director of Finance, Estates and Facilities (if appropriate) to approve applications over £10k, to ensure applications are considered in a timely way. Committee agreed to explore opportunities to work with partners to repurpose aged laptops at the next meeting. The agenda will also include items on the management of independent fundraising, the Charitable Funds Strategy and digital infrastructure requirements, to support donations to the funds.		
2d	**Review of risks**	There are no BAF risks relevant to this committee and no risks were identified.		
3	**Actions to be considered by the Board**	n/a		
4	**Report compiled by**	J Preston, Chair and L Romaniak, Executive Director for Finance, Estates and Facilities	**Minutes available from**	K Christon Deputy Company Secretary

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Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14 August 2025**
Title:	**Communications update**
Executive Sponsor(s):	**Ann Bridges, Exec Director of Corp Affairs & Involvement**
Report Author(s):	**Sarah Paxton, Head of Communications**

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

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

1: We will co-create high quality care	**x**
2: We will be a great employer	**x**
3: We will be a trusted partner	**x**

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
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. The report impacts public confidence with a focus on providing a clear, compelling and consistent narrative, demonstrating change, and showing the positive impact of these changes.* *This will support us to proactively build public confidence and trust.*

EXECUTIVE SUMMARY:

Purpose:

This report provides an update on the progress made on delivery of the Trust's communications strategy in June and July 2025. It includes an overview of key pieces of work, how this supports our objectives and metrics to demonstrate how we continue to measure the impact of our communications.

Proposal:

This update is presented as good assurance in terms of delivery of the communications strategy and related targets.

Overview:

The communications strategy sets out the strategic direction for our communications - what our patients, staff, public and stakeholders can expect from us and guides all of our

communications both internally and externally. It supports us to respond to the strategic context we're working in and is an important enabler in rebuilding public trust and confidence supported by ongoing improvements to our services.

The foundations of this are our communications objectives which are to:

1. Increase public confidence
2. Support a culture of co-creation
3. Strengthen partnerships
4. Enhance staff engagement
5. Provide accessible and timely information

We have included the evaluation reports for both June and July.

In summary, taking a more proactive approach to communications continues to have a positive impact across a range of communications channels and activities including:

1. Press coverage and campaigns:
   - Human interest stories were the main focus of our positive media coverage. Stories included our CAMHS staff in Redcar and co-creation work in Scarborough. We also shared news of our new Augmented Reality mental health training simulator – the first of its kind in the country. This supports our objective to increase public confidence, demonstrating the positive impact our services have on our communities.

2. Media and online presence:
   - 16 media releases were issued (12 in June and 4 in July) which exceeds our KPI.
   - 8 media enquiries were managed including two coroner inquests and adult ADHD assessment waiting times.
   - The team secured 43 pieces of coverage across online news, TV, and radio (20 in June and 23 in July).
   - Media sentiment was on the whole supportive and positive. 95% of coverage in June was positive. 70% of coverage was positive in July, and 12% neutral. As mentioned above, there was coverage relating to an inquest and waiting times which was reflected in some of the media sentiment.

3. Our digital channels
   - Our website had 84,855 page views in June – July. The top three visited pages were careers, services and locations.
   - Our staff intranet had 230,277 in June – July. Top staff intranet news stories included 'Chris's voice video', 'carers use the voice of experience to help others' and 'fun in the sun at retro Ridgeway event'.

4. Social media engagement:
   - Across June and July, our social media content reached 283,329 people, with 107 total posts and 28,797 total followers.
   - Overall, our social media engagement during June and July 2025 remains strong and successful in reaching a wide-ranging audience, generating positive interactions including:
     - Old crisis number deactivated
     - Carers week
     - Learning disability week
     - New simulation suite at Lanchester Road
     - Laura's maternity story – Every Mum Matters
     - Claire and Katie's carer story

- Our LinkedIn presence continues to be one of the most engaged platforms across the country.

Prior Consideration and Feedback:
Public confidence and trust cannot be managed solely through communications. It's important to consider the wider context that we're working in and changes taking place across health and social care at a national, regional and local level, including coroner inquests. All of this impacts our communications approach and tactical delivery, as well as public perception.

Implications:
The implications of not having a communications strategy and supporting delivery plan would impact Board Assurance Framework (BAF) 13 and result in us being unable to mitigate the related BAF risks as far as possible.

Recommendations:
The Board of Directors is asked to note the progress made and take good assurance.

Communications Dashboard

June 2025

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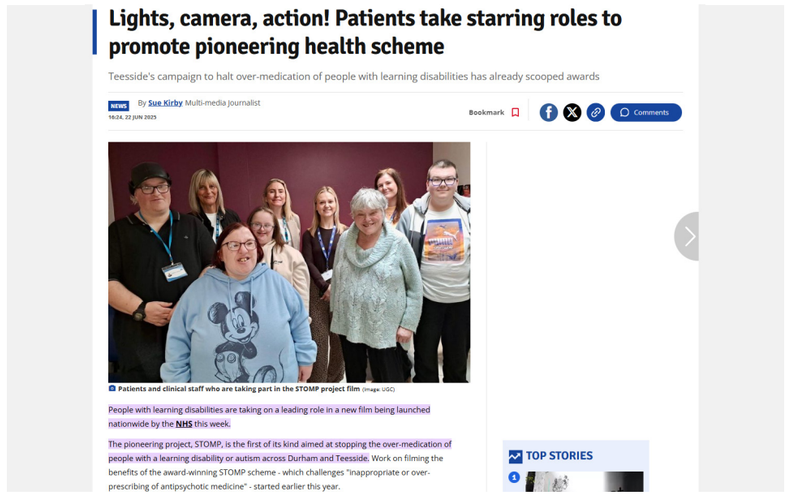
Tees, Esk and Wear Valleys
NHS Foundation Trust

Highlights

Carers week was marked with personal stories of carers and photos of our team's celebrations shared internally and externally

We announced the return of Voyage to Recovery, with participants taking part in team building activities in the lead up before the big sail



Lights, camera, action! Patients take starring roles to promote pioneering health scheme

Teesside's campaign to halt over-medication of people with learning disabilities has already scooped awards

News By Sue Kirby Multi-media Journalist
16:24, 22 JUN 2025

Bookmark Comments

Patients and clinical staff who are taking part in the STOMP project film (Image: UGC)

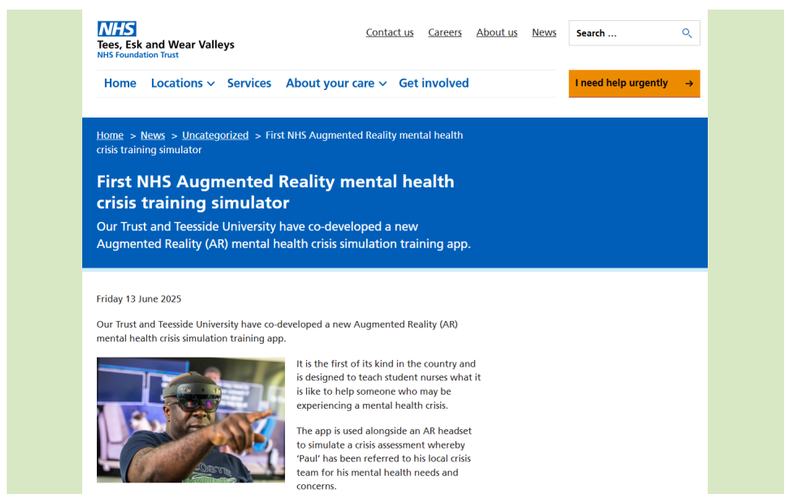
People with learning disabilities are taking on a leading role in a new film being launched nationwide by the NHS this week.

The pioneering project, STOMP, is the first of its kind aimed at stopping the over-medication of people with a learning disability or autism across Durham and Teesside. Work on filming the benefits of the award-winning STOMP scheme - which challenges "inappropriate or over-prescribing of antipsychotic medicine" - started earlier this year.

TOP STORIES

The STOMP film was launched, gaining press coverage during Learning Disability week. It aims to stop the over-medication of people with learning disabilities

As part of Learning Disability week, we shared the story of 367 Thornaby Road, a pioneering example of long term community care



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Home > News > Uncategorized > First NHS Augmented Reality mental health crisis training simulator

First NHS Augmented Reality mental health crisis training simulator

Our Trust and Teesside University have co-developed a new Augmented Reality (AR) mental health crisis simulation training app.

Friday 13 June 2025

Our Trust and Teesside University have co-developed a new Augmented Reality (AR) mental health crisis simulation training app.

It is the first of its kind in the country and is designed to teach student nurses what it is like to help someone who may be experiencing a mental health crisis.

The app is used alongside an AR headset to simulate a crisis assessment whereby 'Paul' has been referred to his local crisis team for his mental health needs and concerns.

We shared the news of our new Augmented Reality mental health crisis training simulator. It is the first of its kind in the country

We announced big wins across our Trust in the 2025 Positive Practice in Mental Health Awards

Communications Objectives

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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 planning for Our Journey to Change strategy refresh • Launched our Star awards • Support for volunteer's week including good news stories
Enhance staff engagement	• Celebrating and raising awareness of Pride month • Support and recommendations on Cito communications • Internally shared 'Chris's voice', the film we created with the family of Chris Irish
Strengthen partnerships	• Annual report finalised • Publication of our quality account • Support for MP meetings in June
Support a culture of co-creation	• Promoted the STOMP film project • Support for carers week – including stories from carers • Personalised care planning communications (developing an animation)
Provide accessible and timely information	• Ongoing work to improve our patient and carer information process • Freedom of Information requests • Staff personas work

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

3
Media enquiries handled by the team

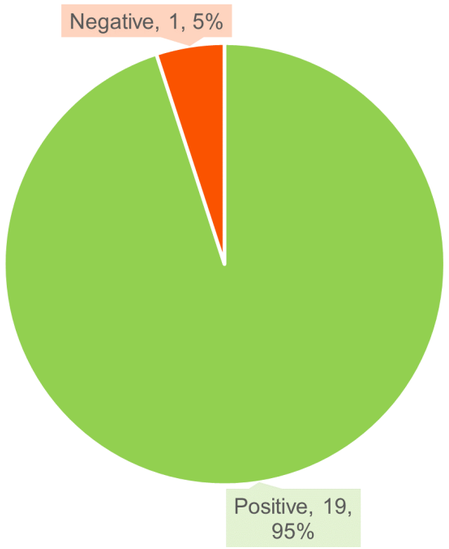
12
Media releases issued

20
Total pieces of coverage across online news, TV, and radio

Some of our news stories

- **Dedicated North East NHS nurse retiring after five decades –** *Northern Echo*
- **'I turned my life around after battling addiction for 25 years and now help others' –** *Chronicle Live*
- **Local NHS worker raises over £500 to support people living with dementia –** *Scarborough News*
- **Lights, camera, action! Patients take starring roles to promote pioneering health scheme –** *Teesside Live*
- **Teesside nurses part of first NHS Augmented Reality mental health training simulation –** *Greatest Hits Radio*
- **£52k occupational therapist, fitness instructor and PA among NHS jobs you can apply for on Teesside** – *Northern Echo*

Media sentiment



Our website

46,874
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

134,275
page views

Top staff intranet news stories

1. Chris's Voice video launch
2. Carers use voice of experience to help others
3. Gypsy, Roma, Traveller history month

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our audience

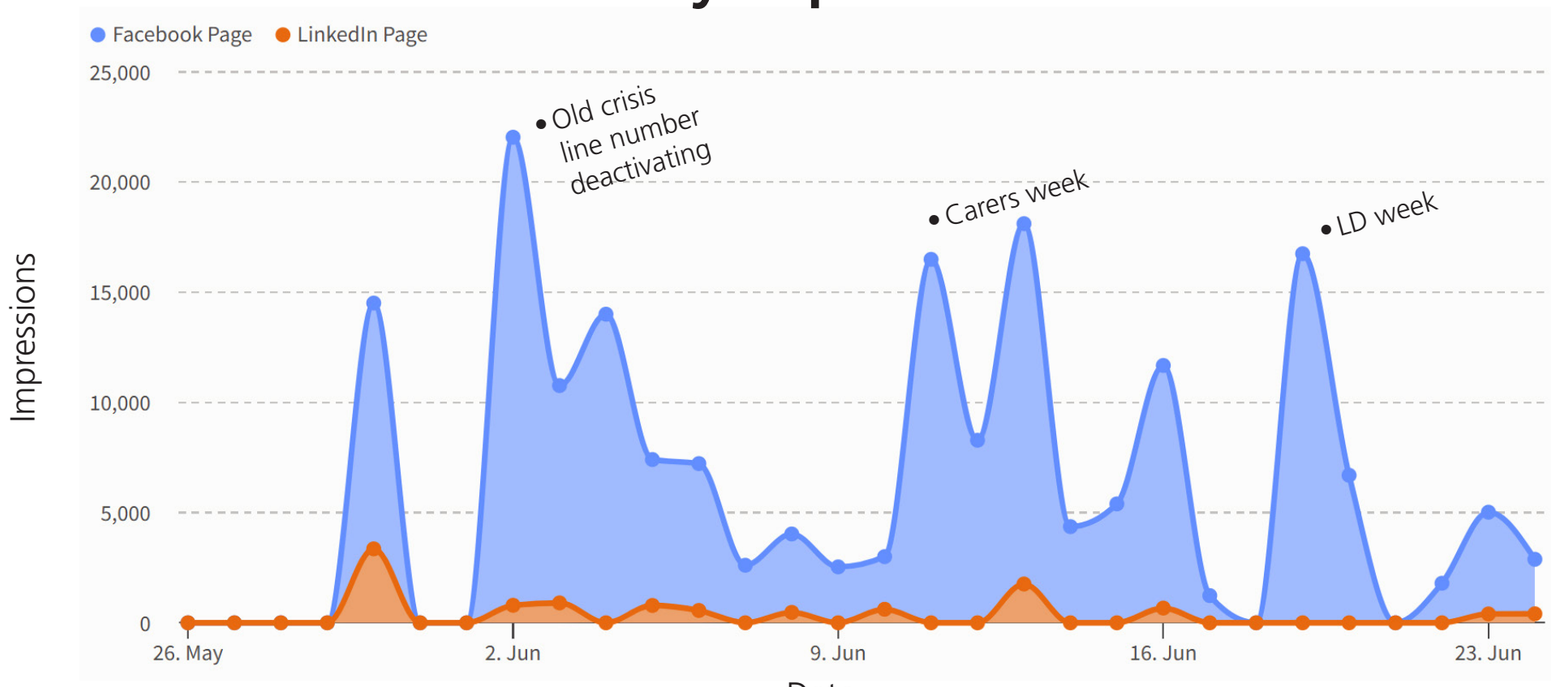
28,617
Total followers

236
New followers

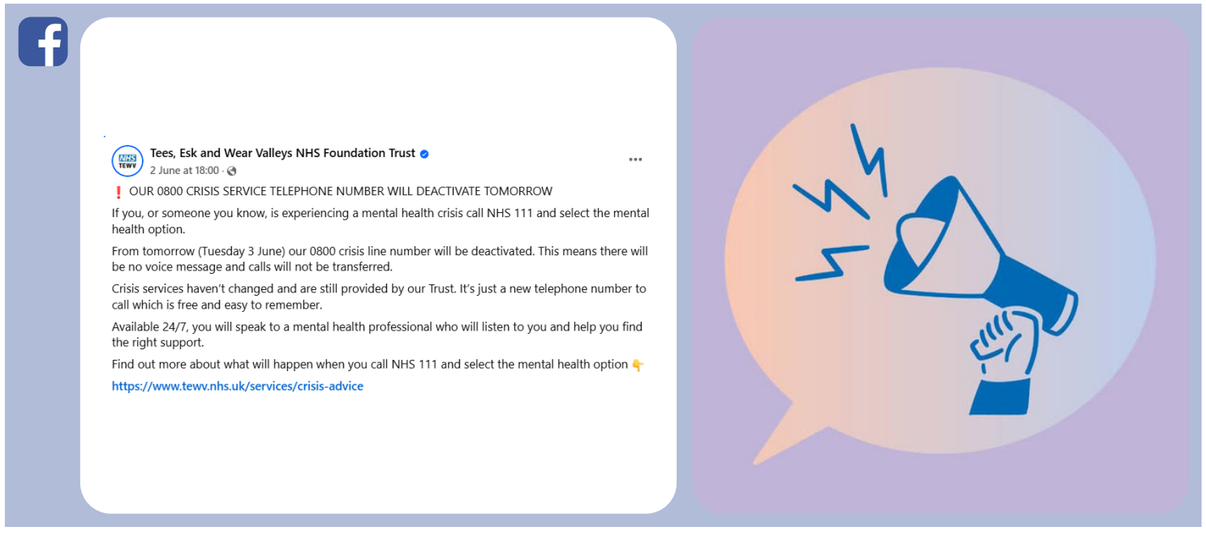
187,613
People who saw our content - impressions

70
Total posts

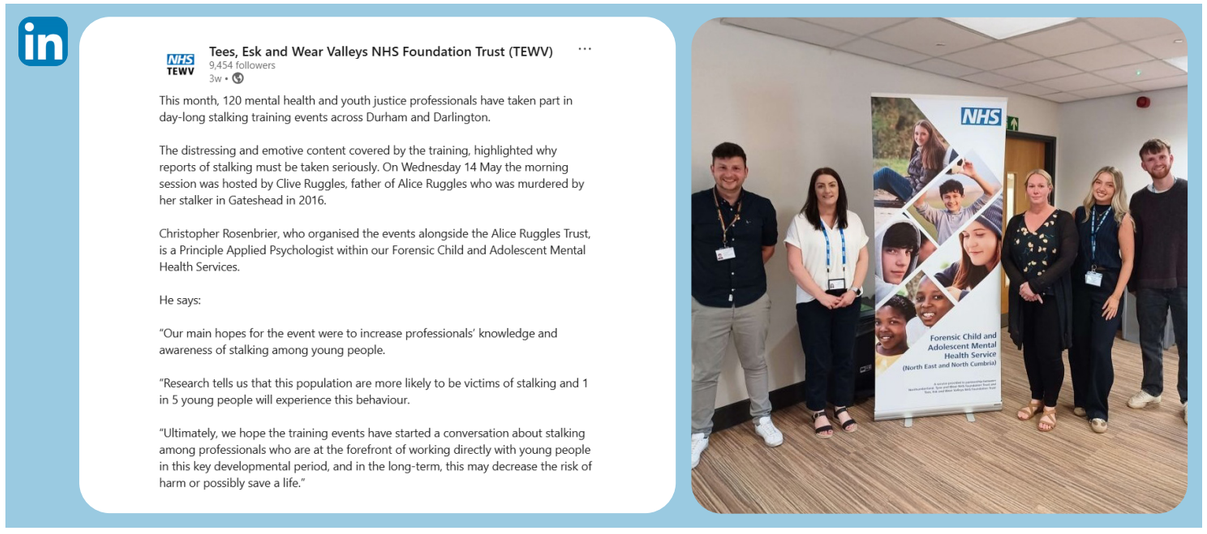
Daily impressions



Top posts



Views 29,564 - Engagement 228



Impressions 2,793 - Engagement 175

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
50
stories posted
~12.5 a week

Email enquires
779
email requests
~26 a day

Team TEWV
staff Facebook group
213
posts
793
comments
2,503
total members
34 new members

All staff emails
18
sent
~4.5 a week

Patient information
8
updated

Policies
105
total policies
279
total procedures and guidelines
6
consultations open
15
revised and published

Freedom of Information requests
36
received
~9 a week
30
responded to
~7.5 a week

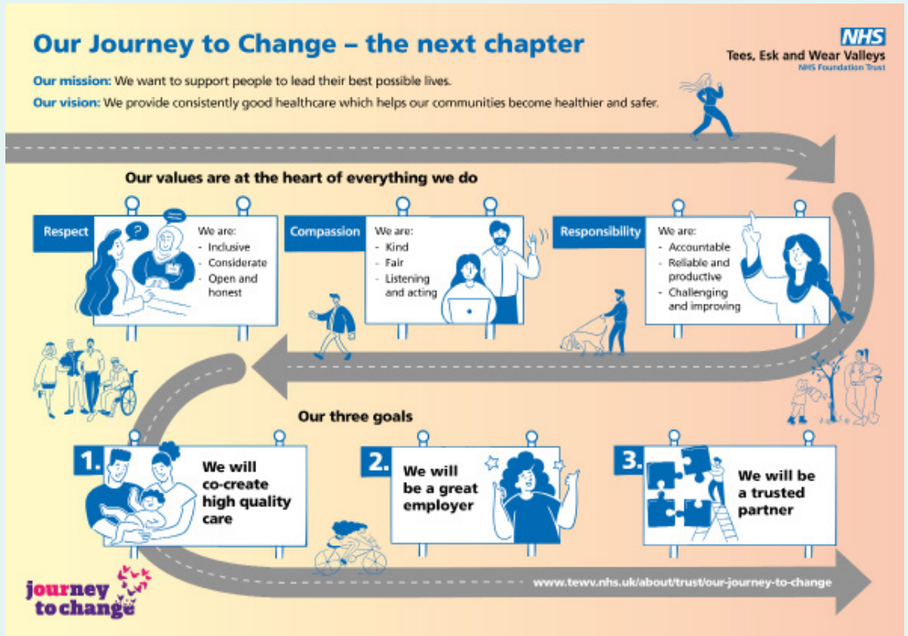
Partner newsletter
11
stories shared

What we're working on

Over the last few months, we've been working on the communications plan to support the next chapter of Our Journey to Change. Due to be shared trust wide and externally from 1 July, the communications will support our strategy refresh with a focus on:

- The significant improvements since the launch of Our Journey to Change in 2021
- How Our Journey to Change has evolved - through reflection and further co-creation our strategy now looks and feels a little different
- Our commitment to continually improving the experience of everyone we support and those we work with and alongside.
- Our future plans and priorities

We'll be sharing communications with our colleagues, people in our care, families and carers, partners and everyone involved with our trust. There's also an ongoing piece of work to update all of the existing narrative and visuals linked to Our Journey to Change. We'll be supporting teams to do this through a planned and gradual process over the next few weeks.



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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NHS Foundation Trust

This month's focus

TEWV 5k, TEWV 10k and TEWV Fun Run

Our very own running events, the TEWV 10k, TEWV 5k and TEWV Fun Run took place in March and April. Hundreds of people of all running abilities entered, with some raising money for charity.

Campaign objectives

Sell out the TEWV 10k 2025 (500 entries)

Outcome: sold 318 entries

Encourage entries to the new TEWV 5k

Outcome: sold 153 entries

Improve the reputation of our Trust by staging two events in 2025 focussed on health and wellbeing

Outcome: high performing social posts, positive feedback and partnership working

How we measured success

Income generation from entries: over £4,000

- TEWV 10k: 318 at £10
- TEWV Fun Run: 40 at £2.50
- TEWV 5k: 153 at £5

Media

Positive media coverage of TEWV 10k runners' stories, launch and post-event in:

- York Press
- Harrogate Informer
- Your Harrogate
- Stray Ferret
- Ilkley Gazette
- Wharfedale Observer

TEWV 5k had positive coverage in the Northern Echo and Darlington Stockton Times after the event.

Partnerships

TEWV 5k took place at HMP Kirklevington Grange Prison which was a great example of partnership working, with prisoners also acting as marshals.

Radio partnership with YO1 Radio for the TEWV 10k which included adverts, social media posts and presenting at the event.

Members of York Mela ran and promoted the TEWV 10k on their Facebook page which formed new community relationships.

Social media

Sue's story and post-event photographs from the TEWV 10k were the 6th and 9th most viewed posts on the TEWV Facebook page in the last 90 days (as of 10 June 2025), with over 20,000 views combined.

Focus on post-event reels and high quality photographs.

- Post-event reels achieved 6.7k views for the 10k and 6.1k views for the 5k
- Photographs reached 9.5k for the 5k and 9.3k for the 10k, with over 30% of people being non-followers of our Facebook page

Humber North Yorkshire ICB attended the TEWV 10k and their video from the day had 900 views on Tik Tok, 250 views on Instagram and 4,700 views on Facebook

Teesside Live posted photographs from the TEWV 5k which had 25 engagements and 4 comments.

Qualitative insights

TEWV 10k

"I thought it was a great event!"

"All of the people who attended as part of the York Mela team found it a really good way to promote the event while doing something fun. We did have people attend the Mela after seeing it at the 10K, which was great!"

TEWV 5k

"Was a fantastic morning, pat on the back to all the amazing runners."

"Well done to all the runners and thanks to all the organisers and volunteers who made it work, fabulous fun."

Considerations for the future

- The 5k and 10k took place within a month of each other so it made it difficult to effectively promote both at the same time
- TEWV 10k took place on Easter Saturday due to limited availability from York Racecourse
- Maintain high quality event, including the medal

Communications Dashboard

July 2025

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Highlights

Co-Creation Week was marked with national webinars, including one about lived experience designed by Liam Corbally

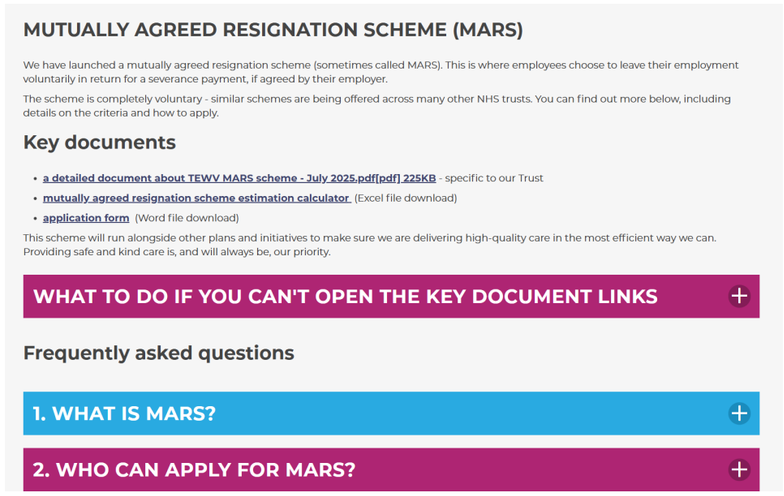
We publicised details of our STOMP team winning two awards in just one week

[A welcome shift from hospital to community](#)

Dr. Ranjeet Shah, group medical director for Durham Tees Valley, shares his views on the NHS 10 Year Health Plan.

Posted Thursday, 3 July 2025
[1 comment](#)

We shared details about the NHS 10 Year Plan, including Dr Ranjeet Shah's thoughts on it



MUTUALLY AGREED RESIGNATION SCHEME (MARS)

We have launched a mutually agreed resignation scheme (sometimes called MARS). This is where employees choose to leave their employment voluntarily in return for a severance payment, if agreed by their employer.

The scheme is completely voluntary - similar schemes are being offered across many other NHS trusts. You can find out more below, including details on the criteria and how to apply.

Key documents

- a detailed document about TEWV MARS scheme - July 2025.pdf[pdf] 225KB - specific to our Trust
- mutually agreed resignation scheme estimation calculator (Excel file download)
- application form (Word file download)

This scheme will run alongside other plans and initiatives to make sure we are delivering high-quality care in the most efficient way we can. Providing safe and kind care is, and will always be, our priority.

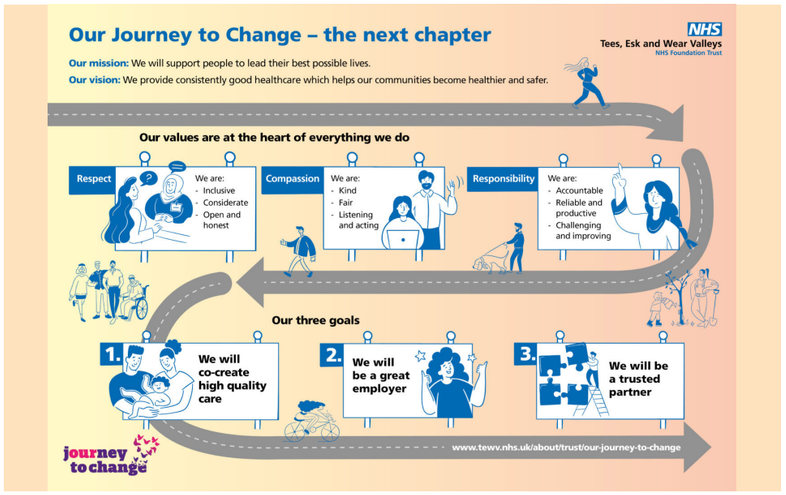
WHAT TO DO IF YOU CAN'T OPEN THE KEY DOCUMENT LINKS +

Frequently asked questions

1. WHAT IS MARS? +

2. WHO CAN APPLY FOR MARS? +

We communicated details of the MARS scheme, with a dedicated intranet page for key documents and FAQs



We updated our co-created strategy, Our Journey to Change, launching the next chapter

We announced the return of our TEWV 10k running event in 2026

Communications Objectives

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	• Good news stories • Continued push for Star Award nominations – over 400 nominations so far • AGM planning • Planning for vaccination campaign
Enhance staff engagement	• Pulse survey communications • Shared an update on the launch of the Government's 10-year health plan • Support and recommendations on Cito communications
Strengthen partnerships	• Council of Governors meeting – included presentations on our communications strategy and our membership communications plan • Met with North East North Cumbria Integrated Care Board communications directors • Met with NHS England communications colleagues on 10-year health plan launch and ahead of planned industrial action • Supported attendance at the Tees Valley Joint Health and Scrutiny committee
Support a culture of co-creation	• A focus on co-creation week • Developed and issued a co-creation newsletter • Personalised care planning communications (finalising animations)
Provide accessible and timely information	• Accessibility campaign • Mutually agreed resignation scheme staff communications • Supported communications requirements for the planned industrial action • Freedom of Information requests

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

5 ↑
Media enquiries handled by the team

4 ↓
Media releases issued

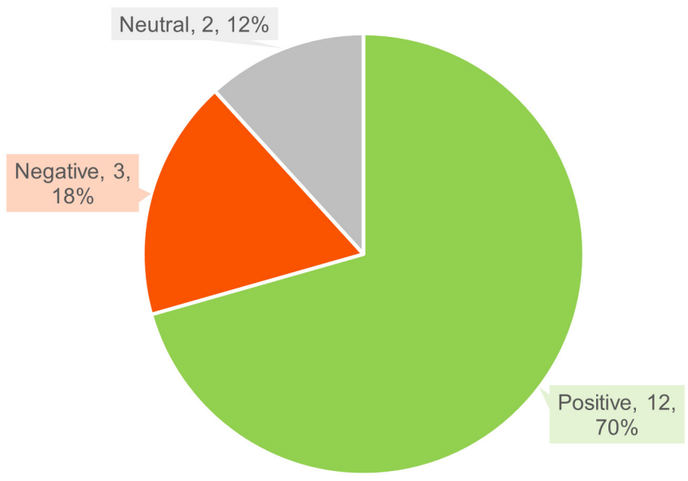
23 ↑
Total pieces of coverage acrossv online news, TV, and radio

Some of our news stories

- **NHS worker swims around Jersey to raise money for County Durham charity -** *Chronicle Live*

  Coverage of Donna Levin inquest - *Northern Echo, Teesside Live and Heart/Capital Radio*
- **Average 618-day wait for adult ADHD assessment –** *BBC News*
- **Augmented reality mental health crisis training app developed –** *Digital Health*
- **CAMHS helping Redcar families ease pressure of life with free essentials –** *Greatest Hits Radio*
- **Two summer exhibitions at Scarborough's Old Parcels Office Artspace dive into the wonders of the deep –** *Scarborough News*

Media sentiment



Our website

37,981 ↓
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

96,002 ↓
page views

Top staff intranet news stories

1. Fun in the sun at retro Ridgeway event
2. Lanchester road hospital opens new simulation suite
3. Lunch and Learn - dual diagnosis

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our audience

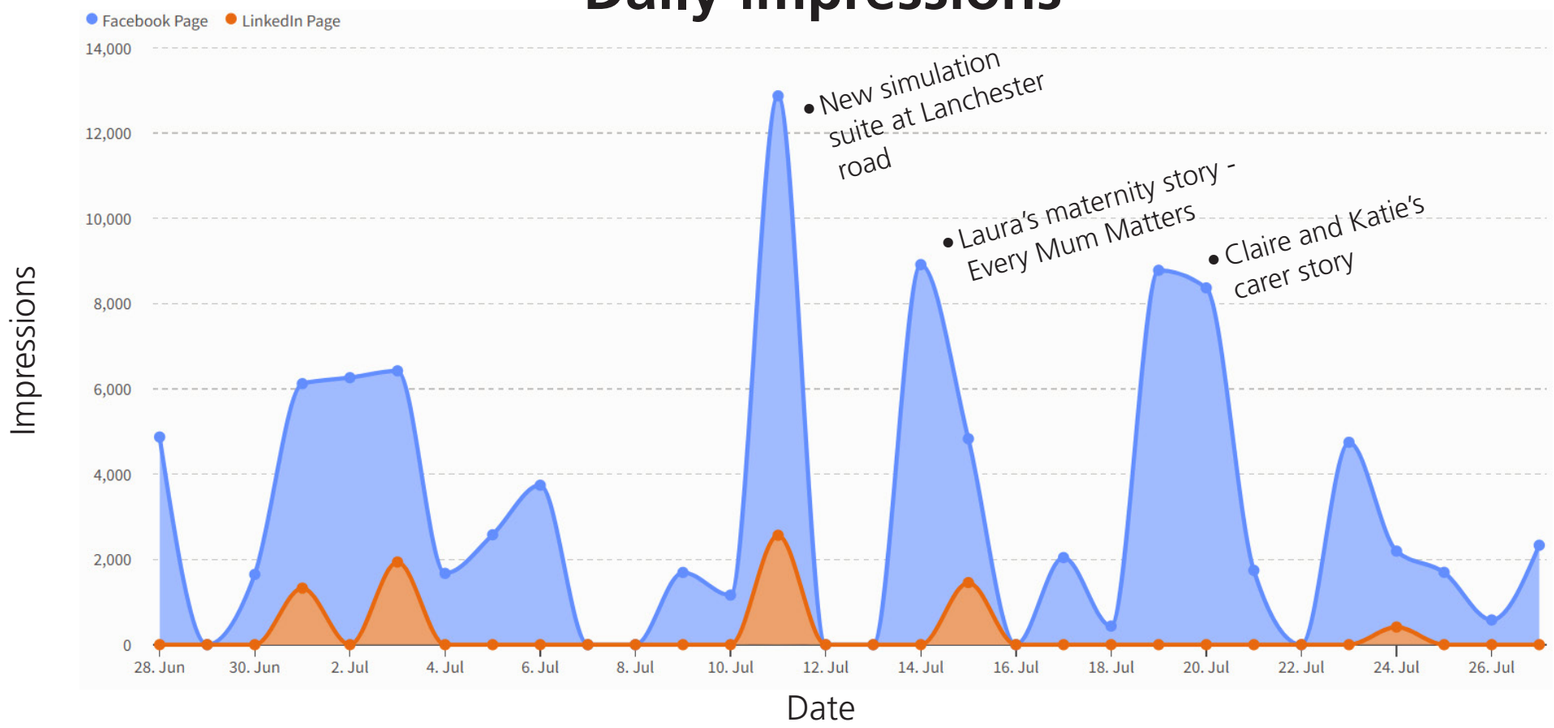
28,797 ↑
Total followers

167 ↓
New followers

95,716 ↓
People who saw our content - impressions

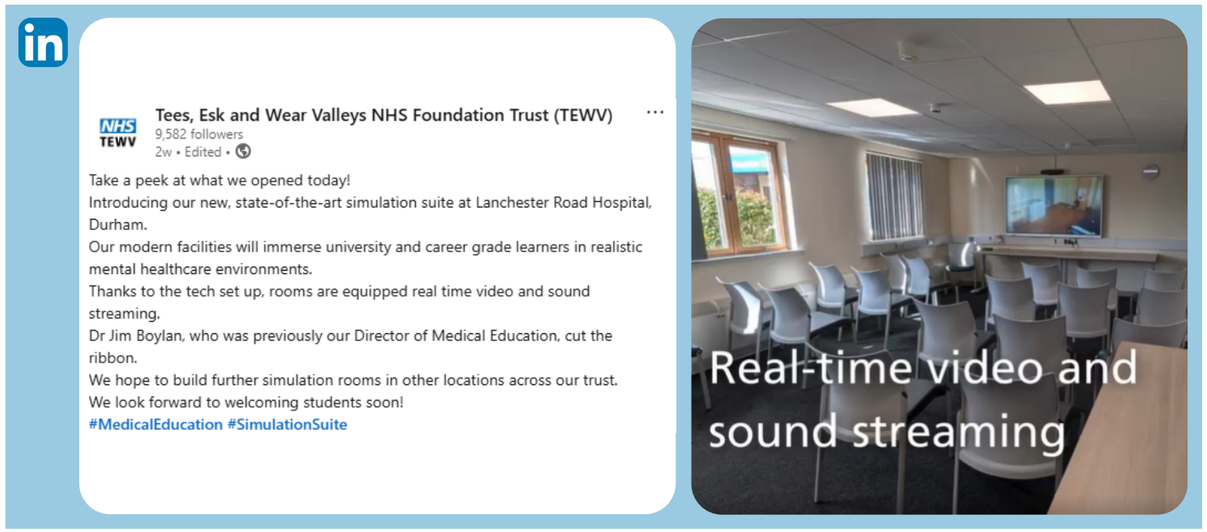
37 ↓
Total posts

Daily impressions



Top posts

Views 15,458 - Engagement 463



Impressions 2,584 - Engagement 298

Our work

NHS
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
28
stories posted
~7 a week

Email enquires
657
email requests
~22 a day

Team TEWV
staff Facebook group
137 posts
329 comments
2,525
total members
26 new members

All staff emails
18
sent
~4.5 a week

Patient information
8
updated

Policies
104 total policies
279 total procedures and guidelines
2 consultations open
14 revised and published

Freedom of Information requests
46 received
~9.2 a week
48 responded to
~9.6 a week

Partner newsletter
16
stories shared

What we're working on

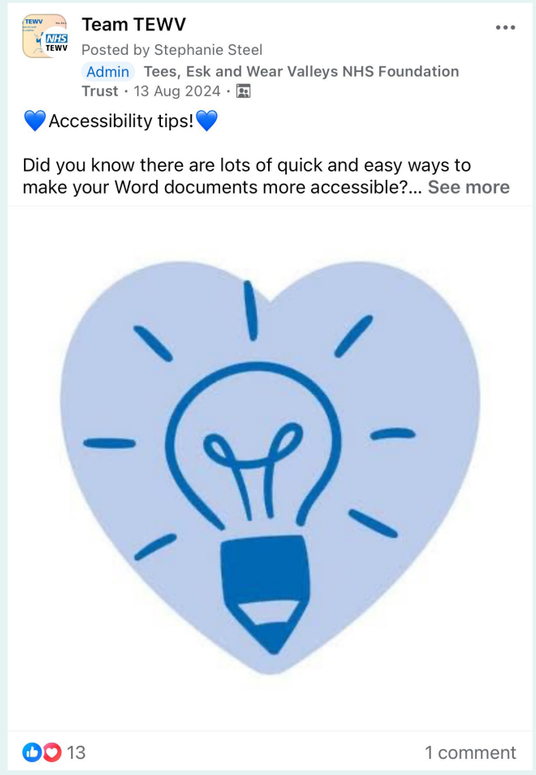
The next phase of our accessibility campaign starts soon and focuses on why sharing information that's easy to understand is so important. We'll share tips, templates and tools so our letters, leaflets and digital messages are easier to understand first time.

Accessibility is always a priority for our team as communicating well helps people get the support they need and complex language creates barriers to care.

The average UK adult reading age is nine, and around half of adults struggle to understand health information which creates health inequalities.

We'll be signposting colleagues to visit the how to make what you write more accessible page on the staff intranet. Our evaluation will focus on how many people visit this page as well as engagement with posts on Team TEWV.

Alongside the campaign we make sure our website is compliant with accessibility legislation and carry out ongoing training on creating accessible information. Our accessibility roadmap sets out our future plans to keep this important work



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

Mental Health Awareness Week
Mental Health Awareness Week (12-18 May) with Mental Health Foundation aims to raise awareness of mental health issues, tackle stigma, and encourage people to prioritize their and others' mental wellbeing. The theme this year was 'Community'.

Campaign objective

Raise awareness of mental health and wellbeing by posting content on Facebook and reaching 1,000 viewers.

Outcome: high performing social posts, positive feedback and partnership working

How we measured success

- 22 pieces of content generated and shared across web, intranet, internal comms channels and social media
- 3 pieces of content covered by press
- An engaged social media audience (including non-followers)
- Good balance of stories captured from across our Trust's wide geographical area
- Achieved objectives to increase social media reach, which evidences the impact of the campaign
- Clear focus on the theme of community, with content planned for every day of the week
- Staff happy for their content to be shared externally

Facebook

In last 28 days (2 May – 29 May):

- There were 27,004 views of our content, our content reached 21,011 people and there were 216 interactions with our content (such as 'likes')
- The most viewed post on the Trust's Facebook page had 6,299 views (51% were non-followers), with a reach of 7,512 and 63 interactions
- Internally on Team TEWV, there was a reach of 6,235 and 319 post engagements (likes, etc)

Top Facebook posts	Views	Reach	Interactions
North Yorkshire Talking Therapies	6,299	7,512	63
Wear It Green Day	6,184	3,764	60
Roseberry Park feel-good fest	3,178	2,322	34
It's Mental Health Awareness Week	3,313	1,749	14
Mental Health Awareness Week round-up	2,978	2,566	19
Recovery College Online	2,618	1,615	15
John's story	2,434	1,483	11

Qualitative insights

"Talking is the very first step to feeling truly heard, understood and not alone. Everyone needs that, however strong. Pick up the phone and see how the team can help."

"Such an important part of people's overall wellbeing – amazing feedback on the impact this service makes to people's lives."

"So proud to be part of this team."

"It's really exciting hearing all about what you will be up to this week. Good luck with all those wonderful activities."

"Great advice."

"It really helped my mum. Thank you. Mum is aware of TEWV now."

Considerations for the future

- Opportunity to create a bespoke website landing page for future weeks
- Encourage more staff to post on Team TEWV
- More personal stories – create the greatest impact and secure coverage
- Encourage more services across the Trust to provide stories or content
- Collaborate with stakeholders for support and more content (if needed)

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